2009 SENATE HUMAN SERVICES

SB 2044

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2044

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-12-2009

Recorder Job Number: 6798

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened the hearing on SB 2044 relating to the moratorium on expansion of basic care bed capacity and the moratorium on expansion of long-term care bed capacity. There is no fiscal impact.

Maggie Anderson, Director of Medical Services for the Dept. of Human Services, appeared in support of SB 2044. Attachment #1.

Senator J. Lee asked Ms. Anderson to recap what was done with the moratorium.

Maggie Anderson said that the moratorium essentially prohibits any new nursing home beds being added to the capacity. It does allow basic care beds to be added contingent upon criteria that are set forth.

Senator Heckaman asked if there has been a drop in the long term care beds.

Ms. Anderson replied that the Turtle Mtn. tribe had a number of nursing home beds which they had to get up and be licensed within 48 months from the point they received them. They were unable to complete that and some of those beds were sold and some went out of service. Aside from that specific situation, she said, they are not aware of anyone delicensing beds. They are finding someone who wants to buy them.

Senator J. Lee cited examples of Good Samaritan Centers moving beds from rural to urban locations.

Ms. Anderson also stated that the Dept. supports the four year extension.

Senator Dever asked if empty beds cost the state.

Barb Fischer, Assistant Manager of Budget and Operations for Medical Services with Dept. of Human Services, took the stand to answer the question. She explained that the rate setting mechanism used to pave the rates for all individuals including private pay individuals is a calculation based on costs divided by census. Even though there are additional beds, if there are costs associated with those vacant beds, it will be paid for by the rates of the other individuals. As the occupancy drops the rate goes up.

Shelly Peterson, President of the ND Long Term Care Association, testified in support of SB 2044. See attachment #2. She also explained that there are three issues why some rural facilities are getting rid of beds (1) staffing crises (2) financial viability (3) majority of residents are overflow from larger communities.

Senator Dever said there had been discussion about the possibility of just making the moratorium permanent, but it seemed to him that it is important to take a look at it every once in a while just to see where they are.

Shelly Peterson said the interim committee did a lot of deliberation and talked about the issues in the four cities and she thinks they came up with a good bill draft to extend it four years and then revisit the issue.

Opposing testimony from **Carol Johnson** who was unable to appear in person was entered into the record. See attachment #3.

Attachment #4 is neutral information from **Sheila Sandness**, Fiscal Analyst for the Legislative Council.

The hearing on SB 2044 was closed.

Senator Erbele moved a Do Pass on SB 2044.

The motion was seconded by **Senator Dever.**

Roll call vote 6-0-0. Motion passed.

Carrier is **Senator Erbele.**

FISCAL NOTE

Requested by Legislative Council
12/08/2008

Bill/Resolution No.: SB 2044

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill would amend and reenact the NDCC section relating to a moratorium on the expansion of basic care bed capacity.

This bill would also amend and reenact the NDCC section relating to a moratorium on the expansion of long-term care bed capacity.

There is no fiscal impact.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	12/11/2008

Date: 1-12-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2044

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Erbele

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2044: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2044 was placed on the Eleventh order on the calendar.

2009 HOUSE HUMAN SERVICES

SB 2044

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SB 2044**

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **4 March 2009**

Recorder Job Number: 10166

Committee Clerk Signature Jean Prindle

Minutes:

Chairman Weisz opened the hearing of SB 2044.

Barbara Fischer, assistant director of the Medical Service Division for the DHS testified in favor of the bill. **(Attachment 1)**

Representative Porter: We are going through legislative session rather than just the one. Is there any particular reason?

Fischer: I believe when they looked at this and it had been extended every time that the Legislature still has the opportunity next biennium to change that. This way it would not have to come up again next session.

Representative Porter: Last time the dates were removed and we thought it was permanent. We thought looking at it every two years was just fine and dandy.

Maggie Anderson, medical services divisions: That was the decision of the interim long-term care committee. It was not a department decision.

Representative Porter: When we did the bed buy back with the IGT funds, how many beds were taken out of service across the state?

Fisher: I believe it was 239 beds. At that time there was $I believe it was 239 beds. At that time there was $4 million appropriated for the bed buy out and we did not spend all of it. The transfer was a 2:1, but the buyout was 1:1.

Representative Porter: When we looked at this in the past there was always concern about moving people across the state and the lack of long-term care skilled beds in urban areas and more openings in rural areas. We have seen where the closest nursing bed to Bismarck has been 80 -100 miles away for a lot of the time. From a population standpoint we are always talking about numbers, what is the Department's take on counties for area for their population of long-term care beds per 1000 people over the age of 65?

Fischer: We would have no opinion on the number of beds per county. It would be the number of beds in the state. There is construction going on in Bismarck right now to add long-term beds.

Chairman Weisz: We are now at about 95% utilization of beds. What's the department's magic number that would be idea utilization for efficiency and availability of beds?

Fischer: That has been consistent for a number of years. As the licensed capacity drops, we have basically been very close to 92-95% on occupancy. We do use 95% occupancy.

Shelly Peterson, president of ND Long-Term Care Association, testified in favor of the bill. **(Attachment 2)**

Chairman Weisz: What is your position—we are at 95% utilization rate and you already indicated that we have a maldistirubtion beds. In prior testimony you said there were 8 beds for sale across the state. What do you think is the ideal utilization rate in the state?

Peterson: Throughout the years beds will generally become available for sale. What happens is that rural facilities have occupancy issues and through their planning inevitably there will be beds for sale. We support what the state health council came up with in 1996—

60 beds per 1000 over 65. We have fewer people going to institutions presently. We have been maintaining people's health and independence for longer periods of time. What we believe will be a better model for the future is absolutely we need skilled facilities. Do we need them in every community and can we staff them in every community—absolutely not. We will probably have more closures in this next two-year period of time. There are levels of care that are not so staff intensive. There is assisted living and there is basic care where you don't have the federal requirement of skilled nursing care. So there are options for rural communities to better meet their needs. We have a federal grant of $8.9 million to expand in-home services. There are a lot of changes on in the system so we do not have the heavy reliance on skilled care in the future.

Chairman Weisz: At what point would you say we are exceeding a proper utilization rate of our skilled cares.

Peterson: For each community it is going to be different. Right now in Bismarck we have a great demand and we need beds. It is hard to say because of the staffing issues in rural ND we have communities drying up and we have facilities sitting out there that may not be there in the future. Is the 100% plus in Bismarck acceptable—No. We have the Benedictines and Good Sam bringing in two facilities. It will take 18 months to build those facilities. When we bring those 300 beds out of rural ND into the four major cities, we will be in a much better position to meet the needs of people. It is not that there is not a demand and need but we don't have staff to deliver the care. We are absolutely in a staffing crisis.

Representative Conrad: When the facilities get the money for selling a bed what do they do with it?

Peterson: Generally use it for remodeling for changing the term of care.

Representative Conrad: Are we taking the money we are saving from these beds and putting that in to home and community based service? What incentives are there for home services?

Peterson: We are in front of Senate Appropriations right now to get money for assisted living. Right now that is 100% private pay market. Low income people do not have access to that level of care. There has been movement to enhancing and improving and increasing spending in that area to better meet needs of people.

Representative Porter: With the addition of the 300 beds in 2009 into the Bismarck market, what does that put the %age per thousand at for Bismarck/Mandan?

Peterson: Those figures were just updated and I will have to get that for you. It was done for the region but I can ask them to pull out the Bismarck/Mandan area.

Representative Porter: Can you do that for the four largest cities?

Peterson: We have to use the entire counties population as well as the entire counties bed count. We can't really get a true picture of the metropolitan area. I can ask if they can pull that out.

Representative Porter: We go through this each session. I see this happen when we transport these patients to nursing homes in Garrison and to the nursing home in Wishek and standing there watching their 60-65 sons and daughters saying good bye for the last time because they have no way to visit mom and dad now because of this displacement. At some point we have to take in to place the displacement this causes those families because what we are doing isn't right and it's not in the best interest of the patient. This is broken and we have to find a way to get this to work.

Peterson: I hear you and I hope we are fixing it.

Opposition:

Carol Johnson, ND Citizen, testified in opposition to bill. **(Attachment 3)**

Rose Marie Birrenkott, testified in opposition to bill. **(Attachment 4)**

Submitting testimony in opposition but not appearing: **Dawn Hopkins (Attachment 5)**

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2044

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 23, 2009

Recorder Job Number: 11384

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's look at 2044 the nursing home moratorium.

Rep. Porter: This issue affects the entire elderly population across the state and every session that does come up and every session there are (inaudible) changes and everything that is done in-between and we are constantly hearing from families talking about displacement just because of the way the system is set up. So I do think this is important enough of an issue that is brought up every session.

Rep. Porter: Move to amend this bill on page 1, line 9, instead of 2013 that it be 2011. And on page, line 4 the same thing.

Rep. Hofstad: Second.

Chairman Weisz: I guess I would support that motion because I think we are running into issues that are coming more apparent and I realize the long term care industry likes the moratorium now because it is (inaudible) which works very well for them. We've reached a point where it is quite a commodity trading these beds. I would hope we would take a look at this again. Larger communities have increasing demands and small communities that are struggling to stay alive.

Rep. Conrad: I agree.

Rep. Hofstad: I to agree that this is the right direction. The problem I have is that we come back here in 2011 in the next session and we don't have any direction. Shouldn't we find some kind of a vehicle to find some kind of a recommendation to look at this thing again. I suspect there are some issues we could resolve before next session.

Chairman Weisz: You make a good point. I agree with you. We could have a study and maybe we need a study.

Rep. Hofstad: This will be upon us again.

Rep. Conrad: Maybe we need to link PACE with the nursing homes and wouldn't have to worry about beds. That might be a way to do something new and different.

Rep. Frantsvog: A (inaudible) to a study may be based on the value of beds.

Chairman Weisz: Let's take a moment on this motion.

Voice Vote: 13 yeas, 0 nays, 0 absent.

MOTION CARRIED ON AMENDMENTS.

Rep. Porter: Maybe we should hold this until this afternoon and have Jason pull out last session's bill on the moratorium that had the study language in it and just put that same language back in.

Chairman Weisz: We can sure do that.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2044

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 23, 2009

Recorder Job Number: 11427

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: We will call the committee back to order. Let's start out with 2044; we have some language for the study. **See attachment #1.**

Rep. Hofstad: Move the amendment.

Rep. Porter: Second.

Chairman Weisz: Discussion on the amendment. We are adding the study to the moratorium. No discussion.

Voice Vote: 13 yeas, 0 nays, 0 absent.

MOTION CARRIED.

Rep. Hofstad: Move a Do Pass as Amended.

Rep. Conrad: Second.

Rep. Uglem: Do we want Michelle to study or do we want the option open?

Chairman Weisz: Even Michelle is still (inaudible) Legislative Council (inaudible).

Roll Call Vote: 13 yes, 0 no, 0 absent.

MOTION CARRIED DO PASS AS AMENDED.

BILL CARRIER: Rep. Kilichowski.

Proposed Amendment to Senate Bill 2044

Page 2, after line 7, insert:

"SECTION 3. LEGISLATIVE COUNCIL STUDY-LONG TERM CARE. During the 2009-10 interim, the legislative council shall study the state's long-term care system including capacity, geographical boundaries for determining capacity, the need for home and community-based services, a methodology to identify areas of the state which are in need of additional skilled nursing facility beds, access, workforce, reimbursement, and payment incentives. The legislative council shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly."

Date: 3-23-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2044

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. HOFSTAD Seconded By Rep. PORTER

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) 13 No 0

Absent 0

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

accept amendment

Adopted by the Human Services Committee
March 23, 2009

YR
3/24/09

PROPOSED AMENDMENTS TO SENATE BILL NO. 2044

Page 1, line 4, after "capacity" insert "; and to provide for a legislative council study"

Page 1, line 9, replace "2013" with "2011"

Page 2, line 4, replace "2013" with "2011"

Page 2, after line 7, insert:

"**SECTION 3. LEGISLATIVE COUNCIL STUDY-LONG TERM CARE.** During the 2009-10 interim, the legislative council shall study the state's long-term care system including capacity, geographical boundaries for determining capacity, the need for home and community-based services, a methodology to identify areas of the state which are in need of additional skilled nursing facility beds, access, workforce, reimbursement, and payment incentives. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly."

Renumber accordingly

Date: 3-23-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2044

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. PORTER Seconded By Rep. HOFSTAD

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Voice

Total (Yes) 13 No 0

Absent 0

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

To Amend
Pg 1 line 9
Change 2013 to 2011
& same thing on
page 2 line 4

Date: 3-23-09
Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep. Hofstad Seconded By Rep. Conrad

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) 13 No 0

Absent 0

Bill Carrier Rep. Kilichowski

If the vote is on an amendment, briefly indicate intent:

Motion Carried
Do Pass as amended

REPORT OF STANDING COMMITTEE

SB 2044: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2044 was placed on the Sixth order on the calendar.

Page 1, line 4, after "capacity" insert "; and to provide for a legislative council study"

Page 1, line 9, replace "2013" with "2011"

Page 2, line 4, replace "2013" with "2011"

Page 2, after line 7, insert:

"**SECTION 3. LEGISLATIVE COUNCIL STUDY-LONG TERM CARE.** During the 2009-10 interim, the legislative council shall study the state's long-term care system including capacity, geographical boundaries for determining capacity, the need for home and community-based services, a methodology to identify areas of the state which are in need of additional skilled nursing facility beds, access, workforce, reimbursement, and payment incentives. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly."

Renumber accordingly

2009 SENATE HUMAN SERVICES

CONFERENCE COMMITTEE

SB 2044

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2044

Senate Human Services Committee

☒ Check here for **Conference Committee**

Hearing Date: 4-15-09

Recorder Job Number: 11863

Committee Clerk Signature Mary K Monson

Minutes:

Senator Erbele opened the conference committee on SB 2044. All members were present. Senator Erbele, Senator J. Lee, Senator Pomeroy, Rep. Pietsch, Rep. Porter, and Rep. Kilichowski.

Rep. Pietsch said the House committee felt it was time to do a long term care study. They felt everything in the section should be looked at. One of the big items is geographical – how many are needed in what section of the state. They changed the date from 2013 to 2011 because they would be reporting back in the 62nd. Something could be done then instead of waiting until 2013.

Senator Erbele asked if she felt they are deficient in all the information they do have in terms of bed capacity, where they are located, where the population is. What is missing?

Rep. Porter replied. The one area that seems to come up every session especially in the Bismarck/Mandan area is that they are running at 100 plus % of capacity. It's displacing a number of families and family members to other areas such as Garrison.

At one point back last session it was reported back to the House that 45% of the occupancy in Garrison were Bismarck/Mandan residents. That meant to have family visitation, someone has to drive 80 miles one way. It's like a staging area to go on a waiting list and go to Garrison,

Ashley, or Wishek and when the bed opens up come back to Bismarck/Mandan. Over the next 18 months in the Bismarck/Mandan area there is going to be some significant changes in capacities. The demand is also moving up but they don't know if the bed numbers will keep up with the demand numbers. Minot made up the other 45% of Garrisons occupancy.

Senator Erbele stated that they have identified the problem and asked if they are hoping the study would say they would need to lift the moratorium.

Rep. Porter said they had plenty of discussions about the moratorium and didn't think anybody felt it should be lifted. There was a lot of general House discussion that in certain areas it might have to be adjusted so it truly reflects the demand of that area and doesn't have to go out to an 80 mile radius in order to get those beds. Some areas have plenty of beds for their demand—Bismarck/Mandan does not—Minot is a little short.

One of the unintended consequences of the moratorium was that it put a bounty on the beds and it made them an asset for sale. Some are holding out for more money even though the bed hasn't been occupied.

Is the 90% occupancy before they are penalized on their Medicaid reimbursement the right number to maybe force them into maybe moving some of the beds into areas where they are needed? It doesn't do any good to have 45% occupancy in the Garrison nursing home from Bismarck when those families don't care to be there.

Senator J. Lee had some reservations about where this all heads. We are still way above what the recommended amount of beds is per thousand for people in skilled care. The emphasis is to move more toward basic care. She pointed out that a shortfall isn't unique to Bismarck/Mandan. It has been that way in her area also. She also had a concern about the budget impact if they looked at addressing the moratorium especially if they look at dividing geographical boundaries up.

She said that maybe this can tie in with basic care and assisted living. There has never been a study on that and there has been an enormous increase in that kind of service provision. There was discussion on the situation at Steele (HB 1327) and that it doesn't violate the moratorium.

Richardton is the critical access designation and was discussed. It fits into this study because of the payment incentives and what is allowed for local tax dollars to be used to buy increased payments from the federal government.

Rep. Porter – there are little pieces all over with long term care from basic care and assisted living to Richardton to staffing issues to the geographical boundaries currently being used that brought together the study.

Senator Pomeroy pointed out that the beds from Steele went to Mandan. It seemed to him that the moratorium is working. They have worked hard to keep the moratorium and make it as good as possible realizing at the same time that it won't be perfect for every situation.

Senator J. Lee asked the House to elaborate on the geographical boundaries and where they were headed with it.

Rep. Porter replied that was the mapping system that came from the Department of Health and how they do the boundaries to determine the beds per thousand individuals over 65. To say what Bismarck/Mandan bed capacity was for that population they were going out 70-80 miles. How far out should that boundary be drawn to be counted into a metropolitan statistical area for beds per thousand? It's way different using MSA than using the health department. One shows a great need and one shows everything is fine.

Senator J. Lee pointed out that the health department isn't going to be concerned with the moratorium. They are just looking at beds per miles whereas the Dept. of Human Services

has to deal with the Medicaid program and its relationship to long term care. They're the ones who are involved with the moratorium. There is an overlap of departments.

Senator Erbele – as a legislature we wouldn't set boundaries anyway would we?

Rep. Porter – it's definitely from the needs of the citizens inside those areas. It's where a lot of the concern comes from.

Senator Erbele asked if there had been conversations with the facility administrators on these issues and if they came with needs for a study to address these particular areas. Is that where this came from?

Rep. Porter said a lot of it came from all the bills that were dealt with from Richardton to Steele and from the public input on the bills.

Senator Erbele – Do you feel there are more Richardton's and Steele's out there to concern ourselves with in the future?

Rep. Porter replied that he believed there were.

Senator J. Lee thought everyone was on the same page trying to accomplish what needs to be done. She asked if it would be worth looking at blending this with the assisted living/basic care bill (HB 1263).

Rep. Porter said the study is also to see if the 90% mark is the right number or if the incentive payment or penalty part should kick in at a higher rate so some of the beds are moved to areas where they are needed.

Senator Erbele said they would meet again and look at the possibility of doing some blending with the two. He also wanted to visit with administrators from his district.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2044

Senate Human Services Committee

☒ Check here for Conference Committee

Hearing Date: 4-17-09

Recorder Job Number: 11923

Committee Clerk Signature Mary K Monson

Minutes:

Senator Erbele brought the conference committee on SB 2044 to order. All members were present.

Rep. Pietsch said that next year (2010) is census time so there will be all new data. That would push to do the study. Because of this the House was willing to recede from that part of their amendments. They wanted to see it come back in 2011 so they can looked at it and decide if and what kind of a study should be done.

Rep. Pietsch made a motion that the **House Recede from House amendments and amend as follows** to maintain the date of 2011.

Second by **Senator J. Lee**.

A short discussion followed that when this information is brought forward in two years it will be beneficial to consider doing something at that time. The data will be there at that time. Baby boomers will be looking at things differently for themselves and their parents.

Roll call vote 6-0-0. Motion carried.

Senate carrier is Senator Erbele. House carrier is Rep. Pietsch.

Date: 4-15-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2044 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ pages(s) _____--_____

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

Motion Made By _____ Seconded By _____

Senators				Yes	No		Representatives				Yes	No
Senator Erbele	P						**Rep. Pietsch**	P				
Senator J. Lee	P						**Rep. Todd Porter**	P				
Senator Pomeroy	P						**Rep. Kilichowski**	P				

Vote Count _____ Yes _____ No _____ Absent

Senate Carrier _____ **House Carrier** _____

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

Adopted by the Conference Committee
April 17, 2009

4-17-09

PROPOSED AMENDMENTS TO SENATE BILL NO. 2044

That the House recede from its amendments as printed on page 1029 of the Senate Journal and page 1055 of the House Journal and that Senate Bill No. 2044 be amended as follows:

Page 1, line 9, replace "2013" with "2011"

Page 2, line 4, replace "2013" with "2011"

Renumber accordingly

Date: 4-17-09

Roll Call Vote #: _____

2009 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2044 as (re) engrossed

Senate Human Services Committee

☒ Check here for **Conference Committee**

Action Taken
- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House Amendments
- ☒ HOUSE recede from House amendments and amend as follows

Senate/~~House~~ Amendments on SJ/HJ pages(s) 1029 --_____

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) 2044 was placed on the Seventh order of business on the calendar.

Motion Made By Rep Pietsch Seconded By Sen. J. Lee

Senators				Yes	No		Representatives				Yes	No
Senator Erbele	P			✓			**Rep. Pietsch**	P			✓	
Senator J. Lee	P			✓			**Rep. Todd Porter**	P			✓	
Senator Pomeroy	P			✓			**Rep. Kilichowski**	P			✓	

Vote Count 6 Yes 0 No 0 Absent

Senate Carrier Sen. Erbele **House Carrier** Rep. Pietsch

LC NO._____._____ of amendment

LC NO._____._____ of engrossment

Emergency clause added or deleted_____

Statement of purpose of amendment_____

REPORT OF CONFERENCE COMMITTEE

SB 2044: Your conference committee (Sens. Erbele, J. Lee, Pomeroy and Reps. Pietsch, Porter, Kilichowski) recommends that the **HOUSE RECEDE** from the House amendments on SJ page 1029, adopt amendments as follows, and place SB 2044 on the Seventh order:

That the House recede from its amendments as printed on page 1029 of the Senate Journal and page 1055 of the House Journal and that Senate Bill No. 2044 be amended as follows:

Page 1, line 9, replace "2013" with "2011"

Page 2, line 4, replace "2013" with "2011"

Renumber accordingly

SB 2044 was placed on the Seventh order of business on the calendar.

2009 TESTIMONY

SB 2044

#1

Testimony
Senate Bill 2044 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 12, 2009

Chairman Lee, members of the Human Services Committee, I am Maggie Anderson, Director of Medical Services for the Department of Human Services.

I am here today in support of SB 2044. The moratorium for nursing facilities and basic care facilities has been in place since 1995 and has been extended each biennium. Throughout the interim, the Department has been in contact with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility and basic care beds that are being shifted through the state. The Department's 2009-2011 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

I would be happy to address any questions that you may have.

Testimony on SB 2044
Senate Human Services Committee
January 12, 2009

Good Morning Chairman Lee and members of the Senate Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent assisted living facilities, basic care facilities and nursing facilities in North Dakota. I am here to testify in support of SB 2044 regarding the basic care and nursing facility moratorium on expansion of beds.

SB 2044 proposes to continue the basic care and nursing facility licensed bed moratorium until July 31, 2013. Without this legislation the moratorium would cease to exist on July 31, 2009, and anyone could build a basic care or nursing facility. We support continuing the moratorium for three reasons:

1. North Dakota is considered to still have a high bed count when you consider the beds per one thousand elderly. North Dakota is currently at 68.9 beds per thousand elderly and the United States average is 49.3. At this point in time, this is still the best yard stick for measuring need and excess capacity. (See Attachment A and Attachment B)
2. The fiscal note to expand facilities beyond our current bed count would be astronomical. Even with the beds decreasing, the nursing facility budget increases an average of 9% every biennium. This has been the rate of increase since the 97-99 biennium. (See Attachment C)
3. The desire of individuals to receive care and services within their own homes, thus any expansion of services should be at that sector rather than at the institutional sector. (See Attachment D and Attachment E)

Past legislative bodies have recognized that a mal-distribution of beds has occurred. In essence, beds may not be in the area where the greatest demand exists. For example, today the four major cities have a population of 263,677

which is 41% of North Dakota's overall population. At the same only 32.6% of the nursing facility beds are located in the four area cities. To address the potential mal-distribution you have authorized the buying, selling and relocation of beds.

First you allowed a two for one sale, meaning in order to sell one bed, you also needed to "give-up" one bed. The bed that was "given up" left the system never to be licensed again. That process removed beds from the total count, as well as allowed for a redistribution of beds. This process occurred for a number of years, until we requested that anyone be allowed to sell and move their beds without giving any up.

In 2001, you also authorized a nursing facility bed buyout program. Again the purpose of the program was to get rid of the perceived excess capacity. Under the program the Department of Human Services would make a quarterly request for bed buyout offers. The Department would pay up to $15,000 per licensed nursing facility bed if the facility closed, up to $12,000 per licensed nursing facility bed if the facility closed at least eight beds or more and up to $8,000 per licensed nursing facility bed if the facility reduced its capacity by seven or fewer beds. The buyout program operated through June 30, 2003. In the end, two facilities closed (New Town-30 beds and Bottineau-32 beds) and a total of 286 beds were reduced from the overall bed count. The total dollars expended for the state to purchase and remove the 286 beds from the system cost $3,435,874. (See Attachment F)

Today, beds are being relocated through the process of buying and selling. For the most part, rural facilities are selling their beds and their urban counter parts are bidding and buying the beds. This allows beds, which may have been sitting empty, to move to areas where they are in greatest demand. This has allowed rural nursing facilities the ability to obtain cash for their "empty" beds, urban areas to better meet the demand for more beds, the state not to expend

additional dollars over the current bed count and the citizens of North Dakota to have access to a more balanced continuum of care.

Once you buy a bed, you are allowed four years to license that bed and put it in service. Whoever owns the beds controls whether they will be sold. This process seems to work well. From January 1, 2009 through the fall of 2010 we will have over 300 rural beds move into the four major cities. (See Attachment G) Only once have we had an entity buy beds and not put them in service within the four year period of time. As you may recall, it was the Turtle Mountain Band of Chippewa Indians that found themselves in that difficult situation. When it was determined they were not able to put their beds in service they quickly worked to sell their beds to other nursing facilities, who then still needed to license those beds within the original forty-eight month process. The Turtle Mountain Band of Chippewa Indians was able to re-sell the majority of their long term care beds.

Today we have another facility that may hit up against the requirement to put the beds in service within forty-eight months. The Benedictine Living Community is constructing a new seventy-one bed nursing facility in Bismarck. The land is purchased and they are slated to begin construction in the spring of 2009. Thirty of their seventy-one beds must be licensed by June of 2010, which allows for only a thirteen to fourteen month construction time.

In 2001 when you authorized the bed buyout program you also gave nursing facilities the authority to convert any or all of their skilled nursing facility beds to basic care beds. This flexibility was allowed and aimed at rural facilities where a gap in care was perceived. Some individuals were seeking admission to the nursing facility, did not meet the skilled criteria and remaining at home was not working. The solution was to allow nursing facilities to convent a portion of their skilled capacity to basic care. Under the 2001 provision, facilities are allowed to:

1. Convert beds once a year,
2. Must convert a minimum of five beds,

3. Allowed to covert basic care beds back to skilled after one year,
4. Can sell the converted basic care beds to anyone, however the new owner does not have the authority to convert their new basic care beds back to skilled.

As of May 2008, nursing facilities that were using this provision included:

Facility	Location	Number of Beds
Southwest Health Care Services	Bowman	5
Four Seasons Health Care	Forman	5
Good Samaritan Society - Mott	Mott	9
Good Samaritan Society – Osnabrock	Osnabrock	6
St. Catherine's Living Center	Wahpeton	16
Pembilier Nursing Center	Walhalla	13
Total		54

We believe the moratorium, which allows for the buying and selling and relocation of beds is the most prudent public policy for the state and its citizens. We believe removing the moratorium and expanding the total number of facilities or beds is not the right direction for North Dakota at this time.

Thank you for the opportunity to testify regarding SB 2044. I would be happy to answer any questions you may have.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street • Bismarck, ND 58501
(701) 222-0660 • www.ndltca.org • E-mail: shelly@ndltca.org

#2

Nation Wide Report on Nursing Facility Beds Per 1,000 Elderly

Attachment A

State	Population 65+	Total Beds	NF Beds Per 1,000 Elderly
AK	35,699	725	20.3
HI	160,601	3,890	24.2
AZ	667,839	16,405	24.6
NV	218,929	5,439	24.8
OR	438,177	12,749	29.1
FL	2,807,597	82,240	29.3
NM	212,225	6,923	32.6
WA	662,148	22,635	34.2
CA	3,595,658	127,051	35.3
SC	485,333	18,333	37.8
WV	276,895	10,936	39.5
MI	1,219,018	48,239	39.6
VA	792,333	31,682	40.0
ME	183,402	7,390	40.3
UT	190,222	7,824	41.1
ID	145,916	6,195	42.5
DC	69,898	3,030	43.3
VT	77,510	3,431	44.3
NC	969,048	43,832	45.2
AL	579,798	26,613	45.9
PA	1,919,165	88,735	46.2
NJ	1,113,136	51,531	46.3
DE	101,726	4,753	46.7
CO	416,073	19,915	47.9
MD	599,307	28,999	48.4
US	34,991,753	1,725,326	49.3
NY	2,448,352	120,784	49.3
GA	785,275	39,965	50.9
KY	504,793	26,217	51.9
WY	57,693	3,051	52.9
NH	147,970	7,829	52.9
MS	343,523	18,308	53.3
TN	703,311	37,646	53.5
WI	702,553	38,619	55.0
RI	152,402	8,918	58.5
MA	860,162	50,704	58.9
TX	2,072,532	123,473	59.6
MN	594,266	35,925	60.5
MT	120,949	7,348	60.8
OH	1,507,757	93,791	62.2
SD	108,131	6,816	63.0
CT	470,183	30,135	64.1
IL	1,500,025	103,028	68.7
OK	455,950	31,394	68.9
ND	94,478	6,514	68.9
AR	374,019	25,969	69.4
NE	232,195	16,282	70.1
LA	516,929	36,740	71.1
MO	755,379	54,332	71.9
KS	356,229	26,043	73.1
IN	752,831	56,413	74.9
IA	436,213	39,587	90.8
Sources:	1. The State Long-Term Health Care Sector Data Resource Book: 2006 Update		
	Reimbursement and Research Department American Health Care Association: March 2007		
	2. Population 65+: U.S. Bureau of the Census, U.S. Census 2000, (http://www.census.gov/main/www/cen2000.html)		
	3. Nursing Facility Beds: CMS OSCAR Nursing Facility Current Survey, June 2006.		

Senate Finance 10
Hearing

#2

Attachment B

NURSING FACILITY AND BASIC CARE BEDS PER THOUSAND		
Region and Area	**Nursing Facility Beds Per 1000 Elderly**	**Basic Care Beds Per 1000 Elderly**
I – Williston	60.47	28.48
II – Minot	59.06	15.62
III – Devils Lake	68.81	17.03
IV – Grand Forks	71.40	14.42
V – Fargo	60.55	19.26
VI – Jamestown	76.66	19.01
VII – Bismarck	61.06	15.37
VIII – Dickinson	72.02	13.36
Statewide Averages	65.3	17.25
Statewide Goal*	60.0	15.0

Information based on ND Department of Health, Long Term Care Capacity Information (2007), as of July 18, 2007.

*Nursing facility goal established by North Dakota Taskforce on Long-Term Care Planning in 1996

*Basic Care Goal established by State Health Council in 1994.

In 1996, thirteen years ago, North Dakota had 89 beds per thousand elderly, the sixth highest rate in the nation.

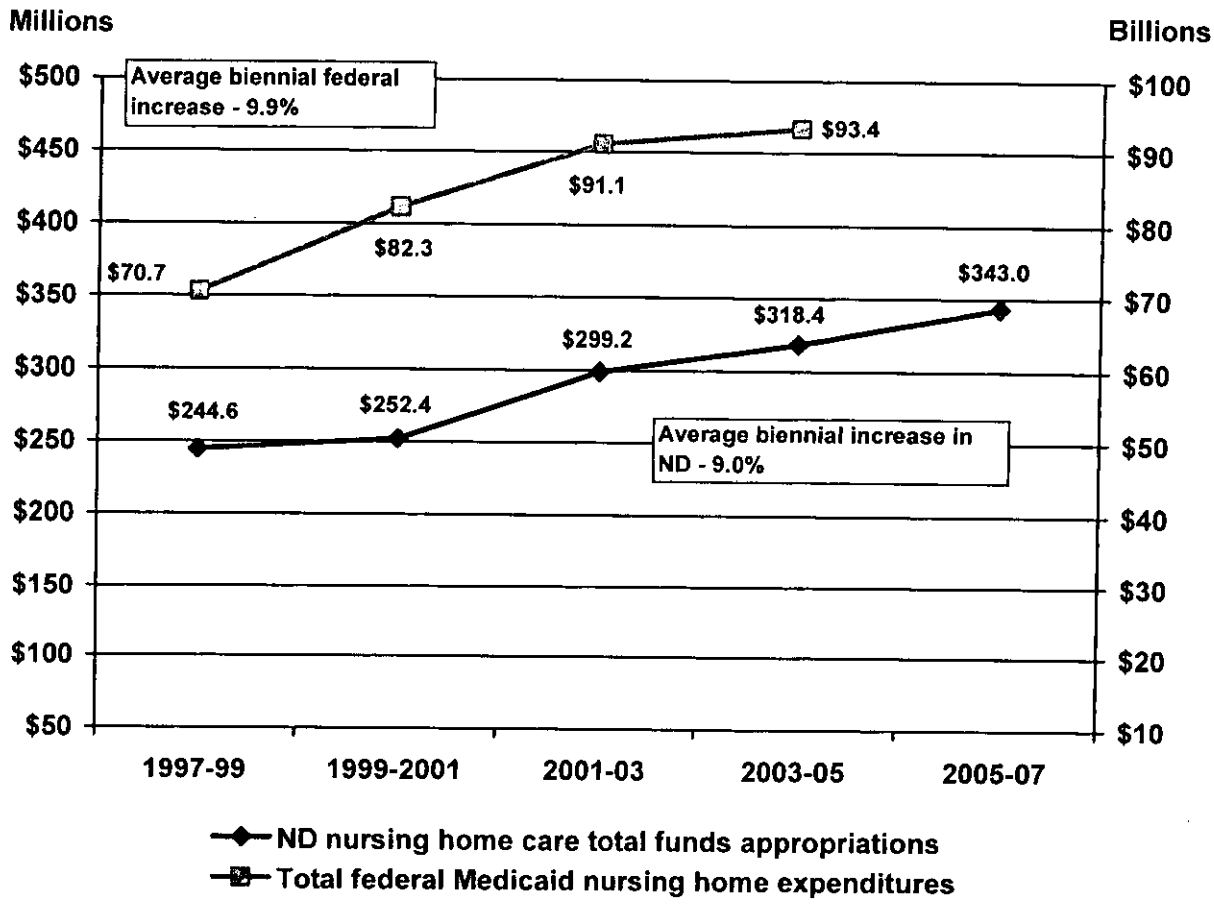
The most recent report on beds per 1,000 elderly (Attachment A) shows North Dakota has fallen to eighth place in the ranking and the good news is that its at 68.9 beds per 1,000 elderly (not 89 per 1,000 elderly)

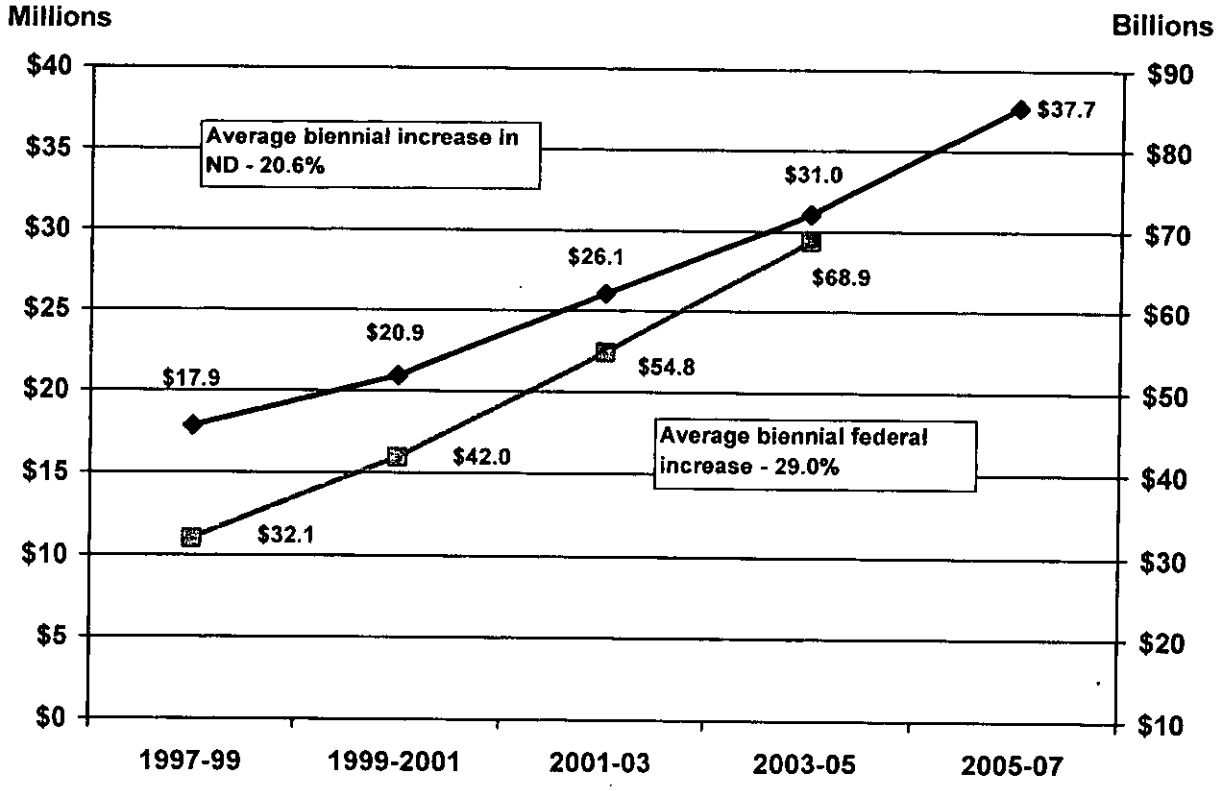
Send to House

North Dakota Long Term Care ASSOCIATION
1900 N 11th St 701.222.0660
Bismarck, ND 58501 www.ndltca.org

#2

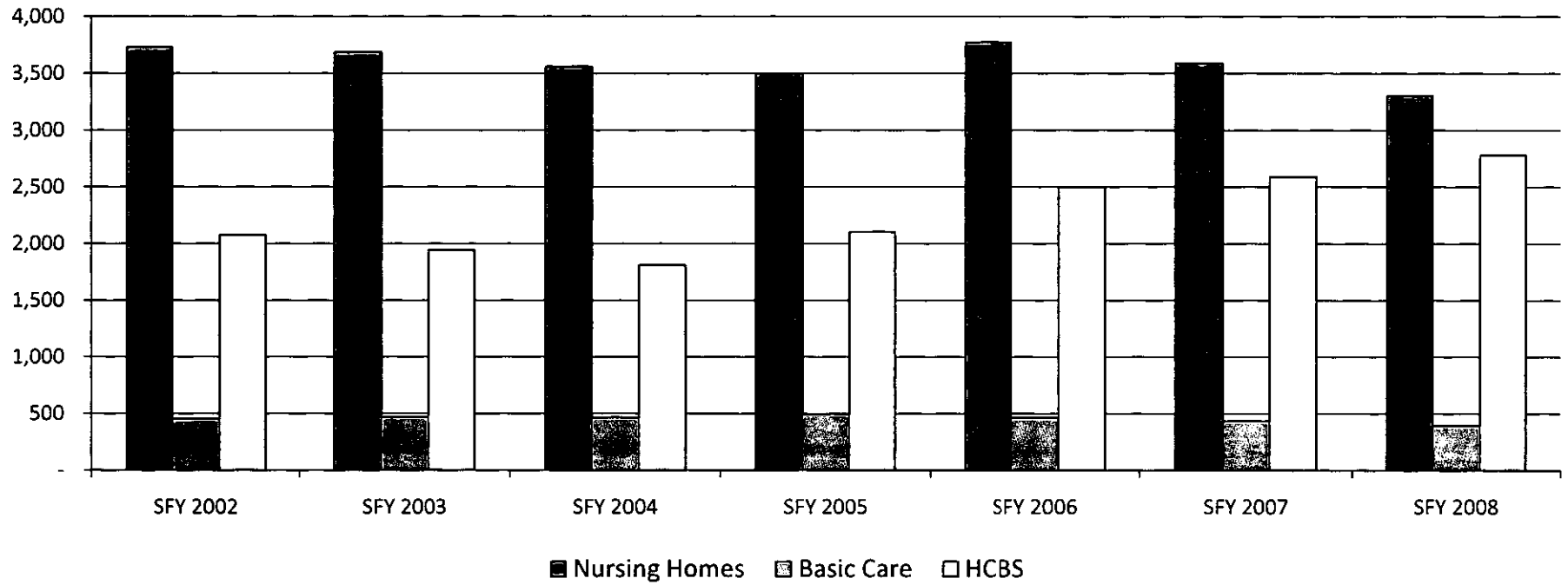
Attachment C





Sent to House

ATTACHMENT D: Trends in Long Term Care



	Nursing Homes	Basic Care	HCBS
SFY 2002	3,730	456	2,078
SFY 2003	3,688	473	1,947
SFY 2004	3,561	469	1,813
SFY 2005	3,501	497	2,104
SFY 2006	3,777	466	2,499
SFY 2007	3,591	439	2,591
SFY 2008	3,305	397	2,785

Source: Medical Services, ND Department of Human Services, September 2008

Department of Human Services
2009 - 2011 Budget to House
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $501,986,472

.03
Basic Care

.13
Home & Community Based Services

.84
Nursing Homes

Attachment E

#2

Attachment F

BED BUYOUT INCENTIVE PAYMENTS

Offers Approved As Of 6-30-2003

Round		Location	Facility	Beds	Per Bed Offer	Total Offer	Payments Authorized	Beds Delicensed
1	1	New Rockford	Lutheran Home of The Good Shepherd	2	$8,000.00	$16,000	$16,000	2
1	2	Larimore	Larimoure Good Samaritan Center	8	$12,000.00	$96,000	$96,000	8
1	3	Bottineau	St Andrew's Health Center	32	$15,000.00	$480,000	$480,000	32
1	4	Devils Lake	Devils Lake Good Samaritan Center	4	$8,000.00	$32,000	$32,000	4
1	5	Westhope	Westhope Home	11	$11,500.00	$126,500	$126,500	11
1	6	Oakes	Oakes Good Samaritan Center	8	$12,000.00	$96,000	$96,000	8
1	7	Osnabrock	Osnabrock Good Samaritan Center	4	$8,000.00	$32,000	$32,000	4
1	8	Northwood	Northwood Deconess Health Center	8	$10,999.75	$87,998	$87,998	8
1	9	Dickinson	St. Benedict's Health Center	8	$11,400.00	$91,200	$91,200	8
1	10	Harvey	St. Aloisius Medical Center	10	$12,000.00	$120,000	$120,000	10
1	11	Ellendale	Prince of Peace Care Center	5	$8,000.00	$40,000	$40,000	5
1	12	Lamoure	St Rose Care Center	10	$11,400.00	$114,000	$114,000	10
1	13	Strasburg	Strasburg Nursing Home	8	$12,000.00	$96,000	$96,000	8
1	14	Hatton	Tri-County Retirement & Nursing Home	2	$7,500.00	$15,000	$15,000	2
1	15	Crosby	Crosby Good Samaritan Center	9	$12,000.00	$108,000	$108,000	9
1	16	McVille	Nelson County Health System Care Center	6	$8,000.00	$48,000	$48,000	6
1	17	Rugby	Heart of America Nursing Facility	23	$12,000.00	$276,000	$276,000	23
1	18	Williston	Bethel Lutheran Home	3	$8,000.00	$24,000	$24,000	3
1	19	Dunseith	Dunseith Community Nursing Home	4	$8,000.00	$32,000	$32,000	4
1	20	Wahpeton	St. Catherine's Living Center	20	$11,400.00	$228,000	$228,000	20
1	21	Garrison	Benedictine Living Center	8	$11,400.00	$91,200	$91,200	8
1	22	Underwood	Prairieview Health Center Inc.	8	$11,997.00	$95,976	$95,976	8
1	23	Arthur	Arthur Good Samaritan Center	17	$12,000.00	$204,000	$204,000	17
1	24	Wishek	Wishek Home For The Aged	8	$12,000.00	$96,000	$96,000	8
1	25	New Town	Good Samaritan Center	30	$15,000.00	$450,000	$450,000	30
4	26	Killdeer	Hill Top Home of Comfort	9	$12,000.00	$108,000	$108,000	9
5	27	Parshall	Rock View Good Samaritan Center	5	$8,000.00	$40,000	$40,000	5
7	28	Lisbon	Lisbon Area Health Services Nursing Facility	8	$12,000.00	$96,000	$96,000	8
8	29	Williston	Bethel Lutheran Home	8	$12,000.00	$96,000	$96,000	8
			Total	286		$3,435,874	$3,435,874	286
						Total Offers	$3,435,874	286
		Uncommitted Funds	**$564,126**			Total Outstanding	$0	0

Senate Appropriations

Attachment G

Redistribution of Nursing Facility and Basic Care Beds
From Rural to Urban North Dakota

January 2009

BISMARCK-MANDAN

Community	Facility	Nursing Beds	Nursing Sub-Acute Beds	Basic Care Beds	Expansion NF Beds	Expansion BC Beds	Time Frame	How Beds Increased
Bismarck	MedCenter One Subacute Unit		22					
Bismarck	St. Alexius Transitional Care Unit		19					
Bismarck	Baptist Home Inc.	141		10				
Bismarck	Missouri Slope Lutheran Care Ctr	250						
Bismarck	St Vincent's Care Center	101						
Bismarck	Benedictine Living Center				71		June 2010	Re-distribution within Corp*
Bismarck	The View			28				
Bismarck	Maple View II East			24				
Bismarck	The Terrace			40				
Bismarck	Waterford on West Century			20				
Bismarck	Edgewood Vista			48		25	December 13, 2007	Basic Care Need
Bismarck	Good Samaritan Society				48	16	May 2010	Re-distribution within Corp**
Mandan	Medcenter One Care Center	120			8		November 2008	Re-distribution within Corp - Underwood
Mandan	Medcenter One Care Center				50		February 2009	Move Steele Beds to Mandan
	Totals	612	41	170	177	41		
	Percentage of Increase				29%	24%		

*Benedictine Living Center: 22-Dickinson, 14-Wahpeton, 8-LaMoure, 9-Ellendale, 11-Garrison, 7-Undetermined at this time.
**Good Samaritan Society: 13-Devils Lake, 7-Osnabrock, 20-Crosby, 5-Lakota, 2-Mohall, 1-Undetermined at this time.

Traumatic Brain Injury Facilities

Community	Facility	Head Injury NF	Head Injury BC	Expansion Head Injury NF Beds	Time Frame
Mandan	Dakota Alpha	11		9	02/2008
Mandan	Dakota Pointe		10		
	Totals	11	10	9	
	Percentage of Increase			82%	

Attachment G

Redistribution of Nursing Facility and Basic Care Beds
From Rural to Urban North Dakota

January 2009

FARGO - WEST FARGO

Community	Facility	Nursing Beds	Nursing Sub-Acute Beds	Basic Care Beds	Expansion NF Beds	Expansion BC Beds	Time Frame	How Beds Increased
Fargo	MeritCare Transitional Care Unit		33					Transferring (1)
Fargo	Elim Care Center	136						
Fargo	Rosewood on Broadway	111						
Fargo	Manor Care of Fargo ND, LLC	109			22		July 2009	Purchased by Bid (2)
Fargo	Villa Maria	138			2		April 2008	Purchased by Bid (3)
Fargo	Bethany Homes	192			40	36	BC-Nov 2009/NF-Jan 2010	BC Need & Purchased by Bid (4)
West Fargo	Eventide Senior Living			24	45		December 2009	Purchased by Bid (5)
Fargo	Good Samaritan Society - Fargo					30	January 15, 2008	Re-distribution within Corp (6)
Fargo	Evergreens of Fargo			72				
Fargo	Edgewood Vista			33				
Fargo	Waterford at Harwood Groves			20				
	Totals	686	33	149	109	66		
	Percentage of Increase				16%	44%		

(1) Transferring 33 beds: 16 - Bethany Homes; 17 - Eventide Senior Living
(2) Manor Care of Fargo ND, LLC: 8-Hatton; 4-Walhalla, 4-Cooperstown, 6-Hillsboro
(3) Villa Maria: 2-Hillboro
(4) Bethany Homes: 8-Grafton, 6-Wishek, 15-Devils Lake, 11-Hettinger. 78 Total: Previous 40 + 16 Meritcare + 22 from University facility.
(5) Eventide Senior Living: 16-Northwood, 8-Strasburg, 5-Devils Lake, 9-Hettinger, 7-Dunseith, 17-Meritcare
(6) Good Samaritan Society: 5-Devils Lake, 5-Crosby, 10-Parshall, 10-Arthur

Attachment G

Redistribution of Nursing Facility and Basic Care Beds
From Rural to Urban North Dakota

January 2009

GRAND FORKS

Community	Facility	Nursing Beds	Basic Care Beds	Expansion NF Beds	Expansion BC Beds	Time Frame	How Beds Increased
Grand Forks	Parkwood Place Inn		40				
Grand Forks	St. Anne's Guest Home		54				
Grand Forks	Woodside Village	118					
Grand Forks	Edgewood Grand Forks Senior Living				20	Approved 10/16/03	Basic Care Need
Grand Forks	The View				15	Approved 03/14/06	Basic Care Need
Grand Forks	Tufte Manor				15	March 2008	Purchased By Bid (1)
Grand Forks	Tufte Manor				15	October 22, 2008	Purchased By Bid (1)
Grand Forks	Tufte Manor				15	February 2011	Purchased By Bid (1)
Grand Forks	Valley Eldercare Center	176		16		April 2010	Purchased By Bid (2)
	Totals	294	94	16	80		
	Percentage of Increase			5%	85%		

(1) Tufte Manor: 15-Turtle Mountain Band of Chippewa, 18-Wilton; 12-Jamestown
(2) Valley Eldercare Center: 6-Cooperstown, 5-McVille, 5-Cando

Attachment G

Redistribution of Nursing Facility and Basic Care Beds
From Rural to Urban North Dakota

January 2009

MINOT

Community	Facility	Nursing Beds	Basic Care Beds	Expansion NF Beds	Time Frame	How Beds Increased
Minot	Edgewood Vista		31			
Minot	Edgewood Vista - ARD		22			
Minot	Emerald Court		28			
Minot	Trinity Nursing Home	292				
Minot	Manor Care of Minot ND, LLC	106		8	July 2009	Purchased By Bid (1)
	Totals	398	81	8		
	Percentage of Increase			2%		

(1) Manor Care of Minot ND, LLC: 8-Hatton

North Dakota long term care facilities are in a staffing crisis.

Did you know?

- Long-term care facilities spend over **$475 million** each year, with **86%**, or **$409 million**, of those expenditures **remaining in North Dakota.**
- North Dakota **leads the nation** in age **85+** population. North Dakota's **60+** population will reach nearly **200,000** by 2020.
- Over **1,700 additional caregivers** will be **needed** over the next seven years to provide care for North Dakota's aging population.
- The **202 long term care facilities** in North Dakota **employ over 14,000** caregivers at an **annual payroll** of nearly **$341 million.**

You can help. #2

Who will care for me?

- **Long term care facilities** provide care for over **14,000** North Dakotans **annually.**
- **Lack of caregivers** was the main factor in the **closing** of one basic care facility and the announcement of a nursing **facility closure** in 2008.
- **34%** of caregivers in long term care are age **50 or older.**
- **14%** of the long term care workforce is **at or over retirement age.**
- The **oldest caregiver** in long term care is a **94-year-old** dietary aide.
- **17%** of nursing facilities **stopped admissions** in 2008 because of **insufficient staffing.**
- Nursing facilities reported over **1,000 open positions** in April 2008—**733** openings were for **Certified Nurse Assistants** (CNAs).
- **49%** of nursing facilities **contracted with agencies** in 2008 to deliver daily resident care—at **double or triple the cost.**
- **CNA turnover** is **51%.**
- **32 weeks** is the average time it takes to **fill** an open **nursing position** in a rural nursing facility.
- Entry level **CNA wages** in rural North Dakota are **$9.54** per hour, or **$19,843** annually.
- Following the **2001** long term care **wage/benefit pass-through**, CNA **turnover decreased** over **30%.**

Your support of the equity pool will help build North Dakota's caregiver workforce for the 21st century.

North Dakota Long Term Care ASSOCIATION

#3

Dever, Dick D.

From: Carol Johnson [caajohns@hotmail.com]
Sent: Monday, January 12, 2009 9:07 AM
To: Lee, Judy E.; Erbele, Robert S.; Dever, Dick D.; Heckaman, Joan M.; Marcellais, Richard; Pomeroy, Jim R.
Subject: Opposition to Moratorium
Attachments: KEY POINTS FOR OPPOSITION TO SENATE BILL 2044.docx

Dear Chairman Lee and Members of the Senate Human Services Commitee:

I had planned on testifying before your committee in opposition to SB 2044 that proposed extending the moratorium on skilled nursing and basic care beds, but because of the weather and an ill husband I will have to forego the opportunity. However, I am passionate that my testimony be relayed so I will use the marvels of technology by attaching my testimony and sending via email.

Several years ago on the way home from work, I ended up in the median of I-94 after a sudden snow storm caused zero visibility. Since that time I heed travel warnings and have a real fear of traveling in adverse conditions. I realize how precious life truly is and how in an instant a person's circumstances can change. I regret that I can not attend the hearing today, but pray that you will take the time to read my testimony as I have done considerable research on moratoriums.

If you have any questions, please feel free to phone me at 701-475-2283 or via email at caajohns@hotmail.com.

Sincerely,
Carol A. Johnson
PO Box 244
521 1st Ave. NW
Steele, ND 58482

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#3

TESTIMONY IN OPPOSITION OF SENATE BILL 2044

by Carol A. Johnson

Chairman Lee and members of the Senate Human Services Committee, thank you for the opportunity to testify in opposition to Senate Bill 2044 that proposes extending the moratorium on skilled nursing and basic care beds until the year 2013. My name is Carol Johnson and I have a keen interest in providing for the needs of the elderly citizens of North Dakota. None of us knows when or if the time will come when we might need 24 hour nursing care, but I pray that if faced with the situation of requiring long-term care, I will have freedom of choice as to where I will reside and that there will be a bed available for me in a quality nursing facility close to my family.

Personally, I find the buying and selling of skilled nursing and basic care beds repulsive. The beds should not be treated as a commodity to be sold to the highest bidder in order to warehouse our elderly in the most efficient and economical way. People in the nursing home industry should be working cooperatively to meet the needs of the elderly and should not be using cut-throat tactics to obtain beds. The licensing of beds should be for the sole purpose of guaranteeing quality care for our elderly, not for restricting the freedom of choice as to where our elderly in need of nursing care must reside.

The current moratorium is flawed for several reasons and to extend it in its current form to 2013 would be disastrous. First, there should be a specific number of licensed beds that follows recommended guidelines based on current and projected population data, not some unspecified, secret number or formula to determine the number of beds. The North Dakota Data Center projects that by the year 2015, there will be approximately 36,000 more North Dakotans in the over 65 age bracket. Will the unspecified secret formula presently used meet those expected needs?

Secondly, demand and supply should be relatively equal and any present disparity will only increase in the future. If demand and supply were somewhat equal, then beds would not be going for 10 to 20 thousand dollars apiece. Why should the legislature be overly concerned with the location of beds when the state pays according to occupancy rates? Simply put-- empty beds mean no revenue and the facility itself will suffer, not the state coffers.

In addition, although, I agree in principle with the concept of full payment for any facility that has an occupancy rate of 90% or higher, there is a big difference in the number of beds available in a 50-bed facility as opposed to the number of beds available in a 250-bed facility when calculating the number of beds available. At the 90% occupancy rate, a 50-bed facility would have only 5 empty beds available whereas the 250-bed facility would have 25 empty beds. With the trend toward moving nursing care facilities to the urban areas at the expense of the rural areas, an urban area with several nursing care facilities could possibly have 50-100 empty beds depending upon the size of the other facilities in the area. Still all of the facilities in the illustration would be operating at 90% occupancy. However, which facility is truly underutilizing the licensed beds -- the 50-bed facility with 5 empty beds or the 250-bed facility with 25 empty beds?

National recommendations are 60 beds per 1,000 for people between the ages of 65 and 84 years of age while the ratio for those ages 85 or older is 453 beds per 1,000. North Dakota currently ranks 4th in the nation for the number of people per capita who are 65 years of age or older and 1st in the number of people per capita who are 85 years or older. Using the national recommendations and population projection for North Dakota, it is estimated that by 2015, there should be 6,276 beds available for people ages 65-84 and 10,265 beds available for those who are 85 years or older. Will the present moratorium help North Dakota meet the expected need of approximately 16,500 beds? Population projections indicate that the over 65 population will increase by 36,000 with the over 85 population doubling by the year 2015 from what it was in 1990 when the moratorium was first enacted. Keeping the moratorium with the same number of beds as in the past makes no sense when the population most likely to be using nursing care services will be experiencing a 36.6% increase. Keeping a moratorium that limits beds is like a city limiting or capping the number of building permits issued based on data that is 25 years old, even though the city is expecting an influx of approximately 36,000 new residents into the city in the near future.

Finally, our elderly have contributed immensely to the very fiber of North Dakota and should have freedom of choice in regards to where and how they want to spend their remaining years. They should not have to worry about whether a bed will be available for them if the need arises nor should they have to leave family and friends to access needed services. Therefore, I ask you NOT to extend the current moratorium. Thank you again for allowing me to testify.

KEY POINTS FOR OPPOSITION TO SENATE BILL 2044

* National recommendations are 60 beds per 1,000 for people ages 65 to 84 and 453 beds per 1000 for people ages 85 and older.

* North Dakota rank 4th in the nation for the number of residents per capita who are 65 years or older

*North Dakota ranks 1st in the nation for the number of residents per capita who are 85 years or older

* North Dakota Data Center projects that while North Dakota's overall population will only increase 1.1% from 2000 to 20015, but the 65 years and older segment of the population will increase by 36.6% during the same time period.

Taken from Population Trend in North Dakota from 1990-2015 by the North Dakota Data Center

Age Cohort	1990 Census	Projected Population For 2015	Projected Increase
Ages 65-84	79,815	104,603	24,788
Age 85 or older	11,240	22,660	11,420
Totals	91,055	127,263	36,208

* Limiting beds to the 1991 levels when there was 91,055 North Dakota residents 65 years or older does not make sense when it is projected that by 2015 there will be 127,263 North Dakota residents who will be 65 years or older, which represents an increase of 32,785 in the segment of the population who will 65 years and older.

* Using national recommendations and the projected population for 2015, there should be 6,276 beds available for people ages 65-84 and 10,265 beds available for those who are 85 years or older.

* Using the national recommendations and the census from 1990, there already is a critical shortage of nursing beds within the state.

* Supply and demand for beds should be close to equal when meeting the needs of the elderly.

* Beds should not be considered a commodity to be sold to the highest bidder.

* People in the nursing home industry should be working cooperatively to meet the needs of our elderly and not using cut-throat tactics to obtain beds.

* Our elderly have contributed immensely to the very fiber of North Dakota and should have freedom of choice in regards to where they want to spend their remaining years

* References

About Nursing Homes by Thomas Day

North Dakota Population Projections: 2003-2020 by North Dakota Data Center

Madame Chairman, members of the committee:

For the record, my name is Sheila Sandness and I am a Fiscal Analyst for the Legislative Council. I am here to present information on Senate Bill 2044 relating to the moratorium on expansion of basic care bed capacity and the moratorium on expansion of long-term care bed capacity. I appear neither for nor against the bill, but just to provide information and answer any questions you may have.

The 2007 Legislative Assembly, in Section 3 of Senate Bill No. 2109, directed a study of the long-term care system in North Dakota, including capacity. The Long Term Care Committee was assigned this study. The Long Term Care Committee's findings and recommendations can be found on pages 268-275 of the "Report of the North Dakota Legislative Council" and include this bill which provides for the extension of to the moratorium on expansion of basic care bed capacity and the moratorium on expansion of long-term care bed capacity through July 31, 2013.

#1

Testimony
Senate Bill 2044 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
March 4, 2009

Chairman Weisz, members of the House Human Services Committee, I am Barbara Fischer, Assistant Director of the Medical Services Division for the Department of Human Services.

I am here today in support of SB 2044. The moratorium for nursing facilities and basic care facilities has been in place since 1995 and has been extended each biennium. Throughout the interim, the Department has been in contact with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility and basic care beds that are being shifted through the state. The Department's 2009-2011 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

I would be happy to address any questions that you may have.

#2

Testimony on SB 2044
House Human Services Committee
March 4, 2009

Good Morning Chairman Weisz and members of the House Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent assisted living facilities, basic care facilities and nursing facilities in North Dakota. I am here to testify in support of SB 2044 regarding the basic care and nursing facility moratorium on expansion of beds.

SB 2044 proposes to continue the basic care and nursing facility licensed bed moratorium until July 31, 2013. Without this legislation the moratorium would cease to exist on July 31, 2009, and anyone could build a basic care or nursing facility. We support continuing the moratorium for four reasons:

1. North Dakota is considered to still have a high bed count when you consider the beds per one thousand elderly. North Dakota is currently at 64.04 beds per thousand elderly and the United States average is 49.3. At this point in time, this is still the best yard stick for measuring need and excess capacity. (See Attachment A and Attachment B)
2. The fiscal note to expand facilities beyond our current bed count would be significant. Even with the beds decreasing, the nursing facility budget increases an average of 9% every biennium. This has been the rate of increase since the 97-99 biennium. (See Attachment C)
3. The desire of individuals to receive care and services within their own homes, thus any expansion of services should be at that sector rather than at the institutional sector. (See Attachment D and Attachment E)
4. The 07-08 Interim Long Term Care Committee chaired by Senator Dever studied the moratorium and concluded the moratorium should continue through June 30, 2013.

Past legislative bodies have recognized that a mal-distribution of beds has occurred. In essence, beds may not be in the area where the greatest demand exists. For example, today the four major cities have a population of 263,677 which is 41% of North Dakota's overall population. At the same only 32.6% of the nursing facility beds are located in the four area cities. To address the potential mal-distribution you have authorized the buying, selling and relocation of beds.

First you allowed a two for one sale, meaning in order to sell one bed, you also needed to "give-up" one bed. The bed that was "given up" left the system never to be licensed again. That process removed beds from the total count, as well as allowed for a redistribution of beds. This process occurred for a number of years, until we requested that anyone be allowed to sell and move their beds without giving any up.

In 2001, you also authorized a nursing facility bed buyout program. Again the purpose of the program was to get rid of the perceived excess capacity. Under the program the Department of Human Services would make a quarterly request for bed buyout offers. The Department would pay up to $15,000 per licensed nursing facility bed if the facility closed, up to $12,000 per licensed nursing facility bed if the facility closed at least eight beds or more and up to $8,000 per licensed nursing facility bed if the facility reduced its capacity by seven or fewer beds. The buyout program operated through June 30, 2003. In the end, two facilities closed (New Town-30 beds and Bottineau-32 beds) and a total of 286 beds were reduced from the overall bed count. The total dollars expended for the state to purchase and remove the 286 beds from the system cost $3,435,874. (See Attachment F)

Today, beds are being relocated through the process of buying and selling. For the most part, rural facilities are selling their beds and their urban counter parts are bidding and buying the beds. This allows beds, which may have been sitting

empty, to move to areas where they are in greatest demand. This has allowed rural nursing facilities the ability to obtain cash for their "empty" beds, urban areas to better meet the demand for more beds, the state not to expend additional dollars over the current bed count and the citizens of North Dakota to have access to a more balanced continuum of care.

Once you buy a bed, you are allowed four years to license that bed and put it in service. Whoever owns the beds controls whether they will be sold. No one, including the state can take them away. This process works well. From January 1, 2009 through the fall of 2010 we will have over 300 rural beds move into the four major cities. (See Attachment G) Only once have we had an entity buy beds and not put them in service within the four year period of time. As you may recall, it was the Turtle Mountain Band of Chippewa Indians that found themselves in that difficult situation. When it was determined they were not able to put their beds in service they quickly worked to sell their beds to other nursing facilities, who then still needed to license those beds within the original forty-eight month process. The Turtle Mountain Tribe spent approximately $1 million dollars buying beds. Last session you may recall they asked for an exception to the moratorium and the forty-eight month rule. The exception was denied and what beds they weren't able to re-sell were lost forever.

In 2001 when you authorized the bed buyout program you also gave nursing facilities the authority to convert any or all of their skilled nursing facility beds to basic care beds. This flexibility was allowed and aimed at rural facilities where a gap in care was perceived. Some individuals were seeking admission to the nursing facility, did not meet the skilled criteria and remaining at home was not working. The solution was to allow nursing facilities to convent a portion of their skilled capacity to basic care. Under the 2001 provision, facilities are allowed to:

1. Convert beds once a year,
2. Must convert a minimum of five beds,
3. Allowed to covert basic care beds back to skilled after one year,

4. Can sell the converted basic care beds to anyone, however the new owner does not have the authority to convert their new basic care beds back to skilled.

As of May 2008, nursing facilities that were using this provision included:

Facility	Location	Number of Beds
Southwest Health Care Services	Bowman	5
Four Seasons Health Care	Forman	5
Good Samaritan Society - Mott	Mott	9
Good Samaritan Society – Osnabrock	Osnabrock	6
St. Catherine's Living Center	Wahpeton	16
Pembilier Nursing Center	Walhalla	13
Total		54

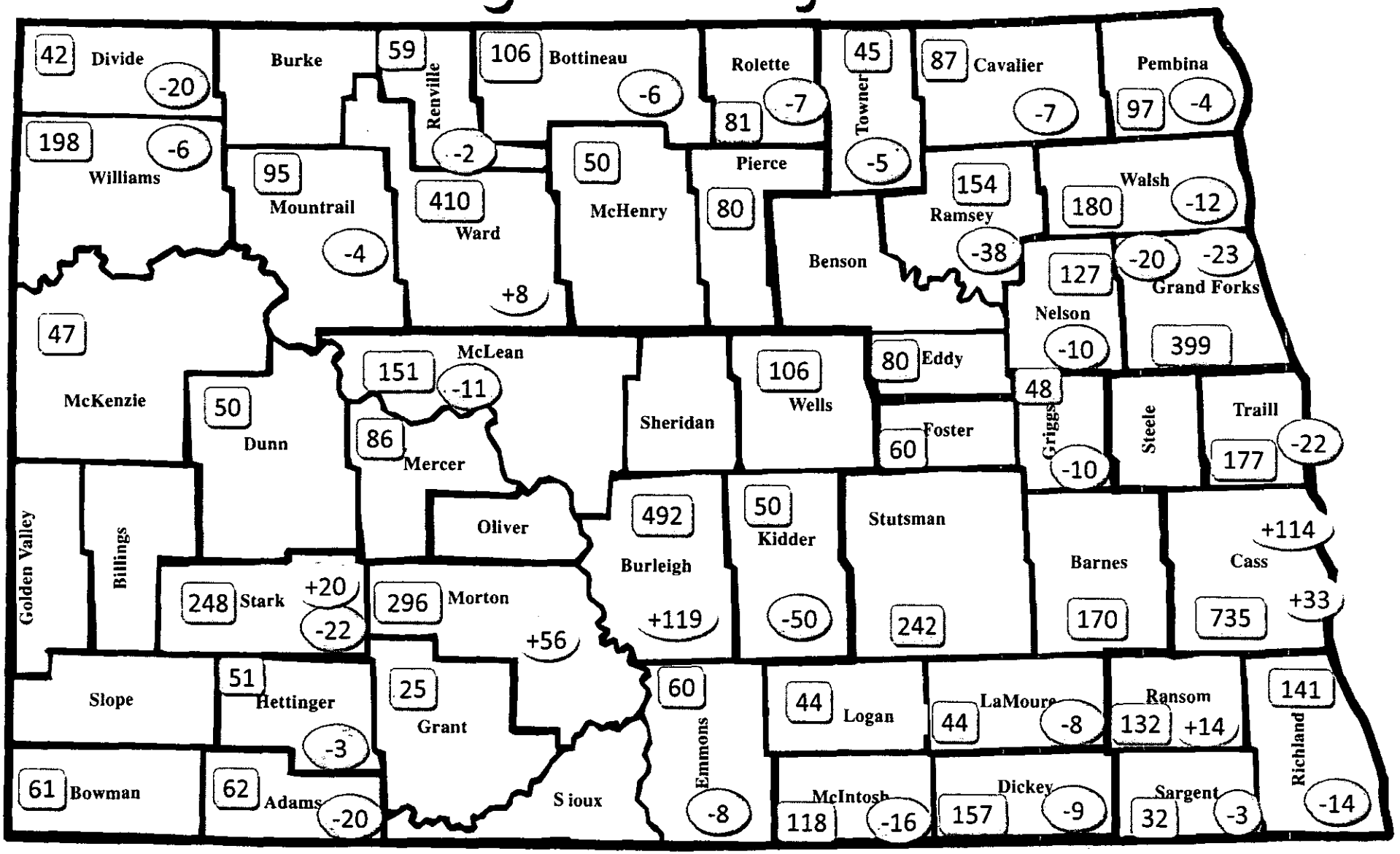
We believe the moratorium, which allows for the buying and selling and relocation of beds is the most prudent public policy for the state and its citizens.

Thank you for the opportunity to testify regarding SB 2044. I would be happy to answer any questions you may have.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street • Bismarck, ND 58501
(701) 222-0660 • www.ndltca.org • E-mail: shelly@ndltca.org

ATTACHME G

Nursing Facility Beds



Purple Box – Number of licensed nursing facilities beds as of January 1, 2009.
Red Box – Number of licensed nursing facility beds decreased or expected to decrease from county (sold or transferred).
Green Box – Number of licensed nursing facility beds expected to increase in the county (purchased or transferred).

#3

OPPOSITION TO SENATE BILL 2044

Chairman Weisz and members of the House Human Resource Committee. My name is Carol Johnson. I am just an average North Dakota Citizen and I am here again to testify before you. This time in opposition to extending the moratorium.

Please, raise your hand if you want to go to a nursing home? Raise your hand if you want to live at home for as long as possible? That settles it. The majority of you want to stay in your home for as long as possible. Let's do away with the moratorium because no one wants to go to a nursing home anyway. Why limit the beds? Let's just leave the nursing home beds empty and buy everybody a new mattress for their bed at home.

Of course, everyone would rather die peacefully at home without ever having to go to a hospital or a nursing home. However, I am here to tell you that sometimes a Higher Power does not grant that wish. Sometimes in spite of in-home care, QSP's, assisted living, or whatever other services have been provided, the only option left becomes nursing home care. That is not to say that all of these other service options shouldn't be exhausted before placement in a nursing home is considered. As part of providing a continuum of services to our elderly that is community-based, nursing home care should be the last part of this continuum of care. However, the present moratorium and the push to move beds out of rural to urban communities limits not only access for our rural elderly, but also restricts their freedom of choice. Why should the rural elderly be forced to leave their home communities? Please do away with the moratorium.

The majority of you have indicated no desire to live in a nursing home. Do you think the Medicaid recipient's desires are any different than yours? Rich or poor or in-between -- rural or urban - no one wants to live in a nursing home so why restrict the number of beds? Even though no one really wants to be in a nursing home, the reality is that there is a need for nursing homes -- a growing need because of the aging of North Dakota's population. However, must that need be met by uprooting people from their home communities? According to the 2000 census, only 8.3 % of North Dakota's elderly were living in group living quarters, such as nursing homes. Yes, I said 8.3% which means that the other 91.7% of the people are living either in family households or alone. This does not indicate to me that there is an over-reliance on nursing home care by our elderly North Dakota citizens. The 2008 Interim Study on North Dakota Long Term Care told the legislators that the number of nursing home residents may increase by 46% or by a total of 2,931 new residents into the system by 2020. Why is the Legislature still hell-bent on limiting the number of beds when presented with this data?

Past testimony to the legislature indicated that the buying and selling of beds has been working well. Working well for who? The state which spent over 3 million to buy up 286 beds? The facilities that are in need of more nursing beds and must pay upwards to $20,00 a bed or for the facilities that have sold off their beds and now have a need for those beds? And most importantly, has it worked well for the elderly who must leave family and friends in order to access services? People requiring nursing care are being turned away from small and large facilities alike in both rural and urban areas. Currently, the statewide occupancy rate for skilled beds is 94%, which by all health care standards is considered FULL. How is the Legislature going to handle the aging crisis in North Dakota? By extending the moratorium? Where is the wisdom in that?

Instead of promoting the buying and selling of beds, maybe the Legislature should be scrutinizing the cost of operating each nursing facility in the state because as of January 2009, there were seven or eight facilities that overspent in direct care costs and another 25 facilities that overspent in indirect costs. Together these facilities overspent in excess of $3 million. On the other hand, there were 44 nursing facilities that received incentive rewards for keeping their indirect care costs below the reimbursement rate. I would sure like to know and I am sure the legislators would also like to know, which facilities they were.

Personally, I find the buying and selling of skilled nursing and basic care beds repulsive. The beds should not be treated as a commodity to be sold to the highest bidder in order to warehouse our elderly in the most efficient and economical way. I feel that empty or unoccupied beds should be worthless and occupied beds should be considered valuable, not only for the revenue that the beds generate, but for the valuable, wonderful person who is occupying those beds. In addition the licensing of beds should be for the sole purpose of guaranteeing quality care for our elderly, not for restricting the freedom of choice as to where our elderly in need of nursing care must reside. How many other businesses or professions does the state of North Dakota limit in regards to the number of licenses granted? (Hunting doesn't count because that is for recreational purposes, not businesses or professions.)

In closing I urge you to review the attachments to my testimony and rethink your decision to extend the moratorium. None of us knows when or even if the time will come when we might need 24 hour nursing care, but I pray that if faced with such a situation, I will have the freedom of choice as to where I will reside and that there will be a bed available for me in a quality nursing facility close to my family. Thanks for allowing me to speak on a subject that is close to my heart.

THE **Population Bulletin**

Vol. 17 No.10, October 2001

North Dakota Elderly Living Alone: 2000

According to the 2000 Census, elderly persons ages 65 years and older totaled 94,478 in North Dakota. Of these persons, a majority (91.7 percent) lived in households. The remaining 8.3 percent (7,832 persons) resided in group quarter facilities such as nursing homes.

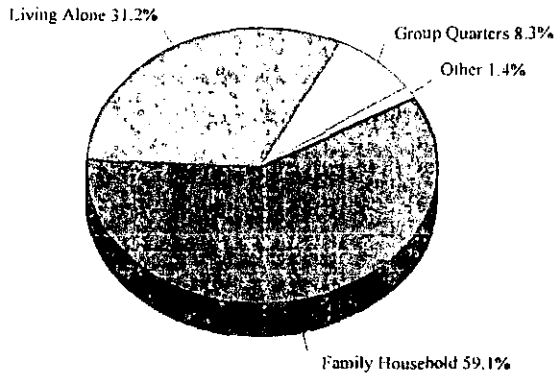
The majority of North Dakota elderly living in households were in family households in 2000. Nearly 31,000 elderly lived in non-family households with 29,487 of them living by themselves. Approximately 6,500 elderly lived in nursing homes.

The number of elderly living alone in North Dakota increased 5.2 percent between 1990 and 2000.

Nationally, North Dakota had the 3rd highest proportion of elderly living alone.

Persons 65 Years and Older by Living Arrangemen

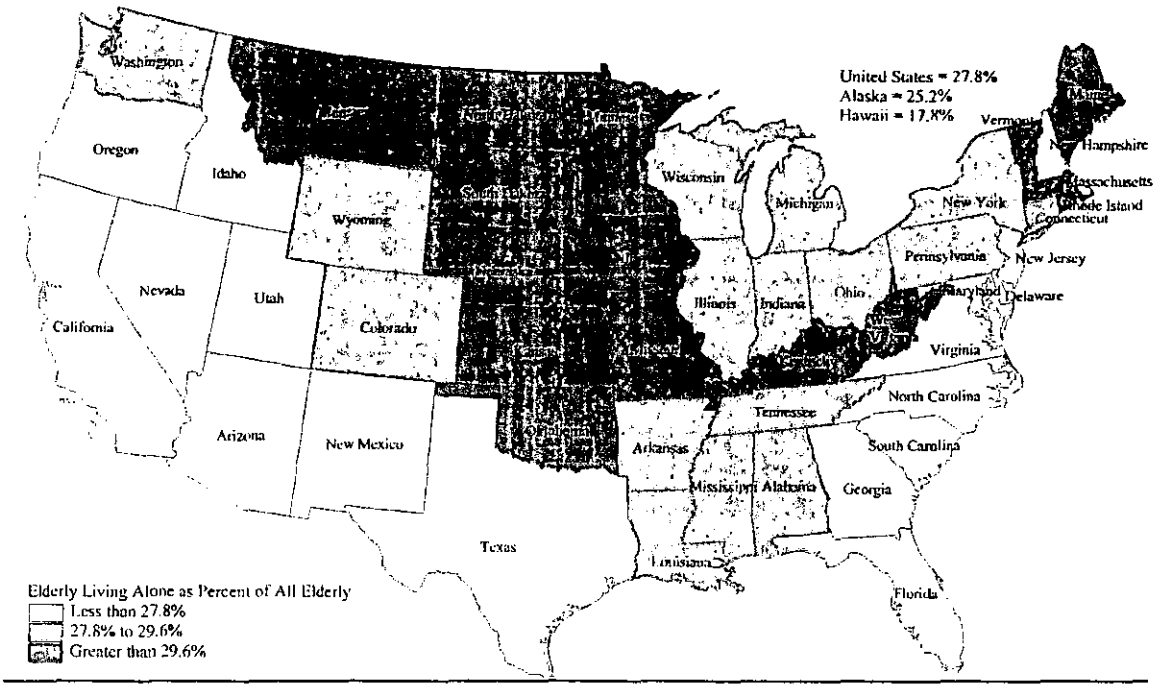
North Dakota: 2000



Source: U.S. Census Bureau, 2000 Census, Summary File 1.

Persons 65 Years and Older Living Alone as a Percent of Total Persons 65 Years and Older: 2000

Source: U.S. Census Bureau, 2000 Census, Summary File 1



The ***Population Bulletin*** is published monthly by the North Dakota State Data Center at North Dakota State University, IACC 424, Fargo, ND 58105; Phone: (701)231-7980; URL: http://www.ndsu.edu/sdc; Richard W. Rathge, Director; Karen Olson, Information Specialist.

Living Arrangements of Persons Ages 65 Years and Older in North Dakota by County: 2000

Area	Persons 65 Years and Older									
		Living in Households							Living in Group Quarters	
			in Family Households		in Non-Family Households					
					Total		Living Alone			
	Total	Total	Number	Percent	Number	Percent	Number	Percent	Number	Percent
North Dakota	94,478	86,646	55,836	59.1	30,810	32.6	29,487	31.2	7,832	8.3
Adams	624	555	345	55.3	210	33.7	201	32.2	69	11.1
Barnes	2,332	2,164	1,364	58.5	800	34.3	778	33.4	168	7.2
Benson	941	897	598	63.5	299	31.8	290	30.8	44	4.7
Billings	142	142	113	79.6	29	20.4	28	19.7	0	0.0
Bottineau	1,522	1,396	898	59.0	498	32.7	485	31.9	126	8.3
Bowman	707	626	383	54.2	243	34.4	234	33.1	81	11.5
Burke	562	562	377	67.1	185	32.9	178	31.7	0	0.0
Burleigh	8,640	7,998	5,233	60.6	2,765	32.0	2,627	30.4	642	7.4
Cass	11,901	11,098	6,985	58.7	4,113	34.6	3,917	32.9	803	6.7
Cavalier	1,107	993	638	57.6	355	32.1	342	30.9	114	10.3
Dickey	1,229	1,058	643	52.3	415	33.8	401	32.6	171	13.9
Divide	674	587	379	56.2	208	30.9	200	29.7	87	12.9
Dunn	625	576	396	63.4	180	28.8	169	27.0	49	7.8
Eddy	682	611	366	53.7	245	35.9	238	34.9	71	10.4
Emmons	1,107	1,026	724	65.4	302	27.3	293	26.5	81	7.3
Foster	803	727	470	58.5	257	32.0	247	30.8	76	9.5
Golden Valley	410	372	250	61.0	122	29.8	120	29.3	38	9.3
Grand Forks	6,368	5,860	3,657	57.4	2,203	34.6	2,089	32.8	508	8.0
Grant	703	650	432	61.5	218	31.0	214	30.4	53	7.5
Griggs	708	651	427	60.3	224	31.6	219	30.9	57	8.1
Hettinger	683	625	411	60.2	214	31.3	210	30.7	58	8.5
Kidder	662	622	404	61.0	218	32.9	205	31.0	40	6.0
LaMoure	1,100	1,032	702	63.8	330	30.0	323	29.4	68	6.2
Logan	623	561	392	62.9	169	27.1	154	24.7	62	10.0
McHenry	1,305	1,247	829	63.5	418	32.0	389	29.8	58	4.4
McIntosh	1,160	990	682	58.8	308	26.6	292	25.2	170	14.7
McKenzie	900	844	554	61.6	290	32.2	282	31.3	56	6.2
McLean	1,900	1,753	1,161	61.1	592	31.2	546	28.7	147	7.7
Mercer	1,233	1,125	737	59.8	388	31.5	370	30.0	108	8.8
Morton	3,693	3,415	2,298	62.2	1,117	30.2	1,082	29.3	278	7.5
Mountrail	1,174	1,033	647	55.1	386	32.9	374	31.9	141	12.0
Nelson	1,019	885	519	50.9	366	35.9	356	34.9	134	13.2
Oliver	293	293	203	69.3	90	30.7	85	29.0	0	0.0
Pembina	1,674	1,538	977	58.4	561	33.5	554	33.1	136	8.1
Pierce	1,127	1,005	647	57.4	358	31.8	336	29.8	122	10.8
Ramsey	2,266	2,013	1,260	55.6	753	33.2	724	32.0	253	11.2
Ransom	1,250	1,028	648	51.8	380	30.4	364	29.1	222	17.8
Renville	575	518	356	61.9	162	28.2	160	27.8	57	9.9
Richland	2,746	2,424	1,590	57.9	834	30.4	801	29.2	322	11.7
Rolette	1,325	1,246	783	59.1	463	34.9	435	32.8	79	6.0
Sargent	740	717	457	61.8	260	35.1	252	34.1	23	3.1
Sheridan	455	442	312	68.6	130	28.6	122	26.8	13	2.9
Sioux	226	221	165	73.0	56	24.8	48	21.2	5	2.2
Slope	137	137	102	74.5	35	25.5	33	24.1	0	0.0
Stark	3,510	3,212	2,102	59.9	1,110	31.6	1,067	30.4	298	8.5
Steele	442	442	318	71.9	124	28.1	121	27.4	0	0.0
Stutsman	3,862	3,526	2,149	55.6	1,377	35.7	1,308	33.9	336	8.7
Towner	670	604	374	55.8	230	34.3	228	34.0	66	9.9
Traill	1,623	1,431	908	55.9	523	32.2	503	31.0	192	11.8
Walsh	2,390	2,190	1,409	59.0	781	32.7	763	31.9	200	8.4
Ward	7,341	6,786	4,402	60.0	2,384	32.5	2,262	30.8	555	7.6
Wells	1,326	1,223	797	60.1	426	32.1	411	31.0	103	7.8
Williams	3,261	2,969	1,863	57.1	1,106	33.9	1,057	32.4	292	9.0

Source: U.S. Department of Commerce, Bureau of the Census, 2000 Census, Summary File 1 Table P30.

Prepared by the North Dakota Legislative Council staff for the Long-Term Care Committee
March 2008

RECIPIENTS OF NORTH DAKOTA LONG-TERM CARE SERVICES - 2007 AND POTENTIAL FOR 2020

This memorandum provides information on the long-term care service capacity in North Dakota and the number of residents accessing those services in 2007 as well as information on the potential number of residents that may be accessing long-term care services in 2020.

The projections of the potential number of individuals accessing the various levels of long-term care services in 2020 are based on the number of individuals accessing the particular type of service in 2007 by age category as a percentage of the population. Therefore, the potential number shown for 2020 assumes the same percentage of the population by age category will access these services as in 2007. A number of factors will affect the potential numbers shown for 2020, including:

1. The health and wellness of the population.
2. Types of alternative services that may be available.
3. Financial ability of the population to pay for alternative services.
4. Demographic changes from current population projections.

The types of long-term care services included are:

1. Nursing home care - Appendix A.
2. Basic care - Appendix B.
3. Assisted living - Appendix C.
4. State supported home and community-based care - Appendix D.

Because of the unavailability of data, information is not included on the number of individuals accessing home and community-based care that is not supported by state-funded programs.

The data used to provide this information was gathered from several sources. In some instances, data was not available for the same time period, for the specific type of long-term care service recipient, or by age category. Because of this, assumptions were made in preparing the data that certain demographic trends would be consistent throughout the population and that similar percentages of recipients would occur among age categories for similar service types. In addition, numbers of residents for certain service types were based on average occupancy percentages when specific data was unavailable. Please refer to the footnotes to the schedules for further explanation of these assumptions.

KEY ITEMS

Key items reflected in the projections include:

Nursing home care

- The number of nursing home residents in 2020 may total 9,289 compared to the current number of 6,358, an increase of 2,931 or 46 percent.
- All regions would experience an increase ranging from a 29.4 percent increase in the northwest region (Williston) to 62.8 percent in the southeast region (Fargo).

Basic care

- The number of basic care residents in 2020 may total 1,831 compared to the current estimated number of 1,317, an increase of 514 or 39 percent.
- All regions would experience an increase ranging from a 22.6 percent increase in the northwest region (Williston) to 59.7 percent in the southeast region (Fargo).

Assisted living

- The number of assisted living residents in 2020 may total 2,704 compared to the current estimated number of 1,923, an increase of 781 or 40.6 percent.
- All regions would experience an increase ranging from a 22.7 percent increase in the northwest region (Williston) to a 59.6 percent increase in the southeast region (Fargo).

State-supported home and community-based services

- The number of recipients of these services in 2020 may total 3,248 compared to the current number of 2,485, an increase of 763 or 30.7 percent.
- All regions would experience an increase ranging from a 15.3 percent increase in the northwest regional (Williston) to 49.2 percent in the southeast region (Fargo).

ATTACH:4

nursing facility beds from July 31, 2009, to July 31, 2011.

Ms. Shelly Peterson, President, North Dakota Long Term Care Association, presented information regarding the current status of long-term care and basic care beds in the state. She said the association supports extending the moratorium because North Dakota has a high ratio of nursing facility beds per 1,000 elderly individuals. She said the ratio was 65.26 nursing facility beds per 1,000 elderly individuals as of December 2007. She said beds are being redistributed from low-demand areas to high-demand areas of the state. She said within the next two years over 300 nursing facility beds and over 180 basic care beds will have moved from rural to urban North Dakota. She said if the moratorium were allowed to expire, urban areas would experience unprecedented growth in the number of beds resulting in more Medicaid funds being spent for institutional care and available rural nursing home beds would have minimal value. A copy of the report is on file in the Legislative Council office.

In response to a question from Senator Dever, Ms. Peterson said nursing facilities are experiences difficulties recruiting and retaining staff, especially in rural areas.

Ms. Amy B. Armstrong, Project Coordinator, North Dakota Medicaid Infrastructure Grant, North Dakota Center for Persons with Disabilities, provided information regarding the results of a QSP survey, including information on the new payment levels approved by the Legislative Assembly, usage, availability of services across the state, and plans for organization of QSPs. She said in February 2008 the North Dakota Medicaid Infrastructure Grant project participated in the dissemination of surveys to North Dakota individual and agency QSPs. She said survey responses were compiled into the *Report of Questionnaires Administered to North Dakota Individual and Agency Qualified Service Providers (QSPs)* and used as a resource in the development of *At a Crossroad, North Dakota Home and Community Based Services - An Overview and Recommendations*. She said the survey indicated that most individual and agency QSPs which provide private (nonpublic funded) QSP services indicated that only 10 percent or fewer of their consumers were private pay. She said the survey indicated that time, travel, and reimbursement were most often noted as barriers preventing the QSP from providing additional services when requested. She said when asked what changes are needed in the QSP program to help QSPs do their jobs better, individual responses included less paperwork, increased reimbursement, access to health insurance and benefits, training, travel and mileage reimbursement, flexibility in services and time limits, and more respite care. She said agency responses to the same question included increased staff, less paperwork, increased reimbursement, flexibility in services and time limits, and more state involvement in training. She said over one-third of both individual and agency QSP responses indicated an interest in participating in a QSP organization. She said the North Dakota Medicaid Infrastructure Grant project has collaborated with the North Dakota centers for independent living to assist in convening regional groups of individual QSPs in three cities and future plans include meetings in additional cities.

Ms. Tammy Theurer, Director of Home Care and Hospice, St. Alexius Medical Center, and Past President of the North Dakota Association for Home Care, and Ms. Sharon Moos, Executive Director, Medcenter One Home Health and Hospice, provided information regarding the new payment levels approved by the Legislative Assembly, usage, and availability of QSP services. Ms. Theurer said a 2006 survey of North Dakota Association for Home Care members found that 17 agencies were providing QSP services with varying levels of reimbursement. She said data obtained from the Department of Human Services indicated an average annual increase in reimbursement of 3.21 percent from January 1994 through January 2006 while the average annual increase in nursing facility rates was 8.92 percent for the same period.

Ms. Theurer said the North Dakota Association for Home Care recently surveyed its members and found that agencies providing QSP services in 2006 continue to provide services; however, personal care services are being limited by many agencies as a result of the cost of travel to rural areas of the state. She said a recent request for services 30 miles from the nearest staff would have resulted in direct costs exceeding $65.00 and a reimbursement payment of $19.64. She said although the client desperately needed services, services were unable to be provided due to the low reimbursement rate.

Ms. Theurer said that while the increase in reimbursement provided by the 2007 Legislative Assembly has allowed agencies to continue providing services in areas that may have been eliminated otherwise, the average cost to provide services today is $27.75 per hour. Increased costs have again made it difficult for agencies to continue to provide services. A copy of the report is on file in the Legislative Council office.

In response to a question from Senator Dever, Ms. Theurer said agencies charge private pay individuals a higher rate to subsidize the lower reimbursement rate.

Ms. Moos said while QSP services and admissions have increased during the past two years, her agency's plan to expand the QSP caseload is limited by the cost of providing QSP services and a growing volume of Medicare home health and hospice patients. She said while the agency is losing more than $6.00 for each hour of QSP service provided, home health and hospice services for Medicare patients offer a higher payment level. She said while serving individuals that provide the highest payment is not the organization's mission, it must manage its

NURSING FACILITY PAYMENT SYSTEM

MINIMUM DATA SET FOR PAYMENT

The state adopted the Minimum Data Set (MDS) for its payment system on January 1, 1999. The MDS provides a wide array of information regarding the health status of each resident. The payment system has thirty-four rates. Each resident is evaluated at least quarterly and the intensity of their needs determines their rate classification.

EQUALIZATION OF RATES

The legislature implemented equalization of rates between Medicaid residents and self pay residents for nursing facilities in 1990. Equalization of rates requires all residents be charged the same rate for comparable services. Minnesota and North Dakota are the only states in the nation with equalization of rates. Nursing facilities are the only providers/private business subjected to an equalization rate system in the State of North Dakota.

RATE CALCULATIONS

The determination of rates is the sum of **four components**: direct care, other direct care, indirect care and property. Today's rates and limits are calculated based on the **June 30, 2006 cost report** and inflated each year. The 2007 legislature directed that rates and limits would be increased by 4% in 2008 and 5% in 2009.

Limits (the maximum that will be paid) are set for all rate components by utilizing the **2006** cost report of all Medicaid nursing facilities, arraying the facilities from least expensive to most expensive, selecting the facility at mid-point (median facility) and then adding either 10% or 20% to the cost of that median facility. The **direct care** and **other direct care** limit is established by adding **20%** to the cost of that median facility. The **indirect care** limit is established by adding **10%** to the cost of that median facility.

Direct Care Rate. Costs in the Direct Care Category include: nursing and therapy salaries and benefits, OTC drugs, minor medical equipment and medical supplies. On January 1, 2009 the direct care limit was set at $109.23 per day. Eight nursing facilities currently exceed this limit. The eight nursing facilities over the limit are spending at least $1,022,621 in nursing that will never be recouped.

Other Direct Care. Costs in the Other Direct Care Category include: food, laundry, social service salaries, activity salaries and supplies. On January 1, 2009 the other direct care limit was set at $20.70 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities exceeding the limit are spending at least $103,772 in costs that will never be recouped.

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1900 N 11th St 701.222.0660
Bismarck, ND 58501 www.ndltca.org

Indirect Care. Costs in the Indirect Care Category include: Administration, pharmacy, chaplin, housekeeping salaries, dietary salaries, housekeeping and dietary supplies, medical records, insurance, and plant operations. On January 1, 2009 the indirect limit was set at $52.28 per day. Twenty-five nursing facilities currently exceed this limit. The twenty-five nursing facilities exceeding the limit are spending at least $2,021,461 in indirect care expenses. These costs will never be recouped.

Property rate includes depreciation, interest expense, property taxes, lease and rental costs, start-up costs and reasonable and allowable legal expenses. The property limit was rebased with the July 1, 2007 rates. The average property rate is $11.58 per resident per day, with a range of $2.00 to $54.18.

Occupancy Limitation – In the June 30, 2008 cost reporting period, fourteen rural nursing facilities reported twelve month occupancy averages at less than 90%. Together they incur $575,060 in penalty costs because they operate under 90% occupancy.

Incentives - A reward is provided to nursing facilities who are under the limits in indirect care. The incentive is calculated for each facility based upon their indirect costs compared to indirect limits. Facilities are able to receive .70 cents for every dollar they are below limits up to a maximum of $2.60 per resident day. In 2009, 44 nursing facilities received an incentive, with the average per day incentive at $1.94. Of the 44 nursing facilities receiving an incentive, they ranged from $0.20 to $2.60 per resident per day. Thirty-five nursing facilities are not eligible for the incentive.

Operating Margin - All nursing facilities receive an operating margin of three percent based on their historical direct care costs and other direct care costs (up to limits). The operating margin provides needed cash flow to cover up front salary adjustments, replacement of needed equipment, unforeseen expenses, and dollars to implement ever increasing regulations. The operating margin covers the gap between the cost report and the effective date of rates (this can be up to 18 months). In 2009, the average operating margin is $3.12 per resident per day.

Inflation - Rates are adjusted for inflation annually. Inflation is a rise in price levels, generally price levels long term care facilities can not control. Examples of price level increases include the 9.7% increase in health insurance and significant increases in fuel. To attract and retain adequate staff nursing facilities need to offer salary and benefit packages that reward people. Approximately 75% of a nursing facility's budget is dedicated to personnel costs. Adequate inflation adjustments are critical for salary and benefits so nursing facilities can compete in the market place. Turnover of certified nurse assistants, the largest pool of employees was 66% in 2000. In 2003, CNA turnover was at 35%. Today CNA turnover is reported at 51%. We need to offer competitive wages or turnover will continue on an upward path.

Annual inflationary adjustments are set every legislative session.

Rebasing – A limit is establish on the maximum that will be paid in each cost category. The 2005 legislature enacted legislation requiring that rates be rebased and updated at least every four years. The 2009 limits are based upon the June 30, 2006 cost report and was inflated forward to 2009. The next time limits will be rebased is January 1, 2013 using the June 30, 2010 cost report.

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NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

LONG-TERM CARE COMMITTEE

Tuesday, March 4, 2008
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Dick Dever, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Dick Dever, Joan Heckaman, Aaron Krauter, Judy Lee; Representatives Larry Bellew, Karen Karls, Gary Kreidt, Ralph Metcalf, Jon Nelson, Vonnie Pietsch, Gerry Uglem, Benjamin A. Vig, Alon Wieland

Members absent: Senator Tim Mathern; Representatives Louise Potter, Clara Sue Price

Others present: Phillip Mueller, State Representative, Wimbledon

See attached appendix for additional persons present.

It was moved by Representative Bellew, seconded by Senator Lee, and carried on a voice vote that the minutes of the previous meeting be approved as distributed.

LONG-TERM CARE STUDY

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, presented a report on the change in long-term care services funding requirements resulting from federal medical assistance percentage (FMAP) changes. She said the additional general fund matching requirements resulting from the FMAP decrease from the 2005-07 biennium to the 2007-09 biennium was $2,460,738 for developmental disabilities community-based care services, $2,279,874 for nursing home services, $156,745 for home and community-based services, and $58,442 for basic care services. A copy of the report is on file in the Legislative Council office.

In response to a question from Representative Kreidt, Ms. Anderson said the number of beds paid for through Medicaid currently averages 3,508 per month. She said the department's 2007-09 biennium appropriation was based on an average of 3,494 beds per month.

In response to a question from Senator Krauter, Ms. Anderson said the department will receive the preliminary 2010 FMAP in April 2008 and the final FMAP in September 2008. Senator Krauter asked that information on the preliminary 2010 FMAP be provided to the committee at its next meeting.

Ms. Anderson presented a report summarizing information on other states that have a high number of nursing home beds per 1,000 elderly that also have nursing home bed moratoriums. She said the North Dakota Long Term Care Association assisted the department in gathering the information. She said of the 14 states that responded to a survey by the American Health Care Association, 6 had a moratorium in place and 11 had a certificate of need process. A copy of the report is on file in the Legislative Council office.

Ms. Anderson presented information on nursing home facility-related costs compared to service-related costs. She said direct costs include nursing and therapy; other direct costs include laundry, activities, and social services; and indirect costs include administration, chaplain, pharmacy, housekeeping, and medical records.

RATES PER DAY FOR SELECT NURSING FACILITY COSTS
June 30, 2007, Cost Reports

	Average Per Day	Percentage	Range	
Property, utilities, etc.	$10.34	6.62%	$1.74	$26.57
Food	6.48	4.15%	$3.29	$9.39
Direct*	90.47	57.91%	$65.06	$115.87
Other direct	10.17	6.51%	$5.96	$15.82
Indirect	38.77	24.82%	$29.56	$131.87
Total	$156.24			

*Average calculated as total nursing facility costs divided by total census. Costs were not case mix-adjusted and limits were not applied.

A copy of the report is on file in the Legislative Council office.

In response to a question from Representative Kreidt, Ms. Anderson said she will provide information to the committee on the current average case mix in the state.

The legislative budget analyst and auditor presented a memorandum entitled *Recipients of North Dakota Long-Term Care Services - 2007 and Potential for 2020*. The legislative budget analyst and auditor said the memorandum provides information on the long-term care service capacity in North Dakota and the number of residents accessing those services in 2007 as well as information on the potential number of residents that may be accessing long-term care services in 2020.

The legislative budget analyst and auditor said the information was compiled with assistance from the Department of Human Services, the State Department of Health, and the North Dakota Long Term Care Association.

The following schedule summarizes information in the memorandum regarding the number of facilities, beds, and qualified service providers providing

ADDITIONAL REASONS TO OPPOSE THE MORATORIUM

* The moratorium and the practice of buying and selling of beds was so UNOCCUPIED beds could be transferred, not for the transferring of OCCUPIED beds. The transferring of occupied beds DOES NOT relieve the shortage of beds in the area to which the beds are being transferred. The moratorium encourages this practice because the demand outstrips the supply of beds.

* Limiting beds not only reduces the competition within the nursing home industry, but compromises the quality of care as well. All facilities -- superior and inferior -- will continue operating because demand outstrips supply. However, lift the moratorium and the superior facilities will remain viable and the inferior facilities will be forced to close because residents and their families will have the option to choose the facility that best suits their needs. The present method of reimbursement based on occupancy rates and the equalization of rates assures this will happen.

* The practice of buying and selling beds reduces the beds to a commodity; beds should be used to meet the needs of individuals in need of 24 hour supervision or care.

* The ND Long Term Care Association in previous testimony stated that by 2020 the number of nursing home residents may total 9,289 as compared to the current number of 6,358. Where are those 2,931 residents going to find beds if the moratorium stays at the current level and quality nursing homes are forced to close?

* ND nursing home facilities currently have an overall occupancy rate of 94%. Anything over 90% by national standards is considered full. How is ND going to meet the needs of our aging population?

* Much testimony has centered around the mal-distribution of nursing beds throughout the state. Since enacting the moratorium in 1999 and with the state buying of 286 beds at a cost of over $3 million, the mal-distribution still exists. A county by county survey indicated there were nine counties without any nursing home facilities and another 19 counties with less than 50 beds per 1,000 for people ages 65 and over. The actual range was from a low of 35.6 beds per 1,000 to a high of 127.7 beds per 1,000. How much more is the state going to spend to redistribute these beds?

* Licensing of beds should be for the sole purpose of ensuring quality control, and not for determining the location of where the beds are located.

* Nursing home care is the last resort for people and is used only when other services can no longer meet their needs or when other alternatives aren't available to them. For example, if the moratorium was lifted, I doubt if we would see people with their suitcases packed lined up waiting to get a bed in a nursing home. However, our elderly and disabled do deserve the security of knowing that a bed will be available for them if need arises. Nursing home care that is close to family and friends should be an option available to ALL citizens -- urban and rural alike.

*The national recommendation of 60 beds per 1,000 was established, not only as a guideline for states who exceeded 60/1000, but also for those states who were below the 60/1000 level. Currently, there are 36 states who have not achieved that ratio while 15 states have exceeded the recommendation, including North Dakota. Instead of bemoaning the fact that North Dakota is over the number of beds, we should be celebrating and not spending better than $3 million to reduce the number of beds. If we exceeded the national ratio of the number of doctors, nurses, dentists, and other health care professionals, would North Dakota citizens be rejoicing or lamenting being in such circumstances?

* Past testimony indicated beds would be worthless if the moratorium would be lifted. **Unoccupied beds** should be worthless. However, occupied beds are extremely valuable, not only because of the revenue generated, but because of the wonderful people occupying the bed. An occupied bed brings in revenue and unoccupied bed does not.

* Does the selling of the beds only prolong the eventual closing the facility a little longer or does it allow the facility to make the necessary adjustments to maintain 90% occupancy? Shouldn't a facility be Couldn't a facility choose not to license the extra beds and return the beds to the state for other facilities to use rather than selling the beds?

* The way nursing homes are funded there are already safe-guards in place to keep supply and demand equal. Nursing homes that fall below the 90% occupancy rate are PENALIZED by being reimbursed at their ACTUAL occupancy rate while facilities that maintain a minimum occupancy rate of 90% are reimbursed at a 100%. Why would a facility want to license more beds than needed when faced with penalties if the beds are unoccupied? Why should facilities needing more beds be forced to bid on beds and pay upwards to $20,000 per bed?

* Safe-guards are also in place that limits who can become a nursing home resident. All prospective nursing home residents must be assessed and screened before entering a nursing home to assess the appropriateness of nursing home placement and a physician must recommend placement in a nursing before anyone can become a resident of a nursing home. North Dakotans with their independent spirit do not clamor to be placed in a nursing home, but rather nursing home placement is a last resort.

* When doing a county by county comparison of the ratio of beds per 1,000 for people 65 and over, data indicated that Burleigh/Morton County has a 65.8 bed ratio while Cass County has a 61.8 bed ratio. In the northern tier Ward County has a 55.9 bed ratio and Grand Forks County has a 62.8 bed ratio. If these urban counties are seeing a need for more beds, what must the need be in the counties with no nursing beds available or a limited number of beds available?

* For several sessions, the Legislature has been told there is a critical shortage of beds in the four largest cities of North Dakota and that there is a surplus of beds in the rural areas. However, data indicates that Bismarck/Mandan has a bed ratio of 61.3 beds per 1,000 and Fargo/West Fargo has a bed ratio of 68.2 beds per 1,000, not including Moorhead. Grand Forks has a bed ratio of 59.5 beds per 1,000, not including East Grand Forks, while Minot has a bed ratio of 74.4 beds per 1,000.

*The chart below indicates the current available beds in the four major cities of the state and the planned expansion to increase nursing bed capacity. If these four urban areas are truly facing shortages of skilled nursing beds with the number of beds above the recommended level of 60 beds per 1,000, what shortages must the rural areas be facing?

CURRENT NUMBER OF SKILLED NURSING BEDS FOR THE FOUR URBAN AREAS OF NORTH DAKOTA

AND ADDITIONAL BEDS PLANNED

URBAN AREA	ESTIMATED POPULATION 2006	PERCENT OF POPULATION 65 YEARS AND OLDER*	ESTIMATED NUMBER OF PEOPLE 65 OR OLDER*	CURRENT NUMBER OF NURSING BEDS**	NUMBER OF BEDS PER 1,OOO	ADDITIONAL BEDS PLANNED**
BISMARCK/	58,333	13.8%	8,059	492		119
MANDAN	16,718	12.7%	2,130	128		50
COMBINED	75,051	13.3%	10,108	620	61.3	169
FARGO/	90,056	10.1%	9,095	688		69
W. FARGO	14,940	6.7%	997	0		45
COMBINED	104,996	8.4%	10,092	688	68.2	114
GRAND FORKS	50,372	9.8%	4,936	294	59.5	19
MINOT	34,745	15.9%	5,351	398	74.4	8

* Based on Estimated 2006 Population Figures

** Based on January 2009 Testimony presented to House Human Services Committee.

* Fargo and Grand Forks areas do not include nursing facilities in Moorhead or East Grand Forks, both of which would increase the ratio of the number of beds per 1,000.

*Part of the shortages in skilled nursing home beds comes from not considering North Dakota's proportion of residents who are 85 years or older. The national recommendation of 60 beds per 1,000 is for people between the ages of 65 and 84 whereas the national recommendation for people 85 years and older is 453 beds per 1,000. With North Dakota being ranked number 1 in the nation as having more people 85 and older per capita than any other state, it is no wonder there is a critical shortage of beds for the truly elderly who are the ones most likely to be the ones that end up in a nursing home.

ADDITIONAL NOTES

* How does the transferring of OCCUPIEDS BEDS relieve the shortage of beds in the area to which the beds are being transferred? Wasn't the intent of the moratorium to move UNOCCUPIED beds to areas where there was a greater need?

* Shouldn't the owners of a nursing facility decide when to close a facility? Leasing operators have the right to terminate managing a facility, but should not have sole control of the beds.

* When there is shortage of nursing beds in the region, does it make sense to close a fully-paid for facility with a history of an occupancy rate of 90% or better, just because skilled nursing beds are not available?

* Recently a new facility in the region was built for a cost of between $12-14 million and with the transferring of patients from Golden Manor and changing rooms from semi-private to private rooms the net gain in nursing home beds amounted to only an additional 30 -40 beds. Doesn't this seem like an excessive amount to spend for so few beds? Particularly in light of a recent survey in which only 10 out of 363 Kidder County residents indicated that having a private room was the most important factor when considering nursing home care.

* As of January 2009, 20 of the 28 residents at Golden Manor were from Kidder County. In addition, of the 15 residents who transferred because they did not want to go to an urban area, 12 were from Kidder County. Golden Manor in the past has been primarily used by the residents of Kidder County and would continue to be used in the future if beds were made available.

* Much testimony has centered around the mal-distribution of nursing beds throughout the state and since 1996 with the moratorium and the buying up of beds at a cost of over $3 million the mal-distribution still exists. A county by county survey indicated there were nine counties without any nursing home facilities and another 19 counties with less than 50 beds per 1,000 for people ages 65 and over. The actual range was from a low of 35.6 beds per 1,000 to a high of 127.7 beds per 1,000. How much more is the state going to spend to redistribute these beds?

*Meanwhile, Burleigh County's ratio is 56.9 beds per 1,000 while Morton County's ratio is 74.7. Cass County's ratio is 61.8 and does not include facilities in the Moorhead area. Grand Forks County's ratio is 62.8 and does not include facilities in East Grand Forks. Finally, Ward County's ratio is 55.9. What counties are truly being underserved? If these four urban areas are indicating a real shortage of nursing beds with those ratios, what must the other counties be experiencing?

* ND nursing home facilities currently have an overall occupancy rate of 94%. Anything over 90% by national standards is considered full. The 85 and older population is the fastest growing segment of ND's population and is also the group most likely to need nursing home care. Where are these oldest of the old going to find a place to spend their remaining days when the facilities are already full?

Opposition to Senate Bill 2044

Chairman Weisz and members of the House Human Services Committee, I am here to speak in opposition to the moratorium. My name is Rose Marie Birrenkott and I have seen first-hand how the moratorium has affected our little community and do not want other communities to experience what Steele has. In less than a month from now, Golden Manor, a facility designed and equipped to be utilized as a nursing facility will sit empty. Not because there are no residents to fill the facility, but simply because there are no beds available due to the moratorium.

If the moratorium was not in place, Golden Manor could have kept their beds; Med Center One could have applied for licenses for their new 128 bed facility, and both facilities would be meeting the needs of the elderly who require 24 hour supervision or nursing care. Residents would not have to be uprooted and family members in both Bismarck and Steele could visit loved ones without having to travel outside of their home area. Furthermore, the state of North Dakota would be addressing the issue of North Dakota's aging population in a positive, pro-active manner. No one wants to end up in a nursing home. People enter a nursing home as a last resort when they have exhausted all other options. Nursing home residents are there because they have moved from being independent, to semi-independent or dependent, to mostly or completely dependent. This is just the natural progression as one ages. Some people's lives are cut short and the progression stops, but for others they continue living longer than they ever dreamed possible and in many cases longer than they want. Some look at living a long life as a blessing and other see it as a curse.

Specifically, I would like to speak about how the moratorium limits access to nursing home services in the rural areas and how the buying and selling of beds has not helped in the redistribution of beds. The goal of the moratorium was to have 60 beds per thousand for people ages 65 and older and to reduce nursing home costs. Using 2000 census figures of actual number of people who are 65 years of age or older in each county and the actual number of beds available in each county as of January 2009, the ratio of beds per 1,000 ranges from 0 to 127.7 beds per 1,000. Nine counties have no nursing home facilities and if Kidder County loses their facility, there will be 10 counties without nursing home facilities. In addition, 10 counties have less than 60 beds per 1,000. The other 33 counties have bed counts ranging from 61.1 to 127.7 beds per 1,000.

(See attachments A and B for a breakdown by counties) Now ask yourself, which counties, --not regions -- are truly being underserved?

Before you jump all over Dickey County for having a ratio of 127.7 beds per 1,000, maybe we should check what the occupancy rates for their two facilities are. According to my information, the 102 bed facility had an occupancy rate of 97% and the 55 bed facility had an occupancy rate of 85% meaning there was a total of 11 empty beds between the two facilities. Not a terribly excessive amount for a county that supposedly has over two times the recommended ratio.

In addition, although, I agree in principle with the concept of full payment for any facility that has an occupancy rate of 90% or higher, there is a big difference in the number of beds available in a 50-bed facility as opposed to the number of beds available in a 250-bed facility when calculating the number of beds actually available. At the 90% occupancy rate, a 50-bed facility would have only 5 empty beds available whereas the 250-bed facility would have 25 empty beds or five times as many beds as the 50-bed facility. With the trend toward moving nursing care facilities to the urban areas at the expense of the rural areas, an urban area with several nursing care facilities could possibly have 50-75 empty beds depending upon the size of the other facilities in the area. Still, all of the facilities in the illustration would be operating at 90% occupancy. However, which facility is truly underutilizing the licensed beds -- the 50-bed facility with 5 empty beds or the 250-bed facility with 25 empty beds?

Also, in regards to occupancy rate, if the moratorium was lifted, facilities would not be adding beds unless there was truly a need for more beds. Since funding is based on occupancy rates, why would a facility want more beds than they can fill? The empty beds translate into lost revenue which in turn translates into lack of viability and sustainability.

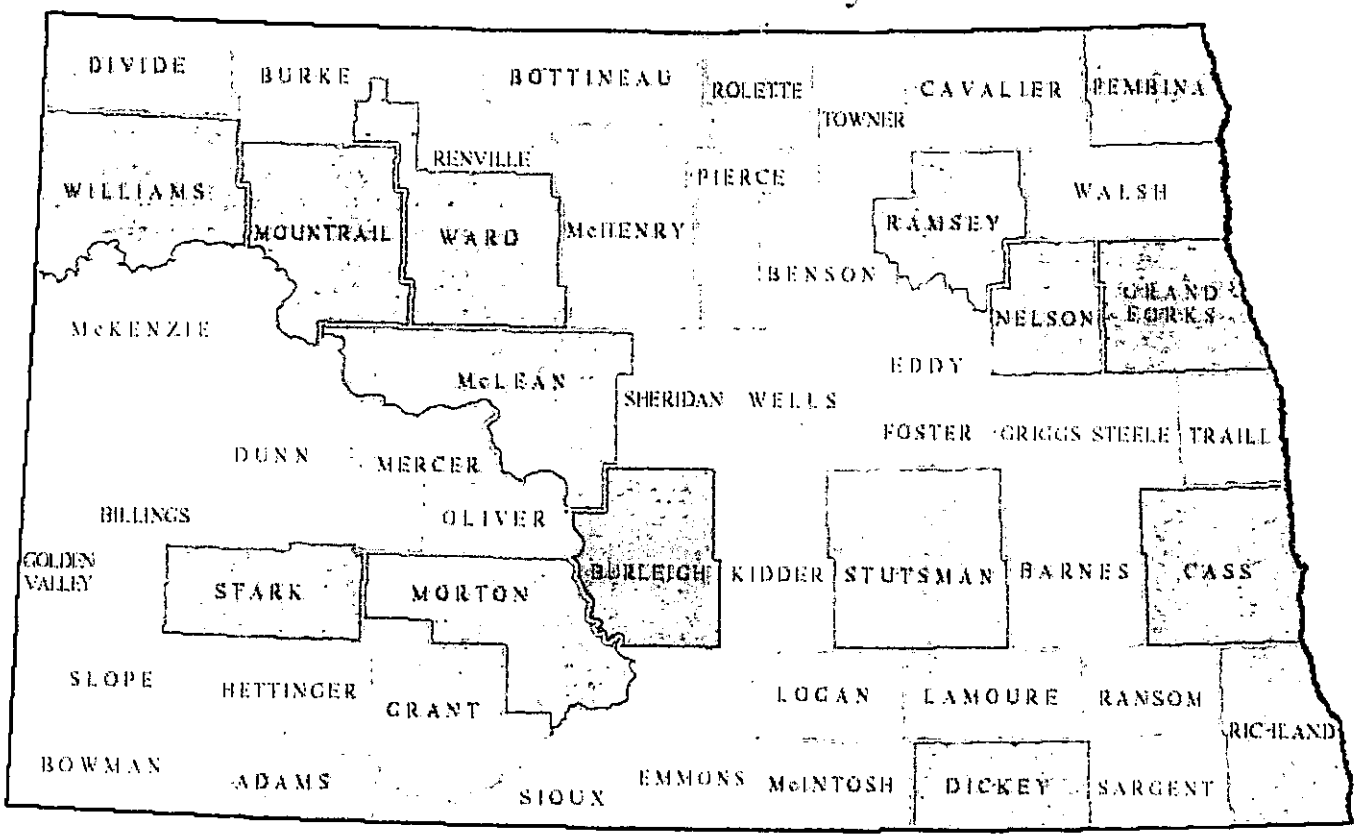
Meanwhile the push has been to move nursing beds to the four urban counties where currently the bed ratios for those counties are Burleigh/ Morton at 65.8; Cass at 61.8; Grand Forks at 62.8, and Ward 55.9. Please remember, the figures for Cass and Grand Forks counties do not include facilities in Moorhead or East Grand Forks, which would make the bed ratios even higher. All four urban areas have been given approval to add more beds in the near future even though three of the four urban areas already exceed

the recommended ratio. If these counties are seeing a need for going above the recommended ratio of 60 beds per 1,000, what must the need be in the counties without any nursing facilities or in counties with less than 60 beds per 1,000?

Yes, these so-called urban counties are all experiencing growth, but in what age categories? Ages 0 to 19? Ages 20 to 44? Ages 45 to 64? Or is it for ages 65 and over? If the influx is comprised of mostly elderly, are the elderly relocating by choice or being forced to do so because no nursing home services are available in their home counties? Relying on composite data from North Dakota's eight service regions without a breakdown by counties, masked or hides the rural elderly and does not accurately reflect who is truly being underserved. According to the North Dakota State Data Center in regards to consolidation issues, what happens is the larger communities' growths are masking smaller communities' decline and political debates are being dominated by large communities. Thus, sparse population bases and vast distances "hide"' rural residents and make them harder to serve. In laymen's terms this simply means the squeaky wheel gets the oil.

Finally, I recognize that the moratorium does make budgeting easier when there is a set number of beds, but it does not take into consideration the needs of one of our most vulnerable segments of the population -- our elderly. It should not matter if these elderly live in rural or urban areas. What should matter is that they have freedom of choice as to where they want to reside and that they can remain close to family and friends. Thank you for hearing my testimony in opposition to the moratorium.

Number of Long Term Care Facilities Per North Dakota County, 2002



Number of Facilities

No Long Term Care Facilities | 1 | 2 | 3 to 5 | 6 to 10

Sources: North Dakota Long Term Care Association; geographic files adapted from the North Dakota Department of Transportation GIS Base Map Data version 4.0

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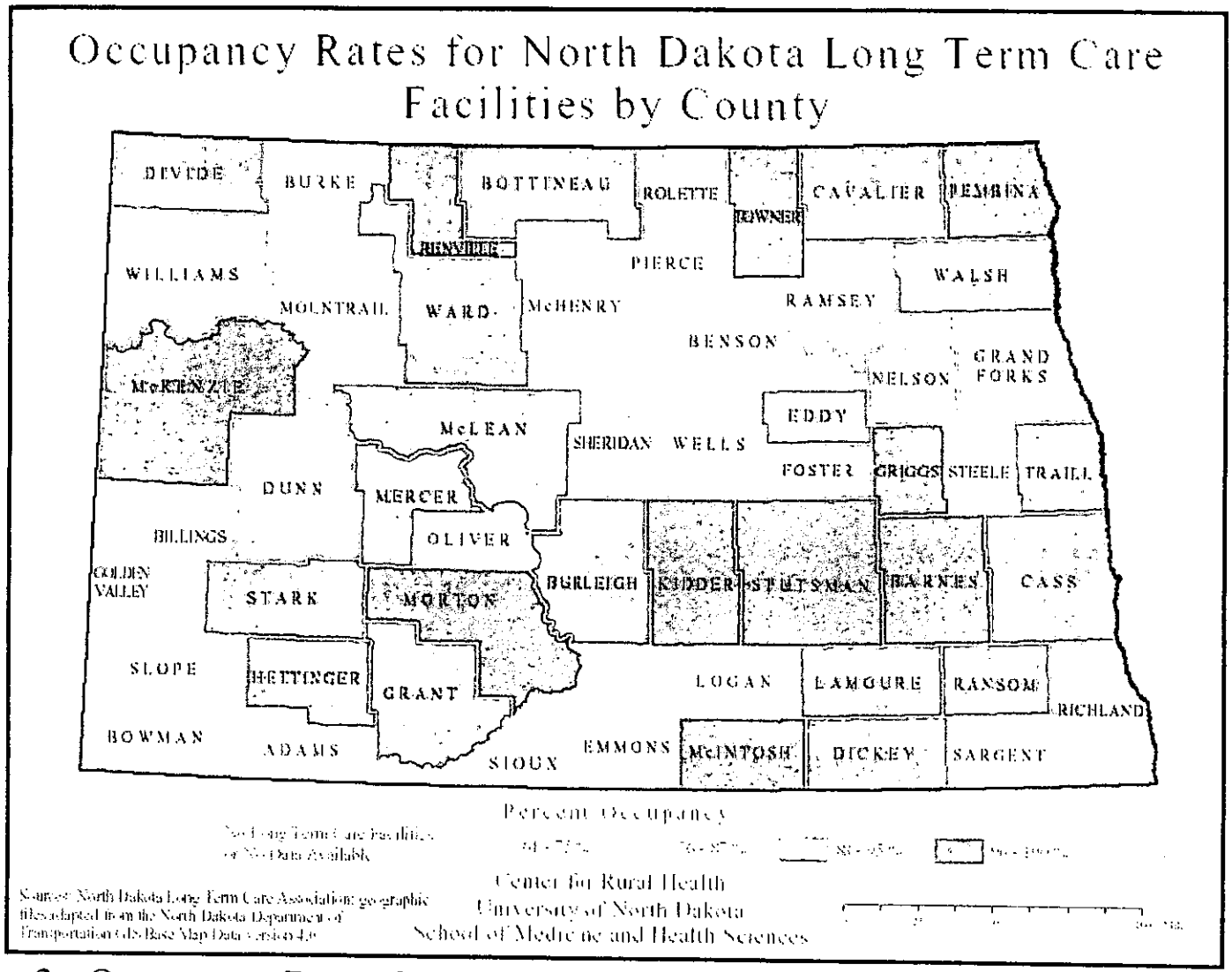

Occupancy Rates for North Dakota Long Term Care Facilities by County
DIVIDE
BURKE
BOTTINEAU
ROLETTE
TOWNER
CAVALIER
PEMBINA
RENVILLE
WILLIAMS
PIERCE
WALSH
MOUNTRAIL
WARD
McHENRY
RAMSEY
BENSON
GRAND FORKS
McKENZIE
NELSON
EDDY
McLEAN
SHERIDAN
WELLS
FOSTER
GRIGGS
STEELE
TRAILL
DUNN
MERCER
BILLINGS
OLIVER
GOLDEN VALLEY
STARK
MORTON
BURLEIGH
KIDDER
STUTSMAN
BARNES
CASS
SLOPE
HETTINGER
GRANT
LOGAN
LAMOURE
RANSOM
RICHLAND
BOWMAN
ADAMS
SIOUX
EMMONS
McINTOSH
DICKEY
SARGENT
Percent Occupancy
Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences

RATIO OF BEDS PER 1,000 BY COUNTIES IN NORTH DAKOTA

COUNTY	# OF RESIDENTS 65 & OVER*	% OF TOTAL POPULATION*	# OF FACILITIES**	SIZE OF FACILITIES**	TOTAL BEDS	RATIO PER 1,000
ADAMS	624	24.1%	1	62	62	99.4
BARNES	2,332	19.8%	1	170	170	72.9
BENSON	914	13.5%	0	-	0	0
BILLINGS	142	16.0%	0	-	0	0
BOTTINEAU	1,522	21.3%	2	81+25	106	69.6
BOWMAN	707	21.8%	1	61	61	86.3
BURKE	562	25.1%	0	-	0	0
BURLEIGH	8,640	12.4%	3	141+250 +101	492	56.9
CASS	11,901	9.7%	6	47+192+136 +109+140+111	735	61.8
CAVALIER	1,107	22.9%	2	63+24	87	78.6
DICKEY	1,229	21.3%	2	55+102	157	127.7
DIVIDE	674	29.5%	1	42	42	62.3
DUNN	625	17.4%	1	50	50	80.0
EDDY	682	24.7%	1	80	80	117.3
EMMONS	1,107	25.6%	1	60	60	54.2
FOSTER	803	21.4%	1	60	60	74.7
GOLDEN VALLEY	410	21.3%	0	-	0	0
GRAND FORKS	6,368	9.6%	4	176+118 45+61	400	62.8
GRANT	703	24.7%	1	25	25	35.6
GRIGGS	708	25.7%	1	48	48	67.8
HETTINGER	683	25.2%	1	51	51	74.7
KIDDER	662	24.0%	1	50	50	75.5
LA MOURE	1,100	23.4%	1	44	44	40
LOGAN	623	27.0%	1	44	44	70.6
MC HENRY	1,305	21.8%	1	50	50	38.3
MC INTOSH	1,160	34.2%	2	44+74	118	101.7
MC KENZIE	900	15.7%	1	47	47	52.2
MC LEAN	1,900	20.4%	3	28+68+63	159	83.7
MERCER	1,233	14.3%	1	86	86	69.7
MORTON	3,693	14.6%	3	86+128+62	276	74.7
MOUNTRAIL	1,174	17.7%	2	42+57	99	84.3
NELSON	1,019	27.4%	3	39+49+39	127	124.6
OLIVER	293	14.2%	0	-	0	0
PEMBINA	1,674	19.5%	2	60+37	97	57.9
PIERCE	1,127	24.1%	1	80	80	71.0
RAMSEY	2,266	18.8%	2	66+88	154	68.0

COUNTY	# OF RESIDENTS 65 & OVER*	% OF TOTAL POPULATION*	# OF FACILITIES**	SIZE OF FACILITIES**	TOTAL BEDS	RATIO PER 1,000
RANSOM	1,250	21.2%	3	54+40+ 38 (Veterans)	132	105.6
RENVILLE	575	25.8%	1	59	59	102.6
RICHLAND	2,746	15.3%	2	37+112	149	54.3
ROLETTE	1,325	9.7%	2	46+35	81	61.1
SARGENT	740	16.9%	1	35	35	47.3
SHERIDAN	455	26.6%	0	-	0	0
SIOUX	226	5.6%	0	-	0	0
SLOPE	137	17.9%	0	-	0	0
STARK	3,510	15.5%	2	164+84	248	70.7
STEELE	442	19.6%	0	-	0	0
STUTSMAN	3,862	17.6%	2	100+142	242	62.7
TRAILL	1,623	19.1%	3	99+42+36	177	109.1
TOWNER	670	23.3%	1	49	49	73.1
WALSH	2,390	19.3%	2	104+80	184	77.0
WARD	7,341	12.5%	3	12+106+292	410	55.9
WELL	1,326	26.0%	1	106	106	79.9
WILLIAMS	3,261	16.5%	2	174+30	204	62.6

* Based on 2000 Census Data ** Based on January 2009 Testimony of NDLTCA

Bismarck is adding 71 beds in June 2010 and another 48 beds in May 2010. With the additional new beds, their ratio will be 70.7.

Fargo is adding 22 beds in July 2009, 40 beds January 2010, 45 beds in December 2009, and 7 beds with no date listed. With the additional new beds, their ratio will be 71.3.

Minot is planning on adding 8 beds in July 2009. With the additional beds their ratio will be 56.9.

Grand Fork is planning on adding 19 beds in April 2010. With the additional beds their ratio will be 65.8.

Conclusions

9 of the 53 counties in ND have no nursing home facilities and another 10 counties have less beds than the recommended level of 60 beds per 1,000 people 65 years and older. (36% of the counties are being underserved)

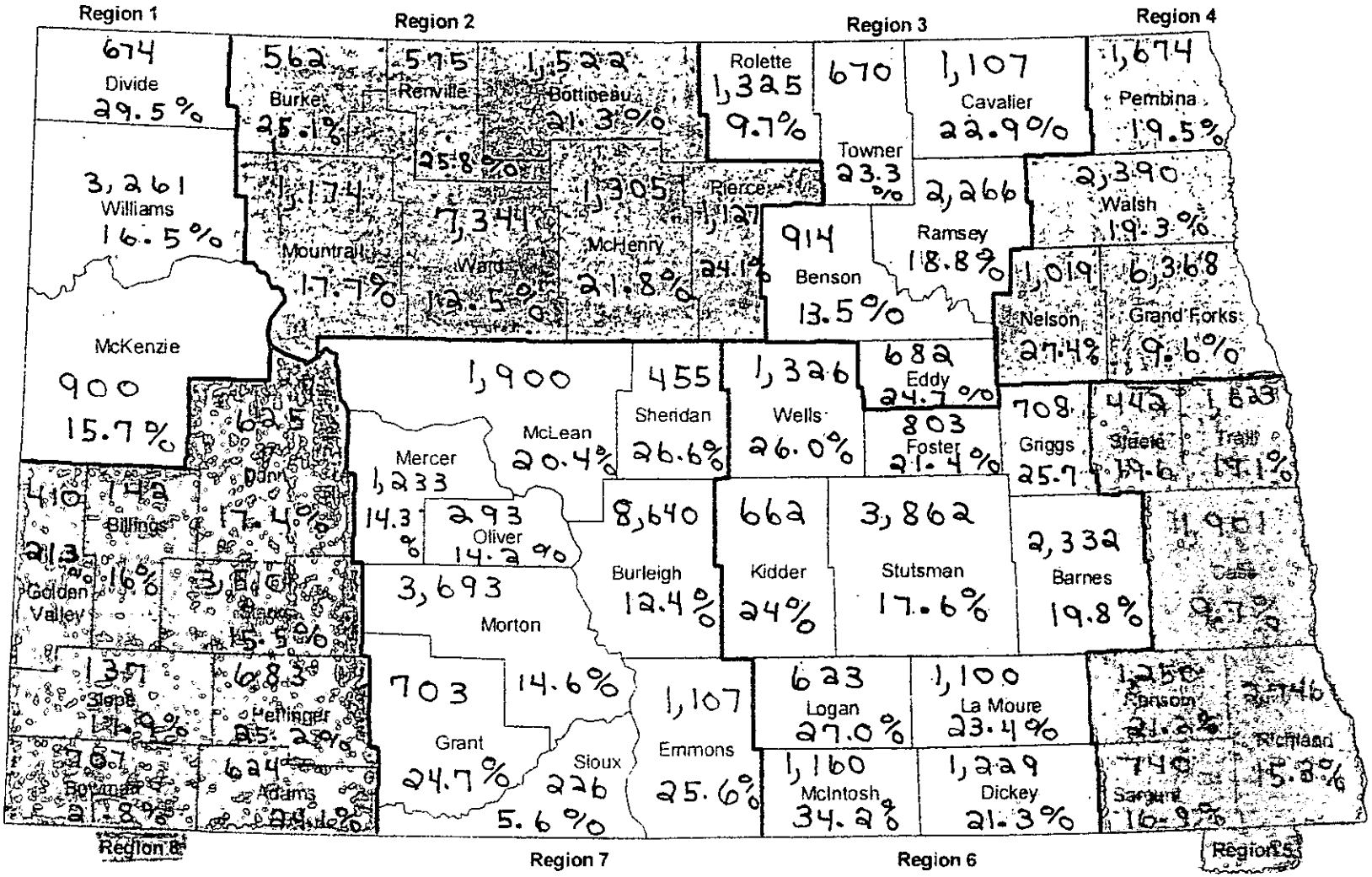
23 of the 53 counties have bed ratios between 61 and 70 beds per 1,000. (43%)

4 counties have bed ratios between 81 and 100 beds per 1,000 (8%)

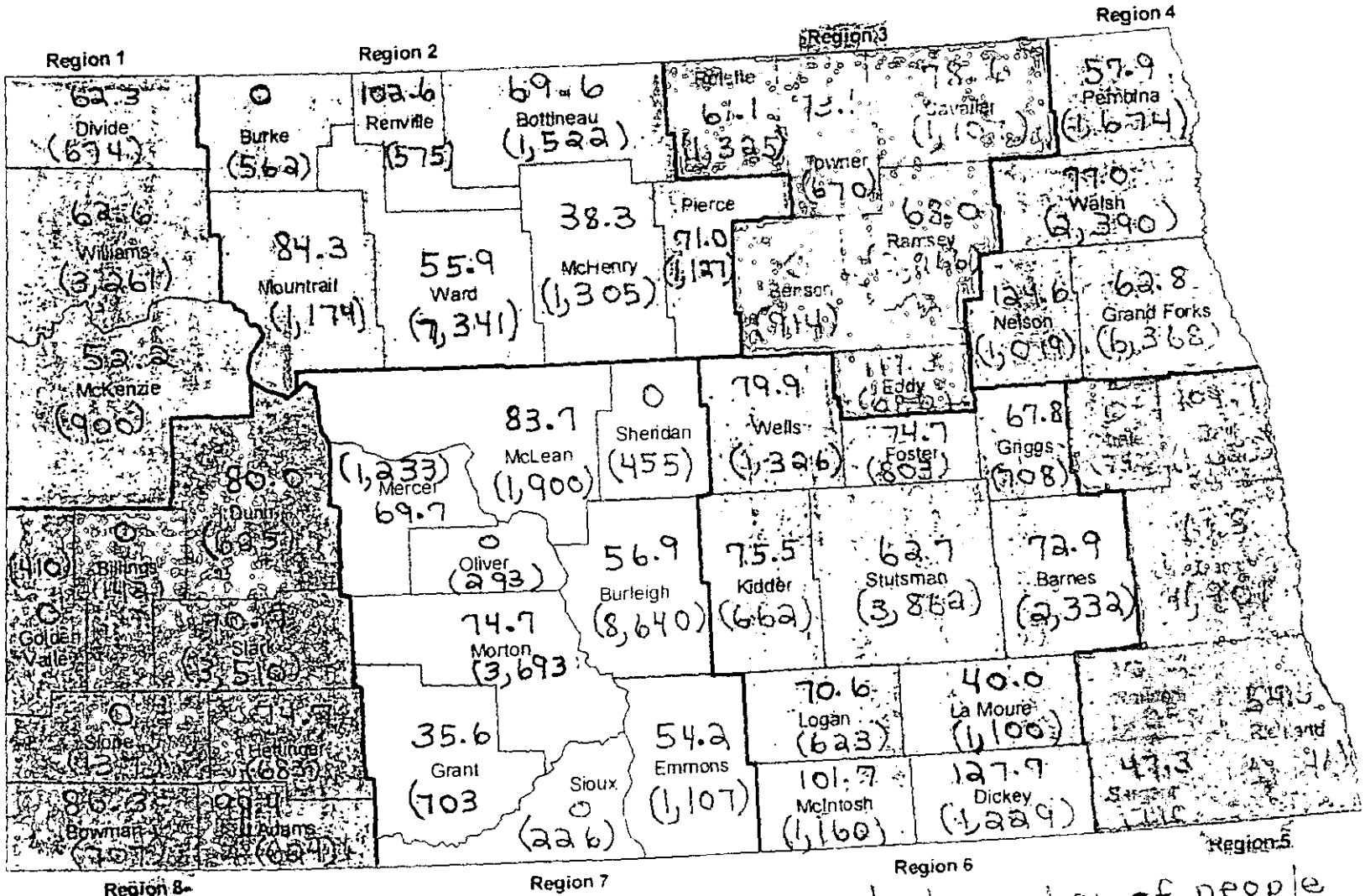
7 counties have bed ratios over 101 beds per 1,000 (13%)

Nationwide, 35 states are under the recommended level of 60 beds per 1,000 and 15 states, including ND are over the 60/1000.

Number of People 65 and over and percentage of Population (Based on 2000 data)



Number of Nursing Beds Per 1,000 by County



Population from 2000 Census of the actual number of people age 65 and over per County ( )

Number of beds per County as of January 2009

Consolidation issues

- Larger communities' growth is masking smaller communities' decline

- Political debates are dominated by large communities

- Sparse population bases and vast distances "hide" rural residents and make them harder to serve

Additional Questions to be Explored

1. What measures should be taken to improve access to nursing home care to the 19 counties that are being underserved by not having any nursing home facilities or are under the recommended 60/1000?

2. What are the occupancy rates for each of the facilities in the counties that have exceeded the recommended level of 60 beds per 1,000?

3. What are the actual occupancy rates for those facilities with occupancy rates under 90%?

4. How many counties see a need to either increase or decrease the number of nursing beds available for the elderly in their county?

5. How many counties have experience the elderly leaving their counties in order to access necessary nursing home care services?

5

Opposition to Senate Bill 2044

Chairman Weisz and members of the House Human Service thank you for giving me the opportunity to speak in opposition to extending the moratorium. My name is Dawn Hopkins and I am a native North Dakotan who recently returned to the state after working and living in the Minneapolis area. I came back to North Dakota to help care for my 94 year old grandmother. I do not believe that the moratorium is in the best interest of North Dakota. The moratorium does not meet the needs of the very population for which it was designed to serve.

The current moratorium is flawed for several reasons and to extend it in its current form to 2013 could be disastrous. First, the North Dakota Data Center projects that by the year 2015, there will be approximately 32,785 more North Dakotans in the over 65 age bracket than there were in 2000. Keeping the moratorium is like a city limiting or capping the number of building permits issued, even though the city is expecting an influx of approximately 33,000 new residents in the near future. Furthermore, according to North Dakota population projections, by the year 2015 the over 85 population will have increased by 7,934 people from what it was in 2000. Keeping the moratorium with the same number of beds as in the past makes no sense when the population most likely to be using nursing care is increasing by almost 8,000 people. Please take time after my testimony to look at the two maps showing the aging of North Dakota's population from 2000 to 2020.

Why should the legislature be overly concerned with the location of beds when the state pays according to occupancy rates? Simply put-- empty beds mean no revenue and the facility itself will suffer, not the state coffers. To the best of my knowledge, the state does not reimburse nursing homes for empty beds nor for beds use by private pay residents. Instead the state pays for only Medicaid recipients and according to data presented by the North Dakota Human Services Department, Medicaid recipients make up approximately 54% of the population residing in nursing homes. Also, as I understand it, the federal government reimburses the state for some of the costs of providing for Medicaid recipients. Shouldn't both private pay residents, which presently make-up 46% of the population in nursing homes and Medicaid recipients have the freedom to choose as to where they want to reside?

I think it is important to remember that the vast majority of citizens of North Dakota are not freeloaders. Our citizens are hard-working individuals, who value freedom of choice, and want to make their own way in the world. They do not expect, nor want hand-outs from the government. However, the reality of the situation is that many of our oldest of the old population never thought they would live as long as they have, nor did they ever imagine that it could cost upwards to $60,000 a year to live their remaining years here on earth. If they had known the cost involved, they maybe would have moved to other states where wages have been traditionally higher. I do not believe that by lifting the moratorium, we will be seeing 85 or 90 year old little men and women carrying their suitcases to the nearest nursing home facility. Their desire to stay at home is just as strong as a younger persons. However, the reality is that for whatever reasons some people's circumstances change. Most often it is because the caregivers, who are primarily family members, can no longer meet the needs of their loved one. Why make the difficult decisions to place a loved one in a nursing home more difficult by moving the loved ones farther away from family and friends?

With the trend toward large chains taking over nursing facilities, the nursing home industry has become big business. Why must we protect the interests of big business at the expense of small, community-based entities whose missions were founded on humanitarian principles? Obviously, there must be a profit or a return on investments if large companies or chains are willing to invest $12-$14 million to build new facilities while small, fully paid for facilities are forced to close because no beds are available.

I find it sort of ironic that there is push to downsize or eliminate small-community nursing homes so that larger facilities can be built to give the "illusion" of a small community within a larger facility. If bigger means better, maybe North Dakota should think about shipping their elderly to the Twin Cities or beyond.

Finally, people in the nursing home industry should be working cooperatively to meet the needs of our elderly and not using cut-throat tactics to obtain beds. The moratorium only encourages such practices and the way the laws are written in regards to the licensing of beds just reinforces such tactics. Why would the legislature want to promote such tactics by keeping the moratorium? Thank you for the opportunity to speak against Senate Bill 2044.

KEY POINTS FOR OPPOSITION TO SENATE BILL 2044

* National recommendations are 60 beds per 1,000 for people ages 65 to 84 and **453 beds per 1000 for people ages 85 and older.**

* North Dakota ranks 4th in the nation for the number of residents per capita who are 65 years or older and **ranks 1st** in the nation for the number of residents per capita who are 85 years or older

* North Dakota Data Center projects that while North Dakota's overall population will only increase 1.1% from 2000 to 20015, the **65 years and older segment of the population will increase by 36.6%** during the same time period.

Taken from Population Trend in North Dakota from 1990-2015 by the North Dakota Data Center

Age Cohort	1990 Census	2000 Census	2010 Projected Population	2015 Projected Population	Projected Increase from 2000-2015
Ages 65-84	79,815	79,752	91,402	104,603	24,851
Age 85 or older	11,240	14,726	18,827	22,660	7,934
Totals	91,055	94,478	110,229	127,263	32,785

* Limiting beds to the 2000 levels when there was 94,478 North Dakota residents 65 years or older does not make sense when it is projected that by 2015 there will be 127,263 North Dakota residents who will be 65 years or older, which represents an increase of 32,785 in the segment of the population who will 65 years and older.

* Moratorium does not take into consideration the number of North Dakotans who are 85 years and older. This the segment of the population most likely requiring nursing services. Currently, it is projected that there are about 18,000 ND residents who are 85 years or older and using the national recommendations of 453 beds per 1,000, there should be approximately 8,000 beds for this segment of the population alone. Presently, a total of only 7,875 beds (6,279 skilled and 1,596 basic care) are available for all people requiring nursing care regardless of age. This shortage of beds will continue to grow in the future.

* The moratorium was first enacted in 1999 and bed capacity was limited to 7,140 beds and in subsequent years the specific number of beds was eliminated. Now 10 years later in 2009, there are only an additional 735 beds available while the over 65 population during this same time period has increased by approximately 19,000.

* Supply and demand for beds should be close to equal when meeting the needs of the elderly. People requiring nursing care are being turned away from small and large facilities alike. A want ad placed several weeks ago with the Long Term Care Association at the recommendation of the ND Department

of Health requesting beds has yielded no results. At the present time it appears that there is no facility willing to sell. What does the future hold in regards to the buying and selling of beds?

* Beds should not be considered a commodity to be sold to the highest bidder. Beds have been going for as high as $20,000 a piece and facilities willing to pay that price can't obtain beds because none are available.

*Licensing of beds should be for the sole purpose of guaranteeing quality of care, not for restricting where the elderly must go to access services. How many other businesses or professions does the state of North Dakota limit in regards to the number of licenses granted? (Hunting doesn't count because that is for recreational purposes, not businesses or professions.)

* With the trend toward large chains taking over nursing facilities, the nursing home industry has become a big business. Why must we protect the interests of big business at the expense of small, community- based entities whose missions were founded on humanitarian principles? Obviously, there must be a profit or a return on investments if large companies or chains are willing to invest $12-$14 million to build new facilities.

* The moratorium compromises the quality of nursing home care. Facilities providing poor quality of care can remain open just because there is a shortage of bed and residents and their families do not have the freedom of choice. By restricting the number of beds available, competition is reduced and there is no incentive to improve the quality of care.

* Isn't it ironic that there is push to downsize or eliminate small-community nursing homes so that larger facilities can be built to give the "illusion" of a small community within a larger facility? If bigger means better, maybe North Dakota should think about shipping their elderly to the Twin Cities or beyond.

* People in the nursing home industry should be working cooperatively to meet the needs of our elderly and not using cut-throat tactics to obtain beds.

* If the moratorium is lifted, facilities will not be adding beds unless there is a need for more beds since funding is based on occupancy rates not on the total number of beds a facility owns. Simply put, empty beds translates into lost revenue for the nursing facility, not the state.

* References

About Nursing Homes by Thomas Day

North Dakota Population Projections: 2005-2020 by North Dakota Data Center

NURSING HOME FUNDING

Rates of reimbursement are determined by combining direct care, other direct care, indirect care, and property costs. The limit (the maximum that will be paid) in each category is established by arraying the facilities from the least expensive to most expensive, selecting the facility at the midpoint and then adding 20% to the cost of that median facility for determining reimbursement.

Direct care includes nursing and therapy salaries and benefits, OTC drugs, minor medical equipment and medical supplies. The January 1, 2009 rate was set at $109.23 per day. EIGHT NURSING facilities spent over the limit allowed by a total amount of $1,022,621. **Which eight facilities overspent and by how much for each of those eight facilities?**

Other direct care includes food, laundry, social services salaries, activity salaries and supplies. The January 1, 2009 rate was set at $20.70 per day. EIGHT NURSING facilities spent over the limit allowed by a total amount of $103,772. **Which eight facilities overspent and by how much for each of those eight facilities?**

Indirect care includes administration, pharmacy, Chaplin, housekeeping and dietary salaries, housekeeping and dietary supplies, medical records, insurance, and plant operations. The January 1, 2009 rate was set at $52.28 per day. TWENTY FIVE NURSING facilities spent over the limit allowed by a total amount of $2,021,461. **Which twenty-five nursing facilities overspent and by how much for each of those twenty-five facilities?**

Property includes depreciation, interest expense, property taxes, lease and rental costs, start-up costs and reasonable and allowable legal expenses. The property limit was rebased with the July 1, 2007 rates. The average property rate is $11.58 per resident per day, with a range of $2.00 to $54.18. **Which facilities exceeded the average property rate and by how much for each individual facility? For example if a 100-bed facility is spending $54.18 per resident a day, their property limit would total $1,977,570 whereas the average property rate for another 100-bed facility following the average limit of $11.58 would only be $422,670.**

Occupancy Limitations - In the June 30, 2008 cost reporting period, FOURTEEN facilities had occupancy rates of less than 90%. Together they incurred $527,060 in **penalties**. Facilities that maintain 90% or more occupancy rates receive 100% reimbursement while those facilities that have less than a 90% occupancy rate receive reimbursement at whatever their occupancy rate actually was. **What was the actual occupancy rate in the fourteen facilities? Was their occupancy rates 88.5 %, 50.5% or somewhere in between? Aren't these penalties a little harsh in an industry that can't predict who will need nursing care in the future, when the care will commence or end, or duration of the care? Also, note that the penalties incurred were down $410,873 from the 2007 level when nineteen facilities paid $937,933.**

Incentives - A reward is provided to nursing facilities who are under the limits in indirect care. The incentive is calculated for each facility based upon their indirect costs compared to indirect limits. Facilities are able to receive $0.70 for every dollar they are below limit up to a maximum of $2.60 per

resident day. In 2009, 44 nursing facilities received an incentive, with the average per day incentive at $1.94. Of the 44 nursing facilities receiving an incentive, they ranges from $0.20 to $2.60 per resident per day. **Which forty-four facilities were rewarded for sound fiscal management? Shouldn't these facilities be publicly recognized?**

OTHER KEY POINTS AND QUESTIONS

North Dakota as of October 2008 had **83 skilled nursing care facilities** with a total of 6,279 skilled nursing beds with an occupancy rate of 94.3% An occupancy rate of 90% is considered full so basically our nursing homes are running at full capacity now, so where will our elderly have to go to access nursing care service?

A 2002 Study Conducted by the Center for Rural Health found that rural nursing staff have been employed longer on average than urban nursing staff, report a higher level of job satisfaction, feel a higher sense of obligation to remain in their jobs, and economic factors are more likely to drive their decision to work in nursing homes. Higher benefits and positive attitude about supervision promote retention.

* Why is there so much publicity and hype about nursing facilities that are unable to maintain an occupancy rate of 90% or better and no mention of facilities that are overspending in each of the categories?

* Why should the state of North Dakota be so concerned about the unoccupied beds in nursing facilities when the state only pays for the occupied beds?

* Based on data about facilities that received incentives and facilities that overspent, can conclusions be drawn as to what is the optimum number of beds a facility should have to operate effectively and efficiently?

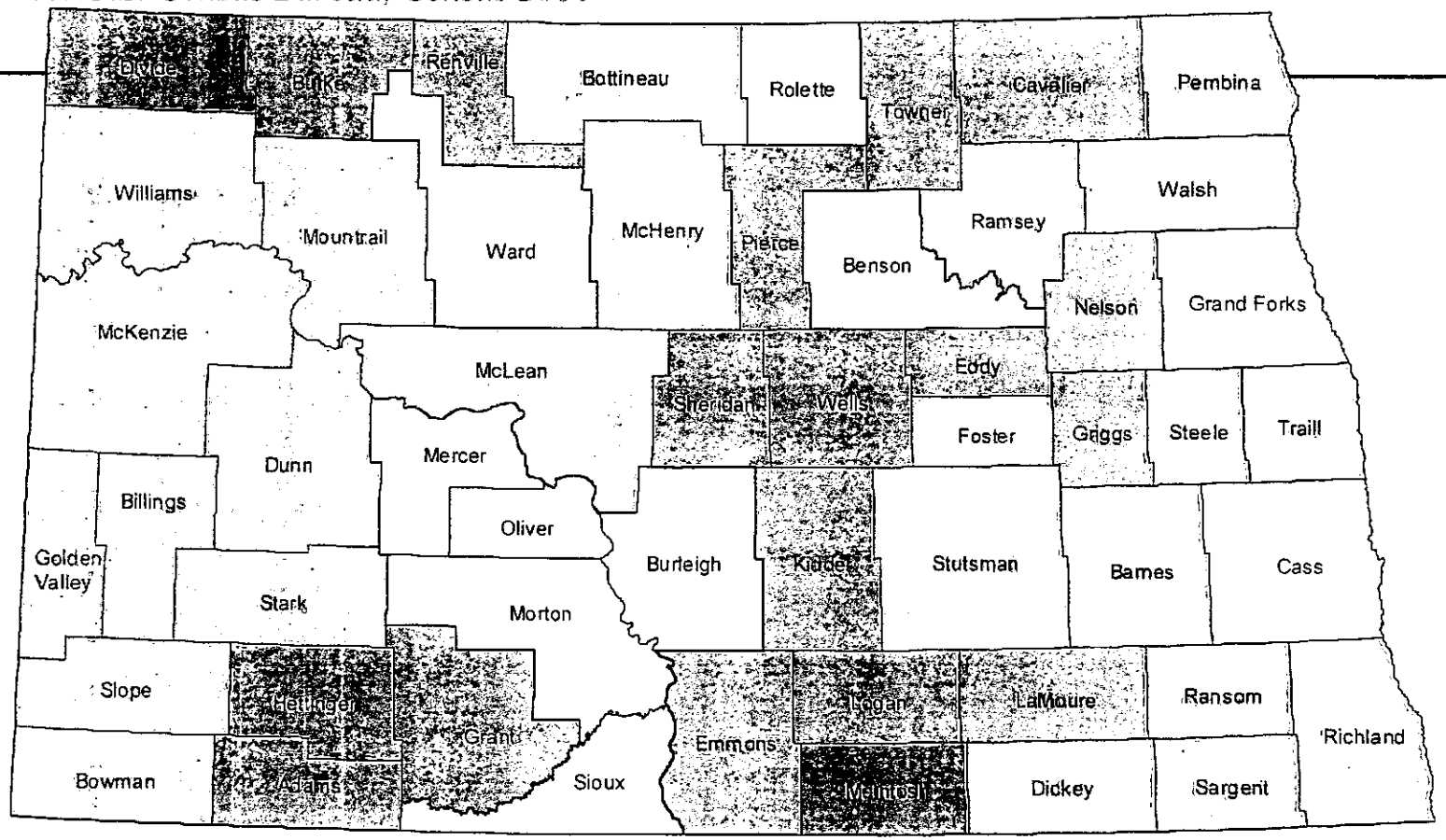
* Is the trend of shifting rural nursing home beds to the four urban areas of the state meeting the needs of ALL of the elderly in North Dakota?

* Urban areas are definitely growing, but in which age groups is the growth increasing the fastest? If it is in the 65 years and over age group is it by their own choice or are they forced to move because there are no services in their home area?

* Staffing is a problem for all nursing care facilities. Will it be easier to find staff in urban areas where jobs are plentiful in a variety of health sectors, such as hospitals, clinics, assisted living and retirement centers or in rural areas where job opportunities are limited?

Persons Ages 65 and Older as a Percent of the Total Population in North Dakota by County: 2000

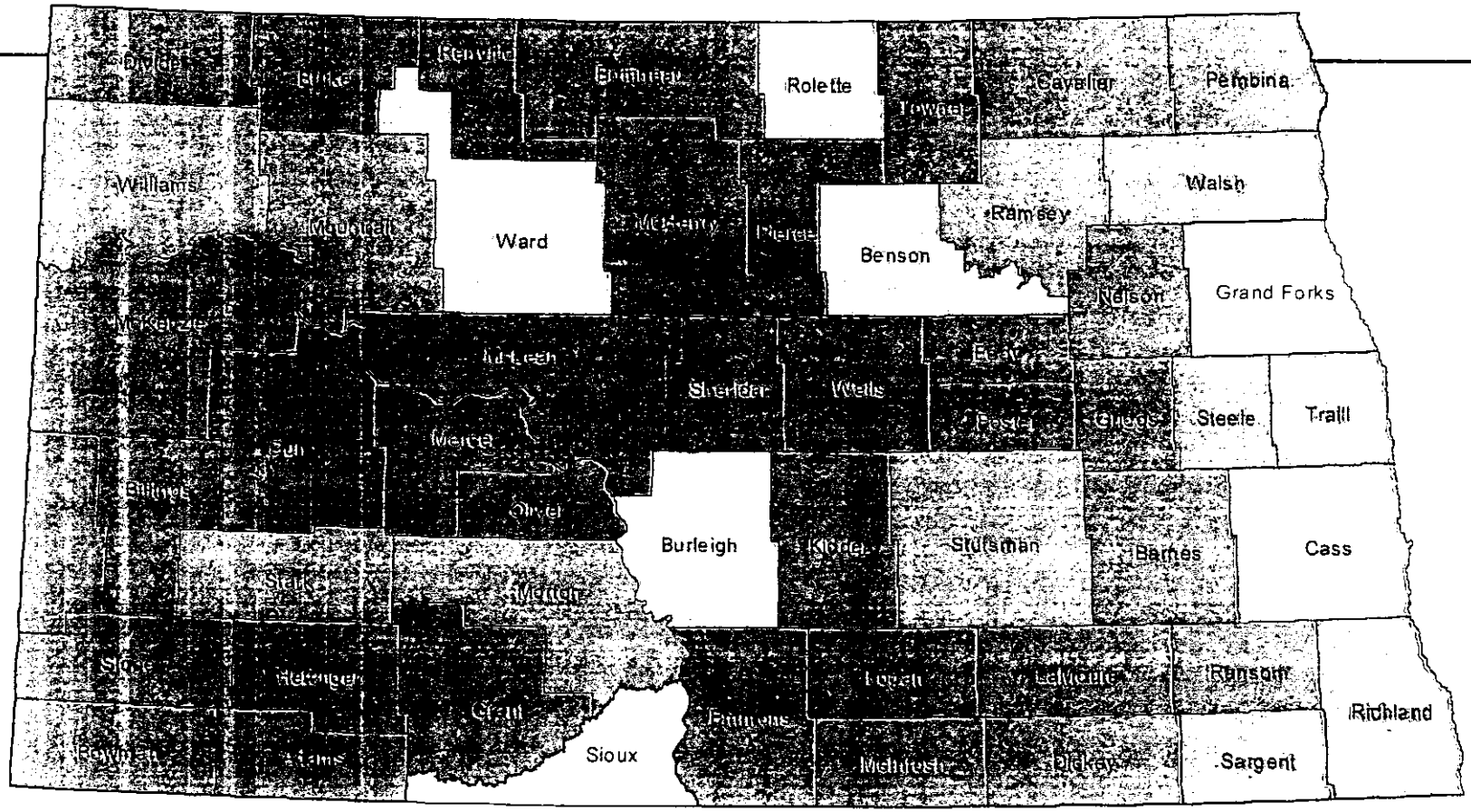
Source: U.S. Census Bureau, Census 2000



- Less than 15%
- 15% to 21.9%
- 22% to 27.9%
- 28% or more

Persons Ages 65 and Older as a Percent of the Total Population in North Dakota by County: 2020

Source: North Dakota State Data Center, North Dakota Population Projections: 2005 to 2020, Sept 2002



- Less than 15%
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