THE VIRGINIA BOARD OF HEALTH PROFESSIONS
THE VIRGINIA DEPARTMENTOF HEALTH PROFESSIONS

STUDY ON THE NEED TO REGULATE ASSISTED LIVING ADMINISTRATORS

October 21, 2004

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The Board greatly appreciates the assistance of the Department of Social Services.

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Executive Summary

Background

At the request of the Virginia Board of Nursing Home Administrators, the Virginia Board of Health Professions (BHP) evaluated the need to regulate administrators of assisted living facilities (ALFs) in Virginia. BHP offers this report for consideration in support of legislation to require licensure of assisted living facility administrators in Virginia.

Methods

BHP's *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions, 1998* governed the study's conduct. Central to the evaluation was application of the following seven criteria (the Criteria):

(1) Unregulated practice of the profession poses a recognizable harm or risk for harm to the consumer resulting from practices inherent in the occupation, the characteristics of the clients served, the setting or supervisory arrangements for the delivery of services, or any combination of these factors.
(2) Practice requires specialized education and training, and the public needs to be assured of initial and continuing occupational competence.
(3) Autonomous practice occurs so that the functions and responsibilities of the practitioner require independent judgment.
(4) The scope of practice is distinguishable from other licensed, certified or registered occupations.
(5) The economic impact due to restriction on the supply of practitioners and the cost of board operations is justified.
(6) Alternatives to regulation have been explored and none are found which would adequately protect the public.
(7) The least restrictive regulation that is consistent with public protection must be recommended.

The Board reviewed the relevant general policy literature relating to long term care, current laws and regulations, licensing and disciplinary information, malpractice data, reimbursement and salary information, information on existing educational and credentialing programs, and media articles. They solicited and received public comment in writing and through public hearing. In addition, to gain insight into the conditions in Virginia's ALFs, a survey was sent to all of Virginia's ALF inspectors from the Department of Social Services (DSS) concerning their observations of supervisory conditions, medication administration issues, and client needs assessments and the facility's capabilities to meet them. BHP also evaluated the distribution and capacities of ALFs across Virginia and considered licensure's economic impact.

Results and Conclusions

The phrase, "assisted living" describes a residential setting in which clients are provided support services with activities of daily living. Residents are housed in assisted living facilities generally because of choice or because they are no longer able to live independently but generally do not require the level of skilled nursing available through a nursing home. What constitutes "assisted living" differs substantially between, and even within, states and is constantly changing to meet increasing market demands.

Approximately half the states, like Virginia, address administration and staffing issues through facility regulations. Twenty-one states currently regulate assisted living administrators as an occupation or profession and determine eligibility in a variety of ways, including national credential program completion, completion of the states' own educational programs, and licensure as a nursing home administrator or other health professional. For Virginia, the current duties, responsibilities, and requirements for practice for assisted living administrators in Virginia are described in §63.2-100 of the *Code of Virginia* and the facility regulations the Department of Social Services (DSS) (§22 VAC 40-71 *et sec*). DSS was consulted throughout the study on matters pertaining to the interpretation of their facility regulations, as well as for relevant licensure and disciplinary information.

There are over 600 ALFs in Virginia with an administrator of record for each. In contrast there are approximately 260 nursing homes and over 560 licensed nursing home administrators. The ALFs vary in size from three to over 4,000 beds, with the majority (61%) serving 50 or fewer residents. Nursing homes average over 100 beds each. Altogether there are 34,725 ALF beds and 29,030 nursing home beds in Virginia, for a total long-term care capacity of 63,755.

Over the past decade, the number of ALFs in Virginia has grown by 16% and the overall capacity in the state has increased by 31%. ALFs are in all areas of the state, from large cities to small towns. Some are in free standing houses, others in campuses, and still others in multi-unit high-rise complexes. They offer services ranging from minor housekeeping and transportation assistance to personal care and health and medication management. There are two levels of licensure, "residential living care" for those with at least minimal assistance and "assisted living care" for those that provide moderate assistance to address the needs of residents with more serious conditions. The overall distribution within each category is best characterized as in a state of flux.

Virginia's ALF consumers include disabled younger adults as well as the frail elderly. Some young residents are relatively independent, but others have serious physical or mental illnesses, impairments, substance abuse disorders, or display abusive, aggressive, or disruptive behaviors. Problems inherent with mixing these populations within the same facility were highlighted by the media as posing a significant danger to the residents.

Disciplinary data from the Department of Social Services, problems cited by the media and echoed in public comment, as well as the DSS inspector survey results revealed

serious problems attributable to lack of knowledgeable accountability at ALFs. Problems with appropriately assessing residents' status to determine fit with the facility's services, inadequate staffing, drug security, medication errors, inadequate funding, and an overall sense that residents, staff, and families did not know "who was in charge" were repeatedly cited. And when someone was "in charge," largely during night and weekend hours, it may have been a marketing director by telephone, or a receptionist, or even housekeeping staff, often with little in the way of adequate education and training to ensure resident health and safety, especially when residents had health issues.

Recommendations

Upon careful consideration of the study's results and application of the Criteria, the Board recommended that legislation be proposed to require licensure of all assisted living administrators. The Board's draft is provided on page 20 of this report.

This decision was predicated upon the trend of increased demand for ALF services in Virginia, a high level of client vulnerability, the need for individual, knowledgeable accountability, and the relative lack of universally accepted credentialing for this occupation. The Board held that administrators of residential care level ALFs should not be exempted from licensure because of the tenuous nature of the "residential care" vs. "assisted living care" categorization, the problems with assessing client status vis-à-vis a facility's capabilities, and the general tendency for clients to remain in a facility, even with status change,

To pose the least adverse impact, the **Board of Health Professions recommended subsuming the licensure of assisted living administrators under a newly constructed Board of Long Term Care Administrators.** As is the case in some other states, this board is to be patterned after the existing Board of Nursing Home Administrators, and will provide additional members with parity in professional representation. Further a resident's guardian could serve in the same capacity as the current Board of Nursing Home Administrator's resident or resident's family member. Among its duties, the new Board of Long Term Care Administrators would be the appropriate body through the regulatory review process to determine the appropriate credentialing for the licensure of assisted living administrators.

The Board also recommended that nursing home administrators who oversee ALFs not be required to attain dual licensure. It is deemed an unnecessary regulatory burden because their licensure oversight already exists and because of the overlap in client base and services required.

Finally, based upon concerns expressed by owners/administrators of smaller facilities, the Board deemed that it would be acceptable for a licensed administrator to oversee more than one facility, as long as it was in keeping with facility regulations.

The Board's legislative proposal which embodies the Board's final recommendation begins on page 20 of this report.

STUDY ON THE NEED TO REGULATE ASSISTED LIVING ADMINISTRATORS[1]

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA BOARD OF HEALTH PROFESSIONS

Background and Authority

In September of 2003, Mary Smith, the Board of Nursing Home Administrators' representative on the Board of Health Professions (BHP) reported that the Board of Nursing Home Administrators had been receiving increasing complaints about assisted living facilities (ALFs). However, her regulatory board could not address them because neither ALFs nor administrators are regulated by them. She noted that currently, like nursing homes, ALFs serve a vulnerable population by providing or coordinating personal and health care services to the frail elderly and others with mental or physical conditions requiring supervision and assistance. She held that the distinctions between the two types of establishments appear to becoming increasingly blurred, especially from a consumer standpoint. She indicated that some nursing homes facilities include assisted living units and some ALFs include nursing home (i.e., skilled nursing) units, often under the same name. She stated that residents often shift from one section to another, and perhaps never realize that the state regulates them and those who oversee their operations differently.

The Virginia Board of Health Professions has the statutory authority to advise the Governor, the General Assembly, and the Department Director on matters relating to the regulation and appropriate level of regulation of health care occupations and professions (ref. §54.1-2510 of the *Code of Virginia*). The BHP Chair assigned the study to the Regulatory Research Committee which began initial work on the project in late 2003. At the next meeting in January of 2004, a representative from the Virginia Health Care Association reported to the full Board that they would request that the General Assembly consider a budget amendment in support of the study. The BHP Chair indicated that the Board would await further action in anticipation of a response from the General Assembly. However, as of the date of the next meeting, April 15, 2004, no relevant budget amendment had been rendered. The matter was again remanded to the Regulatory Research Committee. At the Board's July 15, 2004 meeting, the Board formally adopted the Study Workplan which is provided in Appendix #1.

The Study Workplan is rooted in the Board's formal criteria and policies referenced in *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions, 1998.* Among other things, "the Criteria" assess the degree of risk from

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[1] The use of the term "assisted living administrator" or "assisted living director" refers not only those holding the specific job title of "director" or "administrator" but to those who are chiefly responsible for overseeing the operations of "assisted living facilities" as defined in the Code of Virginia and ensuring the facilities' compliance with applicable state laws and regulations.

unregulated practice, the costs and benefits of the various levels of regulation, and the advantages and disadvantages of the various alternatives to regulation that might protect the public. By adopting these criteria and application policies, the Board has endorsed a consistent standard by which to judge the need to regulate any health profession. The aim of this standard is to lead decision-makers to consider the least governmental restriction possible that is consistent with the public's protection. This standard is in keeping with regulatory principles established in Virginia law and is accepted in the national community of regulators. See Appendix #2 for the Criteria.

Study Scope & Methodology

The key questions for consideration are:

- What is assisted living and what defines the responsibilities of an ALF administrator?
- What specialized skills and training do ALF administrators possess?
- To what degree is independent judgment required in their practice?
- Is their practice distinguishable from other regulated occupations or professions?
- What is the risk and potential risk for harm to the consumer?
- What would be the economic impact to the public if this group were regulated?
- Are there alternatives other than state regulation of this occupation which would adequately protect the public?
- If it is determined that this occupation requires state regulation, what is the least restrictive level that is consistent with the protection of the public's health, safety and welfare?
- How would the work of other agencies which deal with assisted living-related issues be affected?

To help the Committee answer these questions, the following undertakings were accomplished:

1. A review of the general policy literature relating to assisted living and administrators of assisted living facilities.
2. A review of the current relevant laws and regulations.
3. A review of available malpractice insurance coverage data in conjunction with other data to address Criterion One- Risk of Harm to the Public.
4. A review of available reimbursement data to develop an estimate of how regulating this group may affect costs to address Criterion Five – Economic Impact.

5. An initial draft report was provided to the Board at its July 15, 2004 meeting and made available for public comment.

6. A public hearing was held on August 18, 2004 seeking to address the issue of the state regulation of this occupation, and requested input on public health and safety issues germane to current practices as well as the potential fiscal impact which may result from such regulation. Written comment was received until September 3, 2004. The public comment was distributed to Committee members for review.

7. The Committee met on September 24, 2004 to review the report to-date, consider public comment, apply the Criteria and policies, and develop recommendations.

8. The Committee report with recommendations was made available for public comment until October 21 when the Committee met. The final recommendations, including any proposed changes in Virginia statute, were presented to the full Board at its meeting on that date.

9. Board adopted this report for consideration by the Director and Secretary of Health and Human Resources.

10. Included in this report is proposed legislation beginning on page 20.

Defining "Assisted Living"

There is no universally accepted definition. Policy researcher Charles D. Phillips and his associates describe the attempt to define what one means by assisted living as a "treacherous task." (Phillips, Hawes, Spry & Rose, 2000, p. 6). Since the mid-1980's this originally Scandinavian mode of elder care in residential settings has emerged differently throughout the United States. The answer of what constitutes assisted living is evolving and appears to be changing in response to current and envisioned market demands (Centers for Disease Control, 2004, June; Waidmann & Thomas, 2003). From the April 2003 Report to the U.S. Senate Special Committee on Aging, we see that the Assisted Living Workgroup[2] failed to reach consensus on a definition. The National Center for Assisted Living (a branch of the American Health Care Association representing assisted living providers) reports in its *Facts and Trends 2001: The Assisted Living Sourcebook,* that "assisted living" is known by numerous terms throughout the country, including but not limited to "residential care," "personal care," "basic care," "board and care," "housing with services" and "domiciliary care." However it is referenced and whether it is provided within multi-unit complexes, individual homes, whether its freestanding or within a campus setting, assisted living generally refers to housing and care arrangements that provide long-term options for residents who cannot live independently but do not require 24-hours skilled nursing care. Residents typically need help with activities of daily living[3] (such as bathing and dressing) (GAO, April 2004; Hawes, Rose, & Phillips, 1999).

For Virginia, the definition of "assisted living" is found in §63.2-100 of the *Code of Virginia*:

> *A level of service provided by an adult care residence for adults who may have physical or mental impairments and require at least moderate assistance with activities of daily living.*

How Assisted Living is Regulated

Federal oversight is limited to issues associated with reimbursement for direct care services (i.e., Medicaid) and to funding states' long-term care ombudsman programs. The primary governance of assisted living is through the individual states. As assisted living has evolved in the U.S., different states have developed different approaches and are modifying them on an ongoing basis.

About half of the states, like Virginia, address administration and staffing issues through facility regulations. The following 21 states regulate administrators, themselves, through licensure or mandatory certification programs: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Maine, Missouri, Montana, Nevada, New Jersey, North Carolina , Ohio, Oklahoma, Rhode Island, and Utah. In addition, South Dakota

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[2] The Assisted Living Workgroup was brought together by Senate staffers to help develop recommendations to ensure more consistent quality in assisted living services across the country. Coming together beginning in the Fall of 2001, the group was comprised of numerous accrediting organizations, aging/long-term care organizations, consumer advocates, health care professionals, provider organizations, regulatory associations, a state/local government organization and others.

[3] "Activities of daily living" are routinely divided in the into two categories: those involving limitations in activities of daily living (ADLs) and those that involve limitation of instrumental activities of daily living (IADLs). In addition to bathing and dressing ADLs involve other basic, daily, personal functions such as getting in or out of bed or a chair, using the toilet, eating, and getting around in the home. IADLs relate to the ability manage ones own affairs independently. They typically include grocery shopping, housework, preparing meals, using the telephone, taking medications, managing money, and getting around outside of the house (AARP, 2003).

requires that the administrator hold a license as a "health care practitioner." Tennessee and Washington State require licensure as a nursing home administrator, and Wyoming accepts certification as a certified nurse aide (CNA) as proof of competency. For a summary of states' regulations of administrators, see Appendix #3. For an extensive summary of the states' approaches to regulate assisted living generally, please reference the National Center for Assisted Living's *Assisted Living State Regulatory Review, March 2004.*

In Virginia statute, an "assisted living facility" is defined as:

> *. . . any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Mental Health, Mental Retardation and Substance Abuse Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of 18 and 21, or 22 if enrolled in an educational program for the handicapped pursuant to § 22.1-214, when such facility is licensed by the Department as a children's residential facility under Chapter 17 (§ 63.2-1700 et seq.) of this title, but including any portion of the facility not so licensed; and (iv) any housing project for persons 62 years of age or older or the disabled that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban development ,by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an aged, infirm or disabled individual.*
>
> (Ref. §63.2-100 of the *Code of Virginia)*

Assisted living facilities (ALFs) are licensed by the Division of Licensing Programs of the Department of Social Services (DSS). Facilities are inspected periodically (usually twice per year) and when complaints are received. This division also licenses adult day care centers, family day homes, child day care centers, child placing agencies, children's residential facilities, and independent foster homes, none of these other facilities are considered "assisted living."

The DSS Assisted Living Facility Regulations, §22 VAC 40-71 (effective date March 28, 2003), describe an ALF as a:

> *. . . residential setting that provides or coordinates **personal and health care services**, 24-hour supervision and assistance for the maintenance or care of four or more aged or disabled adults in any one or more location, provided that none of the residents has a "prohibited condition."* [4]

[4] "Prohibited conditions" include, for example, the need for continuous nursing, ventilator dependency and advanced dermal ulcers.

As of July 20, 2004, there were 629 ALFs licensed by DSS. Appendix #4 includes a graph and statistics provided by the DSS showing the generally increasing trend in ALFs and capacity. As their table indicates, there has been a 16% increase in the number of facilities between 1994 and 2003, and 31% increase during that time in capacity. This is in keeping with the national trend toward greater use of ALFs. Industry analysts from the National Investment Center (2000) reported that assisted living was one of the most rapidly growing types of service for older persons with disabilities. They reported that from 1991 to 1999 the number of AL beds nationally increased by 115%, from 362, 014 to 777, 801.

The current "Licensed Facility Listing" for ALFs is available from DSS. This listing and an Excel spreadsheet, as well, of relevant data may be downloaded from their web page: www.dss.state.va.us/adult.facilites.html. Appendix #4 also provides a table entitled, "Distribution of ALF's and Client Capacity in Virginia by City" to detail the number and distribution of ALFs and their capacities across the state by the mailing address city.[5] The data were drawn July 20, 2004. Overall there are 185 "cities" listed, with 629 facilities, serving a maximum of 34,725 clients. The following two tables provide rankings of the top 10 localities according to number of facilities and then to their capacity:

Rank	City	No. of Facilities	Rank	City	No. of Facilities
1	Richmond	79	6	Virginia Beach	17
2	Chesapeake	22	7	Norfolk	15
3	Newport News	21	8	Alexandria	14
4	Roanoke	21	9	Petersburg	13
5	Fairfax	19	10	Lynchburg	12

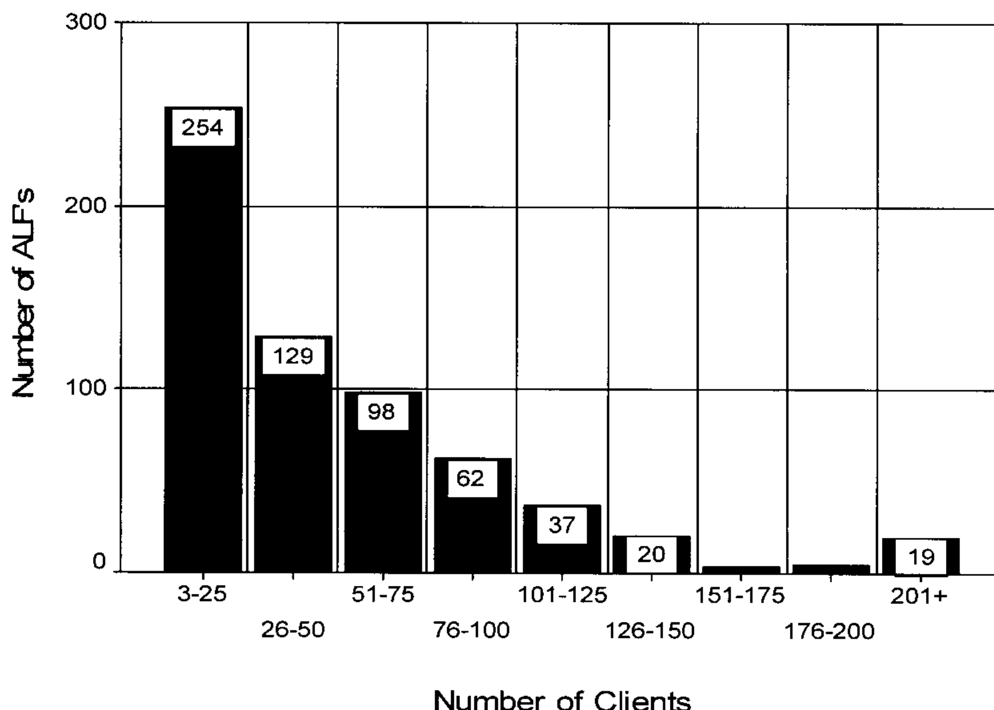
Rank	City	Capacity	Rank	City	Capacity
1	Richmond	4806	6	Newport News	1084
2	Virginia Beach	1723	7	Charlottesville	1068
3	Roanoke	1428	8	Lynchburg	1051
4	Alexandria	1282	9	Fairfax	878
5	Chesapeake	1099	10	Norfolk	700

Richmond far surpasses all other localities in terms of both measures. The central and tidewater areas are also significantly represented. It should be noted, however, that large numbers of facilities are not the norm. Across all localities, the overall median capacity is 36 residents. Of the localities listed in Appendix #4, 89 (48%) have one ALF. Thirty-three (18%) have two ALFs. The following graph depicts the distribution of capacities. Most facilities, 254 (or 41%), serve between three and 25

[5] Although DSS region and fps data were available, the "city" mailing address, which denotes the nearest city or town and surrounding areas, was deemed to better provide the location information for the purposes of this study.

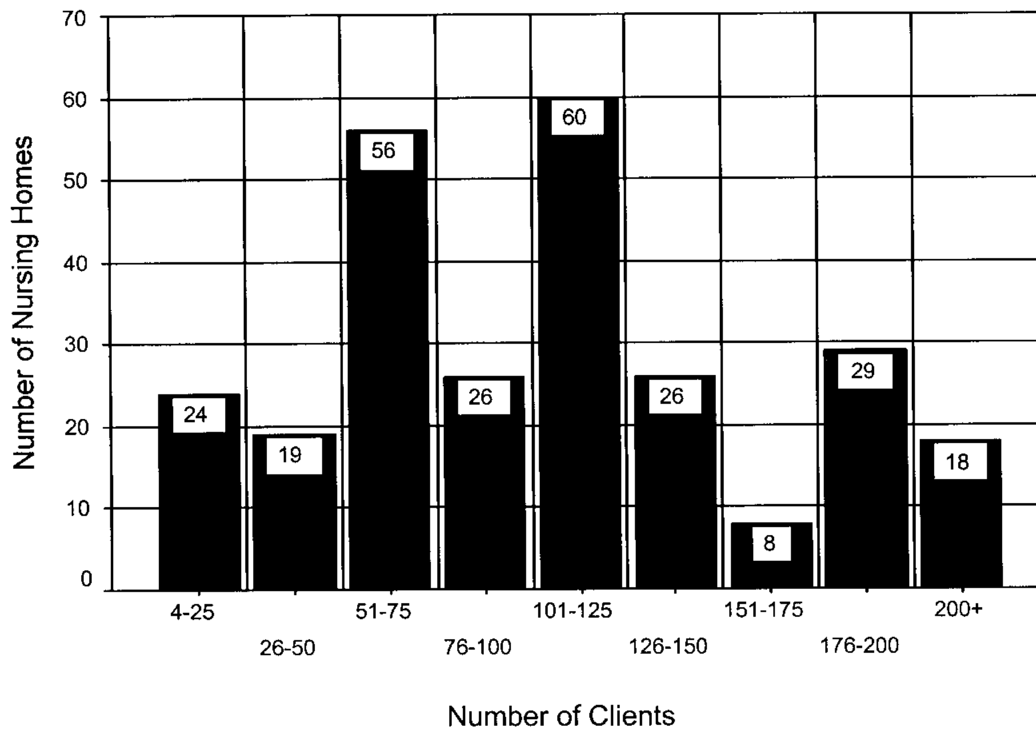
clients. In fact, 61% (383) serve 50 or fewer residents, while 86% have 100 or fewer clients. Only 19 facilities can accommodate 200 or more residents. But they are not necessarily concentrated in the bigger cities. They are distributed rather broadly across the state even in smaller localities such as Bedford, Culpeper, Danville, and Martinsville.

Client Capacity per ALF



Because it was noted that residents often transfer from ALFs to nursing homes and vice-versa, Appendix #4 also provides the table "Distribution of Nursing Homes and Client Capacity in Virginia by City." Note that localities not in the previous ALF listing are denoted by "*." These data were drawn from the Medicare "Nursing Home Compare" website (http://www.medicare.gov). There were fewer nursing homes, by far, than ALFs, only 265 as of May 26, 2004. However, they serve a comparable number of residents (29,030). With 15 facilities and a capacity of 1,991, Richmond again surpasses other areas in access. Virginia Beach has 12 with a total capacity of 1,168 and Norfolk has 8 with a capacity of 993. Most, smaller localities have one to five facilities. Capacities vary from 13 in Sterling to 1,991 in Richmond. In comparison with ALFs, the following graph shows that the overall capacity distribution is different. The majority of nursing homes care for between 100 and 125 residents, with the next largest grouping in the 51 to 75 client range.

Capacity per Nursing Home



The, DSS Regulations provide for two levels of ALF licensure, reflecting two levels of care:

- **Residential Living Care** - refers to facilities that care for individuals who require only minimal assistance with ADLs. The first five parts of the Regulations apply.

- **Assisted Living Care** - applies to facilities that care for individuals who require at least a moderate level of assistance with ADL's. All six parts of the Regulations apply.

Of the 629 ALF's licensed with DSS in July, 328 (or 52%) were classified as providing Residential Living Care, only (two included some ambulatory care). There were no facilities categorized as providing Assisted Living Care, only. However, there is ongoing fluxuation. As of October 18, 2004, there were a total of 618 ALFs; 559 were licensed for Residential Living Care and Assisted Living Care and 59 were licensed as Residential Living Care only.

For placement, residents must be assessed using the Uniform Assessment Instrument (UAI)(see Appendix #5). Persons with certain conditions or care needs may not be admitted or retained in an ALF. Each resident of an ALF must have an individualized service plan which is based on assessed needs. An ALF must provide for services, care, and activities that meet the needs, interests, and abilities of each of its residents. Every resident has rights and responsibilities specified in the Code of Virginia and the standards.

Part I of the Regulations provides the definitions, applicability, types of facilities and scope of services as well as provisions for community service board access. Part II details personnel and staffing requirements which include the licensee, the administrator, staff training, staff duties performed by residents, employee records and health requirements, and other standards for staffing. Part III relates to admission, retention, and discharge of residents. Part IV details a host of resident accommodations, care, and related services. Part V covers buildings and grounds, and Part VI provides for the additional requirements for facilities that are licensed for the higher level of care denoted as "assisted living care." This includes personnel and staffing, resident personal and social data, and resident care-related services. In addition, Part VI covers requirements for facilities with adults with mental illness, mental retardation, or substance abuse and provisions for facilities that care for adults with serious cognitive impairments.

The ALF Administrator

The DSS Regulations Part II require that each ALF have an administrator of record and that the administrator may serve more than one facility. The administrator must meet the following minimum qualifications specified in subsection B of §22 VAC 40-71-60:

- Be at least 21 years of age;
- Be able to read and write, and understand this chapter;
- Be able to perform the duties and to carry out the responsibilities required by this chapter;
- Be a high school graduate or have a General Education Development Certificate; AND
- have completed at least one year of post secondary education from an accredited college or institution; OR
- have completed at least one year of administrative or supervisory experience caring for adults in a group care facility.

EXCEPT – Administrators employed prior to February 1, 1996 shall be a high school graduate or have a GED OR shall have completed one year of successful experience in caring for adults in a group care facility.

The administrator must also meet the general staff requirements specified under §22 VAC 40-71-70:

- Be of good character;
- Be physically and mentally capable of carrying out assigned responsibilities;
- Be considerate and tolerant of aged and disabled persons;
- Be clean and well-groomed; and
- Meet the requirements specified in the Regulation for Criminal Record Checks for Homes for Adults and Adult Day Care Centers (22VAC40-90-10 et seq.).

The duties of the administrator as stipulated in subsection G are to oversee the day-to-day operations of the facility which include:

- Providing services to the residents;
- Maintaining the buildings and grounds;
- Supervising the ALF staff; and

- Either, be awake and on duty 40 hours per week, or have a designated assistant who meets the qualifications of an administrator do so.

With regard to continuing education, within each 12 month period:

- the administrator must attend 20 hours of training related to management or operation of a residential facility for adults OR

- client-specific training needs.

When adults with mental impairment reside in the ALF, at least five of the 20 hours must focus on the resident who is mentally impaired.

Appendix #6 provides a copy of the other rules in this section. They relate to management planning and documentation and the use of a manager in the administrator's absence.

Data from DSS on training for adult care providers indicated that in 2003, the Licensing Division delivered 12 training series, with 61 training sessions attended by 1,382 adult care providers. The Division also sent out three technical assistance mailings. The April 2004 GAO report on efforts by states to improve indicates that appropriate training on regulatory requirements is essential to improving ALF compliance overall.

Characteristics of the Clients

Hawes, Rose, and Phillips in their 1999 national study sampling ALF administrators from 60 geographic areas in the U.S reported that the responders estimated that approximately 24% of their residents required help with three or more ADLs. Approximately one-third of the residents had moderate to severe cognitive impairment. In their research into the characteristics of persons entering ALFs and nursing homes, Waidmann & Thomas (2003) examined a wide variety of demographic, income and health factors. They concluded that assisted living may substitute for nursing homes for some segment of the elderly population. They note that there is some evidence that nursing homes are more likely to serve lower income and older persons and those with more severe disabilities.[6]

Funding to pay for assisted living is currently a mixture of private pay and federal/state dollars, with only minimal involvement by third-party (i.e., long-term care insurance). Two-thirds of residents pay out-of-pocket in widely varying amounts. There are varying estimates of the cost. One estimate reported in the *MetLife Market Survey of Assisted Living Costs,* completed by Life Care Inc. in 2003 places the national monthly base rate in the U.S. at $2,379 (or over $28,500 per year). The National Investment Center (2000) survey of facilities revealed an average of $2,242 per month. Estimates in 1999 by Hawes, Rose, and

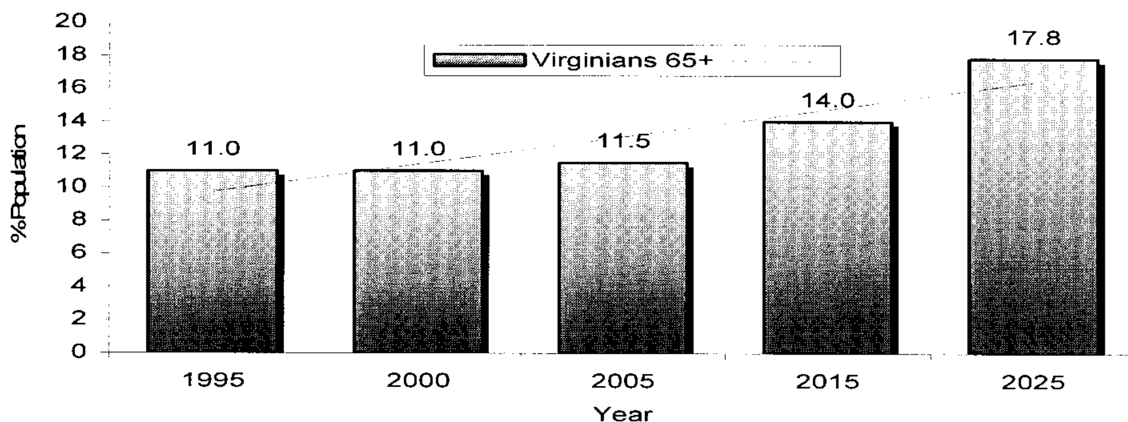
[6] The trend described by Waidmann and Thomas (2003) of the wealthy being placed in ALFs while those with lower incomes tend to be placed in nursing homes may be relevant only when discussing the elderly but not necessarily other consumers of ALFs. Medicaid waivers have allowed those with low incomes the option of addressing their needs for housing and support through AFLs in some instances.

Phillips reflected a range from $12,000 to $24,000 per year. Special care units and services such as medical administration and transportation often cost extra.

The AARP's report, "Beyond 50 2003: A Report to the Nation on Independent Living and Disability," indicates that the vast majority of persons over 50 do not need long-term assistance. However, they speculate that most will likely need assistance at some point. In examining the U. S. Census data and report from 1990 which make projections for 2015 and 2025, it is clear that a greater proportion of Virginia's population will be 65 years and older (see "Virginia's Aging Trend Projection" graph below).

In 2015, the percent of the population comprised of these elderly will be 14% and in 2025 almost 18%. When examining the total U. S. population in 1990, 21.5% were over 60 and above, while in the Virginia population, only 18.9% were. Virginia's over 60 population ranked **44th** in the nation at the time. When examining the elderly, those 85 and above, Virginia ranked **43rd** in the nation. Virginia's old elderly population proportion lagged behind the U.S.'s, with 1.0% in Virginia and 1.2% nationally. However, when examining those 60 and over with mobility and self-care limitations -- those who would likely soon need assisted living or nursing home care -- Virginia ranked **16th** in the nation (17.9% in Virginia and 17.3% nationally). For the 85 years old and older group, Virginia ranked **11th** (54.9% in Virginia and 49.8% nationally). Should this pattern continue, the need for long-term care will be a particularly important aspect of life in Virginia.

Virginia's Aging Trend Projection
1995-2025



In Virginia, consumers of ALF services are not only the elderly but include disabled younger adults. Some are relatively independent, needing only minor assistance with IADL's. Others have more serious physical and/or mental illnesses or impairments. These impairments may include abusive, aggressive, or disruptive behavior. Some have substance abuse disorders. (Communication with Department of Social Service staff, May 2004). Problems with mixing the populations have been highlighted in recent press coverage.

Media Coverage

Beginning in March of 2004, media coverage emerged detailing instances of serious problems in assisted living facilities in Virginia and elsewhere. Articles from the *Washington Post, USA Today,* and the *Richmond Times-Dispatch* detail instances of avoidable deaths and serious injuries to residents. For reference, Appendix #7 provides copies of the selected articles spanning March 17, 2004 through August 8, 2004.

Initial Public Comment

The Regulatory Research Committee held a Public Hearing on August 18, 2004. Although general comment related to assisted living oversight was welcome, the primary focus was to obtain information relating to public health and safety issues, the fiscal impact which may result from regulation of this group, and how the activities of the current state agencies which deal with assisted living-related issues may be affected. Appendix #8 provides the transcript of the hearing. Additional public comment was accepted until September 3, 2004 and is also included in Appendix #8.

DSS Information on ALFs in Virginia

Data provided by the Licensing Division staff in early January of 2004 shows that at the end of FY 2001, there were 679 ALFs with 506 complaints lodged. Of these, 288 were deemed to be valid. The agency took 46 enforcement actions including denial of licensure and revocations (15). For FY 2002, 583 facilities renewed licensure and they received 116 new applications which were processed, yielding 699 licensees by June 30, 2002. There were 471 complaints made that year, with 279 complaints deemed to be valid. At that time, the 2003 disciplinary data were not yet finalized. In their report to the Long-Term Care Subcommittee of the General Assembly on June 29, 2004 greater details are provided regarding capacity, funding, and discipline. Their report along with others making presentations that date is found in Appendix #9.

It was thought that there are certain questions relating to Virginia's ALF, their oversight, and characteristics of the residents which the DSS inspectors might best be able to answer. A survey of inspectors rather than the facilities themselves was conducted for four reasons: (1) concern over the perennial problem of low survey response rates, (2) potential respondent bias; (3) with over 600 facilities, the cost of sending and receiving surveys; and (4) the fact that DSS inspectors have the unique perspective of having observed what occurs in many facilities rather than one. The last point provides the study with cross-sectional views of what is occurring in Virginia's ALFs as well as what goes on in each facility.

As such, the DSS ALF inspectors who directly inspect facilities were asked to answer the following questions:

1. Is there someone in a supervisory capacity to oversee the care and safety of the residents 24-hours a day? Is there a need for such supervision?
2. What are the characteristics of the residents at the facilities:

a. Do most need minimal assistance with activities of daily living?
b. How typical is it that a greater level of assistance is required, including that for individuals with behavioral or substance abuse problems who may pose a danger to the other residents? What steps are taken to ensure the safety of others as well as themselves?

3. What is the typical process used to assess the resident to determine whether the facility can adequately meet the resident's needs? Is this "fit" re-evaluated periodically?
4. Are there data available on medication errors and who makes them? If so, can you establish the backgrounds of those individuals who have made the errors? RN? LPN? Someone who has completed a training program to administer medication pursuant to §54.1-3408 (J)[7]?

The deadline for response was September 24, 2004. Responses were received from 24 inspectors, representing all regions of the state. The survey results were provided to the Committee at the September meeting and are detailed in Appendix #10.

Malpractice Coverage Data

The roles and responsibilities of ALF administrators are so different from state to state, and sometimes from facility to facility, that it is not surprising that there is no known carrier of malpractice insurance for this group. The only available recent information of relevancy is a report from Aon Consulting produced in June of 2004 entitled, *Long Term Care General Liability and Professional Liability: 2004 Actuarial Analysis.*

This report was produced for the American Health Care Association. Although one cannot disentangle assisted living data from the whole, overall, the general U.S. data reflect increasing loss of per diem per beds and increased malpractice claims lodged. There are no data specific to Virginia available. The report indicates that since 1995, the number of claims per bed has been increasing 13% each year. In addition between 1995 and 2001approximately 42% of the claims were greater than $50,000. They further indicate that almost half of the total claim dollars are attributable to litigation costs.

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[7] J. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) a resident of a facility licensed or certified by the State Mental Health, Mental Retardation and Substance Abuse Services Board; (ii) a resident of any assisted living facility which is licensed by the Department of Social Services; (iii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iv) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (v) a program participant of an adult day-care center licensed by the Department of Social Services; or (vi) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services.

With this backdrop, it is not surprising that premiums have increased. The average increase between 2002 and 2003 was 51% which followed increases of 143% in 2002 and 131% in 2001. The smaller providers were the ones most affected by premium increases. Between 2002 and 2003, those with bed counts under 100 received a 73.7% increase, on average, while those with 100 to 250 beds had a 77.2% increase. On the other end of the spectrum, those with more than 10,000 beds experienced a 9.4% reduction. Again, we do not have data specific to Virginia.

Salary Data

Because of the mercurial nature of assisted living, itself, there are little data concerning its staffs' salaries available. The only known survey was produced by the American College of Health Care Administrators (ACHCA) in 2004. It is ACHCA's first attempt at such a national survey and is entitled, "2004 Long-Term Care Administrator Salary Survey." ACHCA is a professional group of administrators of rehabilitation centers, skilled nursing facilities, continuing care residential communities, and assisted living facilities. Only 8% (21) of the responders described themselves as assisted living administrators. The only data available which specifically speaks to AFL administrators is the median salary $65,731. Based on such a small sampling and without knowing whether these ALF administrators compare in any way with those in Virginia, it is ill advised to generalize. Because data collected by the Board would be subject to Freedom of Information Act inquiries and because of the sensitive and usually confidential nature of salary information, it was deemed inappropriate for the Board to gather salary data on individuals.

National Credentialing Organizations and Available Education for Administrators

There are two known national organizations that credential administrators of assisted living facilities in any manner, the National Association of Boards of Examiners in Long-Term Care (or NAB) and American College of Health Care Administrators (ACHCA). NAB provides the "Residential Care/Assisted Living Administrator" (RC/AL) credential.
To attain the RC/AL, individuals must meet the following qualifications approved by the NAB Board of Governors on November 8, 2002. Completion of a 40-hour state approved, RC/AL licensure course covering the NAB RC/ALA domains of practice is required as is passage the NAB RC/ALA Licensure Examination (contracted through Professional Examination Services) and a state law exam, if applicable. The licensure course & exam cover:

- Resident Care Management
- Human Resources Management
- Organizational Management
- Physical Environment Management
- Business/Financial Management

To take the NAB examination the following is required:

H.S/GED +	**2 yrs exp in AL facility (1yr in leadership/management)**
Associates degree +	**1 yr exp in AL facility (6 months in leadership/management)**
Bachelors degree +	**6 months in leadership/management in AL facility**

To maintain the credential, 15 hours per year of state-approved continuing education on subjects related to AL operations, management, and philosophy are needed.

For the ACHCA Assisted Living Administration (AL) Certification, the eligibility requirements are more rigorous than for NAB's RC/AL and reflect advanced rather than minimal competency expectations. The eligibility requirements to sit for the ACHCA AL examination may be met through various combinations of education and experience.

The qualifications to sit for the examination are as follows:

Current NHA license		
Current ALA license		
NAB +	**2 yrs AL mgmt exp in AL environment**	
Bachelors +	**2 yrs AL mgmt exp in AL environment**	
Associates +	**4 yrs AL mgmt exp in AL environment**	
RN +	**4 yrs AL mgmt exp in AL environment**	
HS/GED +	**6 yrs AL mgmt exp in AL environment +**	**40 hrs CE in Core of Knowledge**
LPN +	**6 yrs AL mgmt exp in AL environment +**	**40 hrs CE in Core of Knowledge**

The examination was developed through a contract with Human Resources Research Organization (HumRRO) and based on a job analysis conducted every five years.

Two parts taken by NHAs & ALAs:

Part I – General Administration
- Organizational Management (26%)
- Community Relations and Marketing (10%)
- Financial Management (8%)
- Personnel Management (8%)
- Environmental Management (7%)
- Client Services (7%)
- Food Service (5%)
- Clinical Service (3%)

Part II – Specialty Portion
- Client Services (8%)
- Clinical Services (7%)
- Environmental Management (7%)
- Organizational Management (2%)
- Financial Management (2%)

ACHCA also certifies Nursing Home Administrators and Subacute Care Administrators – Renewal of certificate applies to all certifications.

The Virginia Board of Nursing Home Administrators does not recognize the ACHCA Nursing Home Administrator Examination as being comparable to the NAB Examination.

In order to maintain the credential, certification renewal is required every five years. To renew, an individual must pass the certification examination (both parts), complete the "Executive Portfolio," and complete an executive level course. The Executive Portfolio involves 150 continuing education hours over 5 yrs covering seven CORE areas, with hours distributed as follows:

- Communication (30),
- Human Resources (30),
- Quality Improvement (30),
- Leadership (20),
- Clinical are (20),
- Finance (10),
- Community and Family (10)

The Executive Level Course must be offered by college, university, or non-profit organization and be at least 40 hours in length (applies largely to nursing home administrators and sub-acute certificate holders).

POLICY OPTIONS

It is clear that there is no universally accepted definition for ALF administrators across the states and across all settings. However, for Virginia, what defines being an ALF

administrator is specified by the DSS facility regulations within the two levels of licensed facilities. The required characteristics, competencies, and essential duties for Virginia's ALF administrators are drawn from the regulations and are described on Pages 8 through 10 of this report. They center on the capability to ensure that the facility and its staff are in compliance with the requirements of the regulations. The ALF administrator must be able to comprehend the regulations and translate them by virtue of his abilities into safe and effective oversight of the facility. The minimal competencies presumed are anchored in a general high school curriculum with one year of post-secondary background education which is supplemented by relevant supervisory experience.

Based upon this definition and consideration of available information concerning this field, the Regulatory Research Committee was tasked with making recommendations regarding whether Virginia should regulate ALF administrators and, if so, to what degree. To aid in this effort, the following policy options were provided on September 24, 2004. This listing, although not exhaustive, reflects traditional options discussed in professional sunrise reviews: licensure, voluntary certification, registration, or no professional regulation.

When examining other health professions regulated within the Department of Health Professions' health regulatory boards, the key factors that are associated with each form of professional regulation are: educational requirements, examination requirements, scope of practice, discipline, and continuing education. So, to assist the Committee in its review of the options, the following table provided an essential overview of each factor in relation to the form of regulation. It indicates whether the factor is necessarily required or associated with the form of regulation (Y), is optional (O), or is not required (N).

Form of Regulation	Educational Requirement	Examination Requirement	Discipline	Standards of Practice	Continuing Education
Licensure	O	O	Y	Y	O
Voluntary Certification	O	Y	Y	Y	O
Registration	N	N	Y	Y	O

Option 1 - Licensure

Licensure is the most restrictive level of state regulation and largely confers a monopoly to the group in question. Licensure ensures that the scope-of-practice and the professional title are reserved to individuals who meet certain minimal competencies to safely practice. To select this option for ALF administrators, all six Criteria must be met.

(1) There must be a high risk of harm to the consumer that results from the practices inherent in ALF administration, the characteristics of the clients served, and/or the setting or supervisory arrangements for health service delivery.
(2) ALF administration must be viewed as requiring special skills and training.
(3) The ALF administrator must generally practice autonomously.

(4) The scope of practice of an ALF administrator is distinguishable from other health professions and occupations.
(5) The economic costs to the public of regulating ALF administrators and thereby potentially reducing supply are justified.
(6) Alternatives such as strengthening inspections and injunctions, disclosure requirements and consumer protection laws and regulations are insufficient to address the risk of harm to the public from the unregulated practice of ALF administrators.

Option 2 - Voluntary Certification This is the second most restrictive level of regulation. It presumes a moderate potential for risk of harm to the public that is attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision. It requires that all of the Criteria listed above, except #3 (Autonomous Practice). Voluntary certification provides assurances for the public that the individual ALF administrator who obtains certification has at least a minimal level of competency to safely practice. It affords discipline of the certificate holder. The scope-of-practice is not restricted, but the use of the title "Assisted Living Facility Administrator" (or some variant) would be reserved to those meeting the certification requirements. This method affords consumers and employers with a means of identifying competent practitioners but does not restrict the performance of their duties only to those certified.

Option 3 - Registration

Registration simply requires that all ALF administrators be registered as individual practitioners. Discipline could be taken against the registrant and not simply the facility. There is no test of minimal competency. This option provides accountability of the individual without the potential economic impact of restricting the supply of administrators. Employers and others would be able to track disciplinary history of the individual which should preclude incompetent or unscrupulous administrators from leaving one ALF only to go to another. Criteria #1, #4, #5, and #6 must be met.

For Options #1, #2, or #3, the regulation of the ALF Administrators should be housed within a recognized board which can assure competency, set appropriate standards of care, and take disciplinary action when necessary. The Board of Nursing Home Administrators appears to be the most reasonable candidate because of the similar characteristics of the clients and the flow that occurs between nursing homes and assisted living facilities and vice versa. The Board should have representation from assisted living administrators and may be renamed to better reflect that assisted living administrators have been included as regulants, perhaps renamed the "Board of Long Term Care Administrators," as some of the other states have done.

Option 4 - No Professional Regulation

To select this option, the work of assisted living administrators must be considered ordinary work, with no special, distinguishable knowledge or skill required to adequately protect the public's health, safety, and welfare.

RECOMMENDATIONS

Upon careful consideration of the aforementioned policy options, it was the consensus of the Committee that staff develop a legislative proposal for licensure of assisted living facility administrators which would be distributed for public comment back to the Committee at its meeting on October 21, 2004. In addition to the legislative proposal, the Committee directed staff to conduct a fiscal analysis of the impact of licensure of this group. Appendix #11 provides the legislative proposal distributed for comment, the fiscal impact analysis, and the comment received by October 20, 2004.

At the October 21 Committee meeting, members reviewed the resulting analysis, draft proposal and attendant public comment, both the written comments and additional comments made by the public at the meeting. The resulting final draft recommended by the Regulatory Research Committee and adopted by the full Board begins on the next page. The differences between the initial draft and the final relate to three issues: the need for licensure of all ALFs administrators, the composition of the Board of Long Term Care Administrators, and allowing for and administrators oversight of more than one facility if deemed appropriate according to the Department of Social Services regulations.

The Committee deemed that *all* ALFs should be required to become licensed, not just those for assisted living care level ALFs. The Committee held that licensure of all ALF administrators was warranted given the pervasive problems cited with UAI use in appropriately assessing resident needs. Assisted living facility administrators at all levels should be able to recognize when a resident's condition may warrant additional care, including, if necessary, when a resident may need to move to a different location to obtain adequate care.

Additional amendments relate to the composition of the Board of Long Term Care Administrators. Because there are more ALFs than nursing homes, it was deemed appropriate to provide for parity for the two regulated entities on the Board. So ALF administrators and nursing home administrators will each hold three seats. In addition, it was noted that although §54.1-3101 currently provides for a family member to serve on the Board, family members may not always exist. The Committee reasoned that a resident's guardian should also be allowed to serve in that role.

Finally, subsection B. was added to §54.1-3103 to allow an assisted living administrator to oversee more than one facility, as long as it is in keeping with facility regulations. This was in response to concerns about smaller facilities potentially being required to have a licensee at each facility to oversee the care of a handful of residents while larger facilities may have a single administrator with hundreds of residents. In addition, the Committee corrected the date in the enactment clause to 2006.

The full Board approved the Committee's report and recommendations at its meeting on October 21, 2004. The Board forwards this report to the Director of the Department of Health Professions and Secretary of Health and Human Resources for consideration as a legislative proposal for the 2004 Session of the Virginia General Assembly.

Board of Health Professions
2004 Session of the General Assembly

Recommendation of the Board of Health Professions 10/21/2004

Draft Legislation

A BILL to amend and reenact §§ 54.1-2503, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103 and 63.1-1803 of the Code of Virginia to require licensure for administrators of assisted living facilities and to expand and rename the Board of Nursing Home Administrators as the Board of Long Term Care Administrators.

Be in enacted by the General Assembly:

1. That §§ 54.1-2503, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103 and 63.1-1803 of the *Code of Virginia* are amended and reenacted as follows:§ 54.1-2503. Boards within Department.

In addition to the Board of Health Professions, the following boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Funeral Directors and Embalmers, Board of Long Term Care Administrators, Board of Medicine, Board of Nursing, ~~Board of Nursing Home Administrators,~~ Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, Board of Social Work and Board of Veterinary Medicine.

§ 54.1-3100. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Assisted living facility" means any public or private facility, as defined in § 63.2-100, that is required to be licensed as an assisted living facility by the Department of Social Services.

"Assisted living facility administrator" means any individual charged with the general administration of an assisted living facility, regardless of whether he has an ownership interest in the facility.

"Board" means the Board of ~~Nursing Home~~ Long Term Care Administrators.

"Nursing home" means any public or private facility required to be licensed as a nursing home under the provisions of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 and the regulations of the Board of Health.

"Nursing home administrator" means any individual charged with the general administration of a nursing home regardless of whether he has an ownership interest in the facility.

§ 54.1-3101. Board of ~~Nursing Home~~ Long Term Care Administrators; terms; officers; quorum; special meetings.

The Board of ~~Nursing Home~~ Long Term Care Administrators shall consist of ~~seven~~ nine members, ~~four~~ three who are licensed nursing home administrators, three who are assisted living facility administrators, two who are from professions and institutions concerned with the care and treatment of chronically ill and elderly or mentally impaired patients or residents, and one who is a resident of a nursing home or assisted living facility or a family member or guardian of a resident of a nursing home or assisted living facility. ~~Two~~ One of the licensed nursing home administrators shall be an ~~administrators~~ administrator of a proprietary nursing ~~homes~~ home. The terms of Board members shall be four years.

The Board shall annually elect a chairman. ~~Four~~ Five members of the Board, including one who is not a licensed nursing home administrator or assisted living facility administrator, shall constitute a quorum. Special meetings of the Board shall be called by the chairman upon the written request of any three members.

The Board shall be authorized to promulgate canons of ethics under which the professional activities of persons regulated shall be conducted.

§ 54.1-3102. License required.

In order to engage in the general administration of a nursing home, it shall be necessary to hold a nursing home administrator's license issued by the Board.

In order to engage in the general administration of an assisted living facility as defined in § 54.1-3100, it shall be necessary to hold an assisted living facility administrator's license or a nursing home administrator's license issued by the Board.

§ 54.1-3103. Administrator required for operation of nursing home or assisted living facility; operation after death, illness, etc., of administrator; notification of Board.

A. All licensed nursing homes and licensed assisted living facilities within the Commonwealth shall be under the supervision of an administrator licensed by the Board. If a licensed nursing home administrator or licensed assisted living facility administrator dies, becomes ill, resigns or is discharged, the nursing home or assisted living facility which was administered by him at the time of his death, illness, resignation or discharge may continue to operate until his successor qualifies, but in no case for longer than ~~six months~~ is permitted by the licensing authority for the facility. The temporary supervisor or administrator shall immediately notify the Board

of ~~Nursing Home~~ Long Term Care Administrators and the Commissioner of Health that the nursing home is operating without the supervision of a licensed nursing home administrator or the Commissioner of Social Services that the assisted living facility is operating without the supervision of a licensed assisted living facility administrator.

B. Nothing in this chapter shall prohibit an assisted living administrator from serving as the administrator of record for more than one assisted living facility as permitted by regulations of the licensing authority for the facility.

§ 63.2-1803. Staffing of assisted living facilities.

A. ~~An administrator is any person meeting the qualifications for administrator of an assisted living facility, pursuant to regulations adopted by the Board.~~ An administrator of an assisted living facility shall be currently licensed as an assisted living facility administrator by the Virginia Board of Long Term Care Administrators. Any person meeting the qualifications for a licensed nursing home administrator under § 54.1-3103 shall be deemed qualified to (i) serve as an administrator of an assisted living facility or (ii) serve as the administrator of both an assisted living facility and a licensed nursing home, provided the assisted living facility and licensed nursing home are part of the same building.

B. The assisted living facility shall have adequate and sufficient staff to provide services to attain and maintain (i) the physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and (ii) the physical safety of the residents on the premises. Upon admission and upon request, the assisted living facility shall provide in writing a description of the types

of staff working in the facility and the services provided, including the hours such services are available.

2. That provisions of §§ 54.1-3102, 54.1-3103 and 63.2-1803, requiring licensure of assisted living facility administrators, shall not become effective until July 1, 2007.

3. That the Board of Long Term Care Administrators shall submit the proposed criteria for licensure of assisted living administrators to the chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health prior to January 1, 2006.

Virginia Dept. of Health Professions
Assisted Living
Projected Cost
July 2006 through June 2007

Expenses	
1100 · Personal Services	
1110 · Employee Benefits	
1111 · Employer Retirement Contrib.	2,495
1112 · Fed Old-Age Ins- Sal St Emp	2,142
1113 · Fed Old-Age Ins- Wage Earners	
1115 · Medical/Hospitalization Ins.	9,480
1116 · Retiree Medical/Hospitalizatn	291
1117 · Long term Disability Ins	462
Total 1110 · Employee Benefits	14,870
1120 · Salaries	
1123 · Salaries, Classified	28,000
1125 · Salaries, Overtime	-
Total 1120 · Salaries	28,000
1130 · Special Payments	
1134 · Specified Per Diem Payment	1,000
1138 · Deferred Compnstn Match Pmts	480
Total 1130 · Special Payments	1,480
1140 · Wages	
1141 · Wages, General	-
Total 1140 · Wages	-
Total 1100 · Personal Services	44,350
1200 · Contractual Services	
1209 · Charge Card Purchases	
1210 · Communication Services	
1214 · Postal Services	300
1215 · Printing Services	300
1216 · Telecommunications Svcs (DIT)	200
Total 1210 · Communication Services	800
1220 · Employee Development Services	
1221 · Organization Memberships	1,000
1222 · Publication Subscriptions	
1224 · Emp Trning Courses, Wkshp & Cnf	250
Total 1220 · Employee Development Services	1,250
1240 · Mgmnt and Informational Svcs	
1247 · Legal Services	1,000
1248 · Media Services	400
Total 1240 · Mgmnt and Informational Svcs	1,400
1250 · Repair and Maintenance Svcs	
1253 · Equip Repair & Maintenance	
Total 1250 · Repair and Maintenance Svcs	-
1260 · Support Services	
1267 · Production Services	350
1268 · Skilled Services	
Total 1260 · Support Services	350
1280 · Transportation Services	
1282 · Travel, Personal Vehicle	1,060
1283 · Travel, Public Carriers	100
1284 · Travel, State Vehicles	
1285 · Travel, Subsistence & Lodging	775
1288 · Trvl, Meal Reimb- Not Rprtble	350
Total 1280 · Transportation Services	2,285
Total 1200 · Contractual Services	6,085

Virginia Dept. of Health Professions
Assisted Living
Projected Cost
July 2006 through June 2007

1300 · Supplies And Materials	
1310 · Administrative Supplies	
1312 · Office Supplies	50
1313 · Stationery and Forms	150
Total 1310 · Administrative Supplies	
Total 1300 · Supplies And Materials	200
1500 · Continuous Charges	
1510 · Insurance-Fixed Assets	
1516 · Property Insurance	
Total 1510 · Insurance-Fixed Assets	-
1520 · Capital Lease Payments	
1525 · Building Capital Leases	1,500
Total 1520 · Capital Lease Payments	1,500
1530 · Operating Lease Payments	
1534 · Equipment Rentals	
Total 1530 · Operating Lease Payments	-
1550 · Insurance-Operations	
1551 · General Liability Insurance	50
1554 · Surety Bonds	10
1555 · Workers Compensation	200
Total 1550 · Insurance-Operations	260
Total 1500 · Continuous Charges	1,760
2200 · Equipment Expenses	
2209 · Charge Card Purchases	-
2220 · Educational & Cultural Equip	
2224 · Reference Equipment	-
Total 2220 · Educational & Cultural Equip	-
2260 · Office Equipment	
2261 · Office Appurtenances	200
2262 · Office Furniture	1,200
2263 · Office Incidentals	150
2264 · Office Machines	3,100
Total 2260 · Office Equipment	4,650
Total 2200 · Equipment Expenses	4,650
Total Direct Expense	57,045
Other Expense	
9001 · Allocated Expenditures	
9205 · Dnstry & Nursng Home Admin	23,675
9301 · DP Operations & Equipment	12,544
9302 · Human Resources	2,465
9303 · Finance	6,154
9304 · Director's Office	2,796
9305 · Enforcement	50,000
9306 · Administrative Proceedings	5,000
9307 · Impaired Practitioners	1,000
9308 · Attorney General	1,000
9309 · Board of Health Professions	1,000
9311 · Moving Costs	-
Total 9001 · Allocated Expenditures	105,634
987900 · Cash Trsfr Out- Appr Act Pt. 3	1,200
Total Other Expense	106,834
Total Direct and Allocated Expenses	163,879

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