whole, not merely to the local community in which a firm locates.

Efforts to encourage rural development have been most successful where local people have played a major role in the planning process. When the entire community mobilizes its efforts, significant development can occur.

For example, the shutdown of a large magnesite plant threatened to destroy the small rural town of Chewelah, Wash., in the early 1960's. Instead, the crisis served as a catalyst to draw the townspeople together. With assistance of USDA's community resource development specialists, the town was first successful in attracting a garment manufacturing firm. Then came a large ski area, a golf course, and a large manganese plant.

The manganese plant created a local market for wood chips used to make charcoal needed by the plant. These chips were obtained from precommercial thinning in local forests. As a result, increased employment opportunities were created in the forest industry. In the process, landowners learned better forest management techniques. Through this mobilized planning effort, the community succeeded in developing and using both the human and natural resources already there.

Two communities in Washington experienced a large boom in tourism. Leaders in Leavenworth recognized the town's tourist potential due to its proximity to the mountains and its location along U.S. Route 2. Through a united effort, the exteriors of all buildings on Main Street were remodeled to resemble a Bavarian village. Further north, the town of Winthrop developed its community into an old western town complete with boardwalks, saloons, and stables.

The small community of Ashland in southern Oregon received national attention for its Shakespeare Theatre and the plays performed there. Funds obtained from the Economic Development Administration made it possible to enclose the theatre, permitting performance of its plays year-round. Ashland, Oreg., and Spearfish, S. Dak., where the Passion Play draws vast numbers of summer visitors, are but two examples where development has occurred, not because of any great natural resource, but because of the creativity and successful planning efforts of the local community.

From driftwood products in Newport, Oreg., to balsam fir Christmas wreaths in Mibridge, Me., rural communities are discovering how local talent can develop the potential of what already exists in their area. Such development increases income and employment while enabling rural areas to retain the character, values, and particular uniqueness that makes rural America a desirable place to live.

Nursing Homes: Needs Growing; Costs Rising

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More elderly people are moving into nursing homes even though this approach to health care is relatively more costly than other alternatives. Greater use of nursing homes and the influx of retirees into some rural areas may prompt community leaders to reexamine the priority of problems they are confronting. Increased emphasis is anticipated in investigating health care alternatives, including which services are desirable.

Nursing Home Occupancy Increasing

From 1970 to 1977, nursing home occupancy throughout the Nation increased from 927,000 to more than 1.2 million. This increase meant the proportion of the elderly residing in nursing homes rose from 4.0 to 4.7 percent. Such numbers understate the use of nursing homes, however, because many more elderly reside in nursing homes at some point during their lifetime.

As expected, most nursing home residents were elderly. A large majority, 85 percent, were 65 years or older; about half were 80 years or

older. Census data for 1976 indicate an individual aged 80 years or older is more than six times as likely to live in a nursing home as is an individual in the 65-79 age bracket.

A 1974 nationwide survey revealed that 70 percent of the residents were women. The average age for residents was 79. Only 12 percent had a living spouse. Thirty-seven percent came to the nursing home from a private residence, 35 percent from a general or short-stay hospital, 8 percent from a mental or long-term specialty hospital, and 16 percent from a different nursing or boarding home. Half of the residents stay in the nursing home more than a year and a half.

Occupancy alone does not necessarily measure the need for nursing homes. Some people in nursing homes may not need constant medical care. However, in the absence of alternative home and community health care services, many elderly and disabled persons are placed in institutions. One study in rural mid-Missouri indicated that 15 percent of the clients of home health services would have entered nursing homes if the home health service had not been available. On the other hand, some persons needing constant medical care may not reside in nursing homes because of high costs or lack of facilities in their area.

Nursing Home Costs High

Nursing homes are expensive to build and operate. High costs, which can restrict both their supply and use, are largely due to the nature and extent of services provided.

Health planners recommend that nursing homes offer a full range of services. These include regular physician visits, formal arrangements with physicians for emergency services, skilled nursing care, dietary services including special diets and nutritional counseling, and pharmaceutical and laboratory services. Planners further suggest that nursing homes offer rehabilitative services and therapies, counseling, and have formal arrangements with other medical specialists such as dentists, podiatrists, and opthalmologists.

Recreational, educational, and spiritual services also can improve the well-being of nursing home residents. Most do not leave the home for social or recreational purposes. A great majority of nursing homes sponsor parties and craft classes; furnish recreational facilities such as televisions, libraries, and card games; have beauty or barbershop facilities; and provide telephone accessibility. Visitor lounges are needed because most residents, 61 percent, receive visitors weekly.

In some instances, it may be desirable for nursing homes to offer services to the elderly living elsewhere in the community. For example, some nursing homes offer the meals-on-wheels program or have facilities for congregate meals. Clinic facilities in the nursing home might be made available for medical treatment of the town's residents. Nursing and therapeutic services might be furnished on an outpatient basis.

Operating Costs—Annual operating costs among 18 nursing homes in rural Missouri in 1978 averaged $6,467 per bed exclusive of interest and repayment on the capital investment (table 1). All homes were certified under Medicaid, 15 as intermediate care facilities and 3 as skilled nursing facilities. Although costs in rural Missouri may be somewhat lower than in other areas of the country, such costs may still be beyond the means of many needy people.

Size of the nursing home had little or no effect on operating costs per bed. Those homes having 48-60 beds had annual operating costs of $6,342 per bed, actually lower than the $6,586 for homes with 100 to 140 beds. All three of the homes certified as skilled nursing facilities were in the larger size category, a possible explanation of the higher operating costs.

A national survey by the Department of Health, Education and Welfare revealed that "the major influence on the average total monthly charge for residents in 1973-74 was the certification level of the facility. Average charges increased with higher certification levels regardless of ownership, size, or region classification." Higher certification levels require more intensive staffing of skilled

Table 1—Operating costs, 120-bed nursing home, October 1978

Item	Costs
Salaries	$566,400
Nursing and therapy	344,040
Dietary	76,440
Other	145,920
Supplies and services	209,640
Dietary	89,760
Utilities	41,640
Other	78,240
Total operating costs	776,040
Average cost per bed	6,467

personnel, especially nurses and aids. Contrary to expectations, no economies are apparent among larger nursing homes in per-bed operating costs.

Capital Costs—Capital costs, including both construction and startup costs, averaged $18,402 per bed. Little variation existed in per-bed costs among nursing homes of different sizes.

In the Missouri study, detailed construction cost data were obtained for nine nursing homes built between 1974 and 1978. All cost data were inflated to an October 1978 basis using the U.S. Department of Commerce composite construction cost index. The homes ranged in size from 60–120 beds. Table 2 shows the total construction cost, excluding land, for a typical 120-bed nursing home. Building costs include plumbing, mechanical, and electrical work. Site development includes excavating, landscaping, driveways, sidewalks, and parking lots. Fees include architects' fees, legal and bonding fees, interest during construction, and other financing charges.

Table 2—Capital costs, 120-bed nursing home excluding land, October 1978

Item	Costs
Construction	$2,111,280
Building	1,607,040
Equipment	173,640
Site development	66,240
Fees	264,360
Startup costs	96,960
Total capital costs	2,208,240
Average cost per bed	18,402

In addition to the actual construction costs, a new nursing home needs working capital to pay operating expenses until the home is occupied and patient revenues are received. It is assumed that the nursing home will not achieve planned occupancy until after 3 months' operation. Startup costs are calculated as three-fourths of the first month's operating costs, one-half of the second month's operating costs, and one-fourth of the third month's operating costs.

These data suggest that capital investment, exclusive of land costs, for a typical 120-bed nursing home would exceed $2 million. Particularly in times of high interest rates, a tight money market, and widespread concern about rising taxes and public spending, such capital costs may seriously deter development of needed nursing home facilities in many communities, even with assistance that may be obtained from State and Federal goverments.

Varied Assistance Is Available

The population reversal that has occurred in rural America in recent years, particularly the influx of retirees into such areas as the Ozarks, is changing the nature of problems confronting many local communities. Among these is the need to expand health assistance for the elderly.

A wide variety of services is possible. In addition to nursing homes, these include home health services, visiting nurse programs, day-care centers, congregate meal sites, home delivery of hot meals, provision of housekeepers and handymen, and transportation services. Home health agencies can provide nursing care, therapeutic services, nutritional education, homemaker services, and other social services on a visiting basis in an individual's home. County health departments may also sponsor a visiting nurse program. Day-care centers for the aged can provide nursing, recreational, therapeutic, and nutritional services. Many communities have congregate meal sites or meals-on-wheels programs.

The need for nursing home and other health care facilities doubtless will increase. USDA Agriculture Information Bulletin "Analyzing the Feasibility of Nursing Homes in the Rural Ozarks: A Guide for Local Decisionmakers" offers procedures for estimating the number of potential nursing home residents in a county by zip code areas, for determining capital and operating costs for new nursing homes, and for evaluating alternative nursing home charges.

Several Federal Government programs extend financial assistance for purposes of developing health care services and facilities. Major among these are the Business and Industrial Loans program and the Community Facilities Loans program of the U.S. Department of Agriculture's Farmers Home Administration. The U.S. Department of Housing and Urban Development administers the Mortgage Insurance Nursing Home and Intermediate Care Facilities program, and the Supplemental Loan Insurance Multifamily Rental Housing program.

Editors' Note: A list of references is available from the author.