MAINE VETERANS' HOMES
caring for those who served

February 14, 2023

The Honorable Craig Hickman
The Honorable Laura Supica
Co-Chairs, Joint Standing Committee on Veterans and Legal Affairs
c/o Legislative Information Office
100 State House Station
Augusta, ME 04333

RE: Required Reporting Pursuant to Public Law 2021, Chapter 528 (LD 2001) - "An Act To Clarify State Policy and Legislative Intent Regarding the Maine Veterans' Homes, To Require Notification of Closure of the Maine Veterans' Homes to the Legislature and To Fund Public Homes in Caribou and Machias in Order To Keep Them Open."

Dear Senator Hickman, Representative Supica, and Committee Members:

As required, I am pleased to present to you the findings and recommendations of the Stakeholders Group. As required, the Maine Veterans' Homes (MVH) Board of Trustees convened a Stakeholders Group. Attached to this letter is a report compiled by BerryDunn which details the research findings.

From this report, the Stakeholders made six recommendations, which are detailed in the appendix to this letter. The MVH Board of Trustees has accepted all six recommendations and is taking appropriate action. Details of MVH's response to the recommendations will be presented by me in my annual report to the Veterans' and Legal Affairs Committee.

MVH is grateful to all who participated in the stakeholder meetings and who provided feedback. We are especially grateful to Commissioner Lambrew and the staff of the Department of Health and Human Services, and to General Farnham from the Department of Veterans and Emergency Management. Their leadership and support of the process was invaluable.

We look forward to the opportunity to present these findings in person.

Sincerely,

Sharon Fusco
Chief Executive Officer
Maine Veterans' Homes

Appendix – Stakeholder Group Recommendations

Purpose: In an effort to continue and enhance our focus on veterans in Maine Veterans' Homes and across the state, we have created the following list of shared principles/recommendations that makes financial sense for the sustainability of the organization and meets a 'do no harm' financial criteria:

- *Keep the current non-profit model versus a state-owned or operated Veterans' Homes*
- *Suggest that the legislature examine financing options used in other states, as described in the report to ensure MVH financial sustainability*
- *Maintain quality of care*
- *Remain open in current geographic locations*
- *Diversify services to support a continuum of care for Veterans*
- *Develop shared staff relationship and recruitment strategies to address workforce challenges*

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BerryDunn

Maine Veterans' Homes and Maine Department of Health and Human Services

Veterans' Homes Study

MAINE VETERANS' HOMES
caring for those who served
An independent nonprofit organization serving Maine's veterans and families

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	Submitted On: January 4, 2023

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1.0 Executive Summary

1.1 Introduction and Background

MVH considered closing the Caribou and Machias facilities in late 2021. In response to the feedback received from those communities, the State of Maine passed LD 2001 to provide temporary funding to maintain the Caribou and Machias facilities and establish a stakeholder group. Per LD 2001:

"The Board of Trustees of the Maine Veterans' Homes, in collaboration with the Commissioner of Defense, Veterans and Emergency Management and the Commissioner of Health and Human Services, shall convene a group of relevant stakeholders **to develop a plan for the long-term viability and continuous operation of the Maine Veterans' Homes locations designated in the Maine Revised Statutes, Title 37-B, section 601**. The stakeholder group must include or seek input from veterans and their families, employees of the Maine Veterans' Homes and people in the communities served by the Maine Veterans' Homes. The board shall **present a report summarizing the findings and recommendations of the stakeholder group to the joint standing committee of the Legislature having jurisdiction over veterans affairs no later than February 15, 2023**."

Maine Veterans' Homes (MVH), established by the Maine Legislature in 1977, operates as an independent nonprofit organization, and provides long-term care services to veterans and their family members in six locations, with 628 licensed beds, 450 nursing facility beds and 178 assisted living beds as of March 2022. The MVH Board of Trustees is appointed by the Governor.

MVH is experiencing the similar challenges as other State Veterans' Homes (SVHs), skilled and nursing homes, and the post-acute care industry including:

- Post-pandemic rightsizing
- Decreasing number of veterans
- Veterans moving to other locations for retirement
- Increasing costs of nursing home care
- Workforce challenges
- Demand for care as the Maine population ages.

The fluctuating average daily census (ADC) at MVH presents a specific challenge to MVH. For example, prior to the pandemic, the demand for MVH beds was slowly decreasing. In 2019, the occupancy was nearly 600, down from years prior. During the pandemic period, occupancy ranged from 599 to 582 in 2020 to 453 in 2021 to 512 in mid-2022. In March 2022, when the new Augusta facility opened, management reduced MVH's total available beds from 640 to 628.

1.2 Approach

BerryDunn was engaged by MVH and Maine Department of Health and Human Services (DHHS) as a consultant to the stakeholder group. The scope of work included a comparative study of State Veterans' Homes (SVH) payment systems, preparing and presenting Maine

veteran demand projections for skilled, long-term care and assisted living services, workforce analysis, and conducting focus groups and analyzing findings. These services were to provide information to the stakeholder group to support the stakeholder group's responsibilities per LD 2001.

The following areas were completed as part of this work.

Comparative Study

BerryDunn conducted a comparative study of State Veterans' Homes (SVHs) payment systems, including innovative alternative Medicaid reimbursement models and different payment methodologies noted within Medicaid for veterans versus non-veterans' facilities, as well as state financial support models. We also compared funding models for operations and construction projects, and beds per capita.

We identified ten states based on attributes such as demographics, number of facilities, location of facilities, and further research regarding state financial support models and Medicaid payment methodologies. The selected states included Colorado, Idaho, Kansas, Kentucky, New York, North Carolina, Ohio, Vermont, Washington, and Wisconsin. We summarized any identified innovative or varying Medicaid payment models and differing state financial support models identified in these states.

Demographic Demand Projection

BerryDunn conducted a demographic demand projection to forecast the expected demand (or need) for MVH beds for both the nursing home and residential care components for each of the six MVH locations today and for the next two decades. Using background information shared with us by MVH and DHHS, we researched Maine aging population projections and Maine veteran population, demographics and trends. We also utilized current demand for services as a component in the projections. Both age and service-connected disabilities which may relate to the era of service were factors in the projections.

Workforce Analysis

BerryDunn conducted a workforce analysis. This work included a compiling a summary of current Maine-based initiatives focused on improving access to healthcare workers, in particular workers needed in nursing homes and assisted living facilities. We utilized this information and other workforce data and trends gathered from external sources to compare to current operating trends at MVH. Trends included:

- Direct care hours per patient day
- Staffing as a percent of total expenditures
- Direct care staffing mix.

Focus Groups

BerryDunn completed focus groups at the Caribou, Machias, and South Paris facilities. Three focus groups were held per location which included:

- Residents and Family Members[1]
- Maine Veterans' Home Staff and other community providers
- Civic and Community Leaders

Each group was provided a short background on Maine Veterans' Homes and on LD 2001 at the start of the session. And then each group was led through a discussion on a series of questions used to lead the group through the focus group session. In addition to the participation in the discussion during the focus groups, participants were provided a paper feedback form that asked them to provide input into the attributes of healthcare in a rank order exercise and a comment box to share information that did not come up in conversation. An electronic survey for public comment was also available

1.3 Summary Finding Themes

Based on the work described above, the following finding themes are noted:

- **Comparative Study:** Rising costs and diminishing occupancy have resulted in increases in per diem costs. VA, Medicare and Medicaid regularly increase per diem reimbursement; however recent increases have not kept pace with the increases in the cost of providing care, leaving facilities to manage shortfalls. SVHs are reimbursed under several different mechanisms, which are partially dependent on their ownership structure. In addition to the reimbursement SVHs receive from providing care to residents, some states may also provide add-on payments specific to SVHs, appropriations from state funds for operations, and appropriations for capital projects. SVHs are required to comply with VA operating regulations, which can impact cost. MVH's cost per patient day as noted in Table 5 has been higher than other facilities in Maine, yet MVH's Medicare cost per patient day per Table 8 has been lower than the average of all SVHs in the country.

  Strategic initiatives considered by SVHs nationwide are mostly focused on adjustments to bed capacity and levels of care provided to maximize occupancy and/or reimbursement opportunities. Cost report data from 2019 to 2021 reveals several SVHs decreasing or eliminating domiciliary care (assisted living) programs due to insufficient funding. In Maine, assisted living beds remain available to veterans at all six locations,

[1] With the exception of Machias which was only family member due to the focus on memory care in Machias and the inability for Machias residents to fully participate in a focus group session.

partially due to MaineCare coverage available for such care which is not as readily accessible in other states.

Other national SVHs initiatives include implementing behavioral health and outpatient rehabilitation programs and exploring inhouse pharmacy and adult day programs. MVH currently operates an inhouse pharmacy program and continues to explore opportunities to diversify revenue.

- **Demographic Demand Projection:** The demand for the number of beds hinges on the declining population of veterans in Maine, particularly veterans over the age of 65 in rural areas of Maine. As of 2020, half of the veterans in Maine were 65 years or older. Maine has the lowest number of veterans per SVHs bed within the comparative states evaluated in Table 2. Since the average age that one enters a nursing facility nationally is in their 80's this report focuses primarily on veterans 65 years or older (65+). Exclusive of in-migration, the U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (VANCVAS) projects the number of Veterans 65+ in Maine will decline by 12% (20,000) from 2020 to 2030 and further decline 25% (12,500) from 2030 to 2040. These projected declines will have an impact on MVH's average daily census over the next 20 years.

  Among all Veterans in Maine, regardless of age, there will be a 35% decline (39,000) from 2020 (112,600) to 2040 (73,400). From 2020 to 2030, there is projected to be a 21,000 decline (19%) and from 2030 to 2040, a 18,000 decline (20%).

- **Workforce Analysis:** Nationally and here in Maine, the pandemic contributed to the already anticipated shrinking labor force. The tight labor market has led to higher labor costs and utilization of contract labor as well as reductions or suspensions in admissions due to lack of staffing. Average contract labor costs at SVHs increased by approximately $34 per patient day from 2020 to 2021. Many states, including Maine, are facilitating labor-related programs aimed at increasing labor pool and staff retention, and are considering waivers related to staff certification and delegation of duties requirements. Due to timing, there is no data available yet to forecast the impact of these initiatives on the labor market and occupational projections.

- **Focus Groups:** Focus groups are designed to gather qualitative information. There are vocal groups of supporters for the three MVH facilities for which focus group meetings were held: Caribou, Machias, and South Paris. Across focus groups in all three locations, stakeholders shared their perspective that the need to serve veterans is important, that a cohort of veterans with a shared experience is valuable to veteran residents, the quality of MVH care is high, the bed and services availability in the regions challenging, using in-home support has barriers, keeping a loved one close to home important, and the workforce challenges are real for many, including MVH. There was a strong desire expressed for the MVH facilities not to be closed. Whether that was from the perspective the impact of closure would have on a loved one or from a regional perspective regarding the cascading effect closure would have on hospitals, nursing homes, and other providers in the community.

1.4 Conclusion and Next Steps

This report contains the summary of our work for MVH and DHHS. The report is presented in a summary of information nature. By design, BerryDunn's role was not to provide recommendations or render an opinion. It was to research, gather information, conduct analyses, and provide the information to the stakeholder group to support their work. The next steps for the stakeholder group will be to review this report in its entirety, use the information it contains, and complete the work of the stakeholder group as outlined in LD 2001.

2.0 Introduction

Maine Veterans' Homes (MVH) and Maine Department of Health and Human Services (DHHS) engaged BerryDunn as a consultant in the stakeholder group established pursuant to Maine Revised Statutes 37-B, Section 612. The scope of work included a comparative study of State Veterans' Homes' (SVHs) payment systems, preparing and presenting Maine veteran demand projections for skilled, long-term care and assisted living services, a workforce analysis, and conducting focus groups and analyzing findings. The work was conducted by a number of consultants with a depth of expertise in the senior living industry.

The following sections in the report provide further detail on the information gathered from the work conducted through this project.

2.1 Engagement Team

Tammy Brunetti, CPA | Principal: Tammy leads BerryDunn's Healthcare Practice Group, which provides consulting services, audit, accounting, and third-party reimbursement, to skilled and long-term care facilities and other post-acute care providers, assisted living, residential care organizations, and senior living communities varying in size and complexity. She brings a wealth of experience in gathering industry-specific data for cost reports and financial ratio databases and is experienced in looking for and evaluating trends in demographics and service demands over specific time ranges. She works to analyze this data to assist clients in gaining traction and to support legislative initiatives in a heavily regulated industry. Tammy currently provides assurance or consulting services to over 90 skilled and long-term care facilities throughout the Northeast. Tammy served as the project lead and provided her expertise and support to the team members. She served on the stakeholder group and provided support to further the group's efforts.

Lisa Trundy-Whitten, CPA, FHFMA, CPC-A | Principal: Lisa is a principal in BerryDunn's Healthcare Practice Group and leads the firm's Senior Living Practice. She has concentrated on serving the healthcare industry, senior living organizations, industry associations, and acute care hospitals for the past 20 years. Lisa provides consulting and audit services to a number of organizations throughout the continuum of healthcare located in the Northeast. Lisa has extensive experience working closely with long-term care clients and consulting on third-party reimbursement issues, including cost reporting, certificate of need applications and Medicaid

and Medicare audits. She serves as the firm's subject matter expert on the Patient Driven Payment Model. Lisa led the workforce analysis and comparative study of other states' SVH payment systems portions of the project.

Dan Vogt, BS, COBIT, LSSGB, PMP®, Prosci® CCP, CSM | Principal: Dan is a principal in BerryDunn's Management and IT Consulting Group with more than 20 years of experience providing consulting services for healthcare, state veteran homes, and senior living organizations. Dan has demonstrated experience leading large strategic planning and facilitation projects and is skilled at bridging the gap between technical, business, clinical, and other stakeholders. Dan served as the lead facilitator for the focus group portion of this project.

Nancy Rosenthal | Senior Consultant: Nancy is a senior consultant in BerryDunn's Healthcare Practice Group and has served in healthcare organizations for over 30 years in strategic planning, regulatory, and operational roles. She has contributed to the expansion of several healthcare organizations and has been involved in a number of nursing home and senior service projects. Her expertise is in analyzing the environment, identifying opportunities, planning new programs and services, and implementation. Nancy led the demand projection data and analysis portion of this project.

Olga Gross-Balzano, CPA, LHNA, PMP® | Senior Manager: Olga has been working in healthcare operations and finance for over 20 years, 8 of which have been as a licensed skilled nursing facility (SNF), assisted living, and home care administrator. She uses a practical and straightforward approach, and focuses on staff and stakeholder engagement, education, and collaboration. Her solid understanding of operational, clinical, and business needs enables her to successfully engage decision-makers, vendors, project team members, and end users in goal setting and implementation of new systems. Olga was involved in the comparative study and workforce analysis portions of the engagement.

Jon Findlay, ITIL (F), Prosci® CCP | Manager: Jon is a manager in BerryDunn's Healthcare Management and IT Consulting Practice. Jon provides strategic planning services to a number of healthcare organizations, including SVH, regional hospitals, and other long-term care organizations. His work includes assessing current environments, interviewing stakeholders, organizing findings, developing recommendations and strategic initiatives, and participating in the creation of deliverables. Jon was involved in the focus group aspects of the engagement.

3.0 Comparative Study

This section provides information about how BerryDunn conducted work, actions taken, people involved, and information sources used to complete the comparative study of SVHs.

3.1 Work Performed

BerryDunn conducted a comparative study of SVHs' payment models, including organizational structure, reimbursement, state funding for operations and construction projects, and beds per capita. The firm summarized any identified innovative or varying Medicaid payment models and differing state financial support models. BerryDunn used the three-step approach outlined below for the study:

1. **Assemble National Data** – BerryDunn compiled comparative information from other SVHs. The firm did so through research, publicly available information, and direct outreach to other SVHs. The data was analyzed from a national and regional perspective, as well as by targeting individual states with facilities of comparable sizes and demographics.

2. **Analysis** – BerryDunn analyzed the available comparative data. The firm identified trends, similarities, and differences between MVH and other SVHs. BerryDunn considered factors such as how SVHs are organized, funded, sized, and what eligibility criteria they use. The firm identified 10 states that most closely align with Maine demographics and geography to perform further research regarding state financial support models and Medicaid payment methodologies. The selected states were Colorado, Idaho, Kansas, Kentucky, New York, North Carolina, Ohio, Vermont, Washington, and Wisconsin.

3. **Summarization of Findings** – BerryDunn summarized the analysis for use by the stakeholder group. The complete report of statistics and benchmarks is available in Appendices A through J of this report.

3.2 Background and Demographics

The Veterans Administration (VA) provides facility-based (institutional) care through three venues: VA owned and operated Community Living Centers (CLCs), formerly known as VA Nursing Homes; Community Nursing Homes (CNHs); and SVHs. In fiscal year (FY) 2010, almost 72% of the VA's facility-based care occurred in CNHs and SVHs. (Source: Fact Sheet, NASVH.org). Table 1 below summarizes services provided by facility type, and requirements for admission.

Table 1 – VA Long-Term Care Services, Locations and Admission Requirements

Facility Type	Ownership & Management	Services	Number of Facilities, 2022	Locations, Population Served
CLC	VA	Short- and long-stay services for eligible veterans regardless of age, post discharge from the hospital and in preparation for home and community-based care.	134 (1 in Augusta, Maine)	Locations: on or near VA Medical Center campuses Population served: veterans
SVH	State-owned and operated facilities (except MVH operating as an independent nonprofit). VA does not manage SVHs.	Skilled nursing and rehabilitation services, long-term care, memory care, and respite services. Some facilities host adult day health care programs.	151 (6 in Maine *)	Locations: 50 states and Puerto Rico Population served: minimum occupancy consisting of 75% veterans; family members
CNH	VA contracts with privately owned and operated skilled nursing facilities.		2,620 (11 in Maine **)	Locations: 50 states and Puerto Rico Population served: no military service requirement

In Maine, long-term care services are provided to veterans at all three facility types.

Unique to SVHs across the nation, MVH operates as an independent nonprofit organization. MVH facilities are licensed by the State of Maine and Centers for Medicare & Medicaid (CMS) to provide nursing and assisted living services (also known as domiciliary care or residential care) at six locations, originally determined by the Maine Legislature, with a total of 628 licensed beds (450 nursing facility and 178 assisted living beds as of March 2022).

*Located in Caribou, Augusta, Bangor, Machias, Scarborough and South Paris.

**Located in Auburn, Bath, Biddeford, Canton, Deer Isle, Dexter, Farmington, Houlton, Madawaska, Portland and Yarmouth.

3.3 Demographics of Comparative States

Table 2 – Summary of SVHs Long-Term Care Beds and Veterans Served

State	Number of Locations	Nursing Care Beds	Domiciliary (Assisted Living) Beds	Number of Veterans	Veterans per Capita	Veterans per SVH Bed	Maximum Authorized SVHs Beds
Maine	6	450	178	101,652	7,424	162	****362
Colorado	5	554	20	370,677	6,259	646	1,114
Idaho*	3	254	36	115,549	6,103	398	394
Kansas	2	228	213	172,750	5,846	392	518
Kentucky	4	681	none	257,452	5,672	378	818
Montana**	3	245	none	85,401	7,741	348	281
New York	5	1,372	none	676,295	3,321	493	2,209
North Carolina***	4	499	none	654,365	6,162	1,311	1,900
Ohio	2	595	205	689,905	5,787	857	2,143
Vermont	1	130	8	34,915	5,400	253	142
Washington	4	517	28	517,912	6,555	950	1,687
Wisconsin	2	230	40	319,280	5,380	1,182	1,062

Sources: Beds and locations (CMS Provider Information, May 2022); veterans and veterans per capita (https://worldpopulationreview.com/state-rankings/veterans-by-state); maximum number of nursing home and domiciliary bed (38 Code of Federal Regulation (CFR) 59.40).

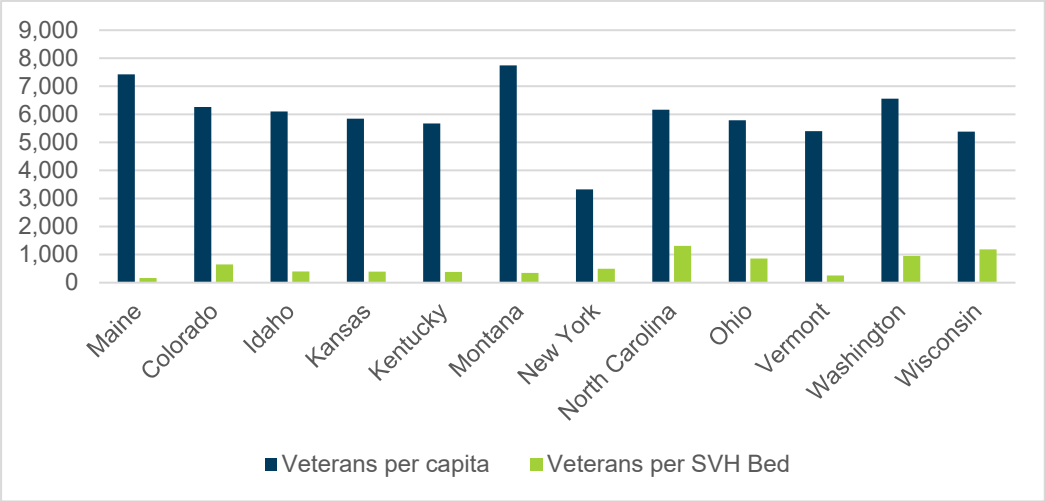
*Idaho is opening a fourth location in Post Falls in November 2022; in addition, Idaho is replacing the existing Boise facility.

**Montana opened its Butte location of five cottages, each with 12 bedrooms. The new location is the only facility able to take Medicare and Medicaid residents (CMS certified).

***North Carolina will be opening a fifth location in Kernersville in late 2022; this location will not include any domiciliary beds.

****Maine is over the maximum number of beds authorized by the VA; per discussion with management, it is understood that Maine was grandfathered from the maximum because it had already submitted grant applications for the residential care facilities when maximums were established.

Figure 1 – Veterans per Capita and per SVHs bed, 2022



Of the comparative states, Maine has one of the highest number of veterans per capita; however, Maine has the lowest number of veterans per available bed.

3.4 VA Funding Available for Long-Term Care Services

38 CFR Part 51 *Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes* regulates the VA funding for SVHs that provide nursing home care, domiciliary care, or adult day healthcare to eligible veterans. VA reimbursement rates for SVHs (summarized below in Table 3) increase annually by approximately 2% – 3%. The increases have not kept pace with the rising cost of care over the past three to five years.

Table 3 – VA Reimbursement Rates, SVHs

Level of Care	FY2021 Basic Rates (2.9% increase)	FY2022 Basic Rates (2% increase)	FY2023 Basic Rates (2.6% increase)	Average Nursing Facility-Specific Service-Connected Rates (70+% disabled), FY2022
			Rate calculations are based on the criteria outlined in 38 CFR 51.40	Rate calculations are based on the criteria outlined in 38 CFR 51.41
Nursing home care	$ 115.62	$ 117.93	$ 121.00	$ 444.32
Domiciliary care	$ 49.91	$ 50.91	$ 52.23	N/A
Adult day healthcare	$ 92.12	$ 93.96	$ 96.40	N/A

In addition to the per diem rates, 38 CFR Part 59 defines VA funding available for construction or acquisition of SVHs facilities for furnishing domiciliary or nursing home care to veterans, and for expanding, remodeling, or altering existing buildings for furnishing domiciliary, nursing home, and adult day healthcare to veterans in SVHs. In addition to defined application requirements, in order to receive funding, the planned project must be ranked sufficiently high on the priority list for the current federal fiscal year. 38 CFR part 59.40 specifies the maximum number of nursing home care and domiciliary care beds for veterans by state, based on available 10-year demographic projections of demand for nursing home and domiciliary care by veterans who at such time are 65 years of age or older and who reside in that state (currently using 2020 projections). In determining the projected demand, the VA considers travel distances. The current calculated maximum beds in Maine is 362, which includes both nursing and domiciliary beds. A complete summary of the current calculated maximum beds available by state is included in Appendix V.

MVH has accessed this construction grant funding for the initial build of the facilities, significant renovations, and the new Augusta location. The new Augusta facility was funded 65% from a VA construction grant, and 35% from debt financing and MVH board-designated investments.

Additionally, the VA provides payments to SVHs for the hiring and retention of nurses, designed to reduce nursing shortages at SVHs. Facilities receiving such per diem payments have a documented nursing shortage. Funding may cover up to 50% of the eligible employee incentive program costs and is not applicable to the statutory benefits or salaries. 38 CFR Part 53 establishes procedures for distribution and reporting on this type of funding. Suggested uses of funds include, but are not limited to, scholarships for continuing nursing education, sign-on bonuses for nurses, student loan forgiveness, and improvements to working conditions (not involving remodeling). MVH accessed this funding for a three-year period, the maximum period eligible.

3.5 COVID-19 Funding

Due to the economic hardships caused by the COVID-19 pandemic, significant federal funding has been made available to SVHs. Many SVHs received Health Resources Services Administration (HRSA) Provider Relief Funding (PRF) as a subunit of state governments, and the reporting periods for use of the funds has not yet been exhausted. Therefore, BerryDunn is not able to determine how much PRF funding was made available to SVHs. Amounts authorized for each facility can be located at https://www.hrsa.gov/provider-relief/payments-and-data.

In March 2021, the VA allocated $1 billion in aid to SVHs. The sources and allocations of funds are as follows:

1. $500 million from the American Rescue Plan Act for construction grants and $250 million to SVHs designated for operating needs based on each state's share of total veteran residents in nursing home and domiciliary care;

2. $150 million from the CARES Act for construction needs to modify buildings to prepare, prevent, and respond to mitigate the risk of COVID-19;

3. and $100 million from the Consolidated Appropriations Act of 2021 for grants for emergency payments to prevent, prepare, and respond to COVID-19.

Several states acted through Medicaid state plan amendments and options available to them through the national declaration of emergency to provide additional COVID-19 funding to nursing facilities. In general, there was no differentiation in the funding between SVHs and other nursing facilities. Examples of COVID-19 funding at the state level include the following:

1. Maine provided a Temporary Rate Increase to facilities from March to May 2020, then an Extraordinary Circumstances Allowance add-on during periods of outbreaks. In addition, supplemental payments totaling $123 million in state fiscal year 2022 and $25 million in state fiscal year 2023 were provided to nursing facilities, residential care facilities, and adult family care homes state-wide. All such funding is cost settled.
2. Colorado provided a one-time supplemental payment equivalent to an 8% increase in the Medicaid rate.
3. Kansas issued a $20 daily add-on to its per diem rates for 120 days.
4. Kentucky paid an additional $29 per day to all prospective pay facilities; the SVHs were not eligible for the add-on payment as they are cost settled.
5. Montana issued supplemental payments of $40 per day, based on claims from March to June 2020.
6. North Carolina provided a 15% add-on to the Medicaid rate to be used to prevent, prepare, and respond to COVID-19. The add-on will not be settled on the cost report.
7. Washington provided an add-on payment at a flat rate of $29 per day.
8. Wisconsin maintains a fund to support direct care workers.

3.6 State Reimbursement Methodologies

For SVHs, the VA per diem rate payments detailed above only cover a portion of the costs of care. States have various approaches to funding the shortfall, such as profits from private paying residents, claim-based reimbursement from Medicare for short-stay rehabilitation (up to 100 days, as medically necessary), claim-based and lump-sum adjustment payments from state Medicaid waiver programs, and state General Fund appropriations. Non-veterans (family members) are not eligible for the basic per diem rate payments and require a combination of private pay and private insurance (such as Medigap for short stay or long-term care insurance) or Medicaid funding, if eligible.

State reimbursement methodologies vary, are not well-summarized, and are further complicated by COVID-19-related enhancements and supplemental payments. Many SVHs rely on some form of state appropriations (from general or other funds) to bridge the gap between claim-based reimbursement and the cost of care. Table 4 highlights critical elements of reimbursement methodologies.

Table 4 – SVHs State-Specific Reimbursement Methodologies

State	Ownership Structure	Payors Accepted				Described more fully in footnotes below table			
		Medicaid	Medicare	VA	Private	SVHs – Medicaid Reimburse-ment Type	State Appropria-tions for Operations	State Appropria-tions for Capital	Non-COVID Add-Ons or Special Arrange-ments
Maine*	Independent Not for Profit	•	•	•	•	Cost Based – with Caps	Y	N	Y
Colorado	State Owned – Under CDHS	•	•	•	•	Prospective Payment System	N	N	N
Idaho	State Owned	•	•	•	•	Cost Based – 100% of Allowable Cost	Y	Y	N
Kansas	State Owned	•	•	•	•	Prospective Payment System	Y	Y	N
Kentucky	State Owned	•	•	•	•	Prospective Payment System – with Add-Ons	N	Y	N
Montana	State Owned – One Contracted Facility	(one facility CMS certified in 2022)		•	•	Prospective Payment System	Y	Y	N
New York	State Owned – One Facility	•	•	•	•	Prospective Payment System	Y	Y	Y
North Carolina	State Owned Under NCDMVA	•	•	•	•	Cost Based – 100% of Allowable Cost	N	N	Y
Ohio	State Owned	•	•	•	•		Not reported	Y	Not reported
Vermont	State Owned	•	•	•	•	Cost Based – 100% of Allowable Cost	Y	Y	N

State	Ownership Structure	Payors Accepted				Described more fully in footnotes below table			
		Medicaid	Medicare	VA	Private	SVHs – Medicaid Reimburse-ment Type	State Appropria-tions for Operations	State Appropria-tions for Capital	Non-COVID Add-Ons or Special Arrange-ments
Washington	State Owned	•	•	•	•	Prospective Payment System	Y	Y	N
Wisconsin	State Owned	•	•	•	•	Prospective Payment System	N	N	N

*Maine – Medicaid reimbursement is cost-based, with caps on direct care and routine costs based on 110% of per-group median (rebased every two years). Capital-related building costs and provider taxes are reimbursed at cost, subject to preapproved limits.

State Appropriations for Operations

Maine – LD 2001, S.P. 719 – *Act to Fund and Support Veterans' Homes in Caribou and Machias and Require Legislative Approval for the Establishment and Closure of Veterans' Homes* appropriated and allocated $3.5 million in state fiscal years 2022 and 2023; funds were appropriated from the general fund, other special revenue funds, and included federal matching.

Kansas – Kansas has additional funding from operations appropriated from the state's Cigarette Tax Fund.

Montana – Montana has additional funding from operations appropriated from the state's Special General Fund, which is a percentage of the cigarette tax.

New York – New York has additional funding from operations appropriated from the state's General Fund to support cost of pension expense.

North Carolina – North Carolina supports operations from the Veterans' Trust Fund (special revenue fund) established in 1994. This fund was established with a combination of state appropriations and donations; current operations are not funded through appropriations from the state. In addition, the fund supports most capital projects. Occasionally, SVHs access the state's Capital Infrastructure Fund for smaller capital projects.

Vermont – Vermont has additional funding from operations appropriated from the state's General Fund.

Washington – Washington has additional funding from operations appropriated from the state's General Fund.

Add-Ons or Special Arrangements for SVHs Not Made Available to Other State Nursing Facilities

Idaho – Idaho has a different reimbursement methodology from that of other nursing facilities in the state; moved to 100% cost-based reimbursement in July 2021.

Kentucky – Kentucky has a different reimbursement methodology from that of other nursing facilities in the state; as noted above, the SVHs receive an additional add-on to their rate to support payroll costs.

Montana – Montana has four SVHs. One is operated by the state, which receives an allocation from the State Special Fund, and the other three homes are managed by a private contractor and do not receive any additional funding allocations.

New York – New York provides additional payments to SVHs to fund pension costs.

North Carolina – North Carolina has a different reimbursement methodology from that of other nursing facilities in the state.

3.6.1 Nursing Facility Reimbursement

As mentioned above, the cost of providing care may not be covered by the available claims-based reimbursement, leaving a gap (shortfall) of non-reimbursed costs. These costs normally stem from increases in cost to provide services, such as wage increases, cost of supplies, and utilities. Many of these costs are outside the SVHs' control. At times there are also additional and unfunded costs incurred to comply with new laws, regulations, or ordinances.

MVH experienced an increase in required minimum wages, cost of COVID-19 infection control compliance, cost of meeting minimum staffing ratios by caregiver licensing type, and other increases. There are increased costs related to receiving additional COVID-19-related funding and compliance and reporting the related use of these funds (such as Medicaid, HRSA Provider Relief Fund, VA COVID-19 funding, construction grants, and other reporting).

Most individuals interviewed thought their facilities and states were in "survival mode," trying to navigate the pandemic and impact on current workforce shortages. A few SVHs are working with alternative Medicaid reimbursement models, including:

1. New York – Implemented Medicaid managed care; however, it has not been implemented as quickly as expected due to the impact of COVID-19.
2. Idaho – Implemented Medicare/Medicaid Coordinated Plan (MMCP) plan, which coordinates Medicare and Medicaid services for dual-eligible individuals. A number of benefits, such as medical, behavioral health, dental, and prescription drugs are available via MMCP, as well as long-term care services, such as adult day care, chore/homemaker services, and respite care. Third-party insurers participate in the Idaho Medicaid program.
3. Kentucky – Has a quality-based add-on to the prospective payment rate.

3.6.2 Domiciliary Care (Assisted Living) Reimbursement

In recent years, BerryDunn has seen a decline in the number of domiciliary care (assisted living) units. Providers cite low reimbursement as a major reason for eliminating this service. While assisted living services allow more independence and choices while providing necessary support services at a significantly lower cost, only a few states nationwide have provisions for some form of Medicaid reimbursement for long-term institutional care services beyond nursing facilities. Without Medicaid funding, the VA rate for domiciliary care of $52.23 (FY 2023) per day does not come close to covering costs. Traditionally, veterans are expected to cover the difference between VA reimbursement and the facility's established daily rate with personal funds. For many, this makes the domiciliary care option cost prohibitive.

In December 2018, the VA changed enforcement of existing rules that include a work requirement for veterans under the domiciliary care per diem stipend program, which impacts eligibility. MVH was granted equitable relief from this enforcement through September 30, 2021 and was therefore able to bill for residents who were initially deemed ineligible. MVH is required to file for equitable relief annually to continue to bill for certain veterans deemed ineligible under the domiciliary care per diem stipend program. Such billings approximated $916,000 and $538,000 for the years ended June 30, 2022, and 2021, respectively.

MVH facilities are uniquely positioned to be able to continue providing an assisted living option (in Maine Private Non-Medical Institution [PNMI] or Residential Care Facility) in all six locations, with a total of 178 beds, due to many residents' eligibility for MaineCare (Maine Medicaid) claim-based per diem reimbursement. However, Medicaid does not fully cover costs of assisted living care either, leaving a sizeable shortfall annually. Using as filed MaineCare cost report information, BerryDunn summarized data related to the number of residents served in this care model, and the total MaineCare shortfall in the payment for the cost of this for care in Table 5.

Table 5 – MVH Medicaid Shortfall, FY2021

	Average MaineCare Rate, per Resident Day	Average Cost of Care per Resident Day	MaineCare Shortfall, per Resident Day	MaineCare Days, FY2021	MaineCare Revenue	MaineCare Cost	MaineCare Shortfall
Nursing Facilities *							
MVH – Augusta	$288.80	$413.11	($124.30)	17,796	$5,139,485	$7,351,746	($2,212,262)
MVH – Bangor	$319.66	$422.49	($102.83)	19,021	$6,080,253	$8,036,239	($1,955,986)
MVH – Caribou	$301.38	$475.51	($174.13)	8,352	$2,517,126	$3,971,455	($1,454,330)
MVH – Scarborough	$328.55	$516.19	($187.64)	14,722	$4,836,913	$7,599,398	($2,762,485)
MVH – South Paris	$336.11	$519.60	($183.49)	10,627	$3,571,841	$5,521,753	($1,949,912)
Domiciliary Care / Assisted Living **							
MVH – Augusta	$122.37	$298.19	($175.82)	6,258	$765,791	$1,866,073	($1,100,282)
MVH – Bangor	$121.78	$206.86	($85.08)	7,686	$936,001	$1,589,926	($653,925)
MVH – Caribou	$126.94	$299.66	($172.72)	5,979	$758,974	$1,791,667	($1,032,693)
MVH – Scarborough	$147.11	$245.22	($98.11)	7,751	$1,140,250	$1,900,700	($760,451)
MVH – South Paris	$107.95	$237.83	($129.88)	6,887	$743,452	$1,637,935	($894,484)
MVH – Machias	$148.77	$294.51	($145.74)	7,384	$1,098,518	$2,174,662	($1,076,144)
Total MaineCare Shortfall, MVH FY2021							**$(15,852,952)**

Source: BerryDunn database of Maine Nursing Home cost report filings

*Nursing Facility Average State-wide MaineCare Rate Per Resident Day FY 2021 = $281.67, MaineCare Cost Per Resident Day FY 2021 = $321.57

**Assisted Living Average State-wide MaineCare Rate per Reisdent Day FY 2021 = $161.11, MaineCare Cost Per Resident Day FY 2021 = $133.18

3.7 Comparative Benchmarks

Occupancy has been declining nationwide since 2019, driven by both diminishing referrals (infection control concerns; reduction of elective procedures, such as joint replacements; and hospital capacity limitations) and facilities' ability to accept patients (suspension of admissions due to inadequate staffing).

Table 6 – Average SVHs Facility Occupancy, 2020 and 2021, CMS-Certified Facilities

Nursing Facilities Group	State	SNF/NF		DOM		Total Facility	
		2020	2021	2020	2021	2020	2021
MVH							
	Maine	89.02%	71.44%	95.88%	78.38%	90.68%	72.38%
Comparison Group							
	Colorado	80.75%	61.98%	N/A	N/A	80.75%	61.98%
	Idaho	81.77%	65.93%	52.00%	39.50%	79.33%	63.93%
	Kansas	71.15%	70.60%	N/A	N/A	71.15%	70.60%
	Kentucky	68.08%	50.93%	N/A	N/A	68.08%	52.23%
	New York	85.90%	47.55%	N/A	N/A	85.90%	47.55%
	North Carolina	90.65%	79.00%	N/A	N/A	90.65%	79.00%
	Ohio	90.55%	62.05%	N/A	N/A	90.55%	62.05%
	Vermont	92.50%	76.50%	80.70%	70.00%	91.90%	76.20%
	Washington	93.43%	88.10%	N/A	N/A	93.43%	88.10%
	Wisconsin	89.45%	83.05%	N/A	N/A	89.45%	83.05%
		83.91%	66.48%	66.35%	54.75%	83.65%	66.44%
Average All U.S. SVHs		**82.19%**	**67.48%**	**86.65%**	**69.90%**	**84.91%**	**69.52%**

Source: Publicly available Medicare cost report filings

MVH's skilled and long-term care units show strong average occupancy as compared to peers in northeast states and even nationally. Higher occupancy helps lower per diem costs for building-related and administrative expenses not related to occupancy levels.

It is important to note in Table 7 that many of the low occupancies presented are the direct result of staffing shortages. SVHs have reported deliberately keeping occupancy low due to staffing and reimbursement issues. One SVH in the comparison group reported a 53% current occupancy rate despite a wait list of approximately 200 individuals seeking care.

Rising costs and diminishing occupancy results in high increases in per diem costs. While the VA, Medicare, and Medicaid regularly increase per diem reimbursement rates, the increases

have not covered the increased cost of providing care, leaving facilities with hard-to-manage shortfalls.

Table 7 – Average VA SNF Service-Connected Rates, FY2022

Nursing Facilities Group	State	Rural	Urban	Average
MVH				
	Maine	$ 414.68	$ 457.09	$ 431.64
Comparison Group				
	Colorado	$ 470.25	$ 471.49	$ 470.50
	Idaho	N/A	$ 436.04	$ 436.04
	Kansas	$ 401.68	N/A	$ 401.68
	Kentucky	$ 404.50	$ 415.77	$ 410.13
	New York	$ 422.31	$ 579.07	$ 516.37
	North Carolina	$ 406.10	$ 435.46	$ 428.12
	Ohio	$ 408.56	$ 454.44	$ 431.50
	Vermont	$ 455.68	N/A	$ 455.68
	Washington	N/A	$ 511.20	$ 511.20
	Wisconsin	$ 437.70	$ 473.33	$ 461.45
		$ 431.86	$ 478.98	$ 458.99
Average All U.S. SVHs		**$ 421.66**	**$ 456.33**	**$ 444.32**

Medicare Part A reimbursement in SNFs includes room and board costs and all patient medical needs and services, with a few exceptions. Reimbursement is one per diem rate based on patient assessment data (consolidated billing rules). The daily rate includes reimbursement for all nursing labor, physician visits, transportation, medications, therapy services, laboratory, and imaging services, which could be extremely costly. In some instances, the cost of the prescribed medication alone might exceed the daily rate reimbursed by Medicare. Privately owned facilities frequently place emphasis on carefully prescreening patients prior to making an admission decision and coordinating care during short stays. Due to their commitment to serving veterans and their families, SVHs may not have same patient preadmission screening practices.

Table 8 – Average SVHs Medicare Revenue, Cost and Shortfall per Diem, 2020 – 2021

Comparison Group	State	Medicare Revenue per Diem		Medicare Cost per Diem		Medicare Shortfall per Diem	
		2020	2021	2020	2021	2020	2021
Maine							
	MVH	$ 527.08	$ 538.33	$ 627.45	$ 791.36	$ (100.36)	$ (253.03)
Comparison Group							
	Colorado	$ 531.26	$ 536.26	$ 830.53	$ 910.27	$ (299.28)	$ (374.01)
	Idaho	$ 523.38	$ 518.07	$ 592.93	$ 751.86	$ (69.56)	$ (233.78)
	Kansas	$ 462.78	$ 558.73	$ 972.73	$ 495.05	$ (509.95)	$ 63.68
	Kentucky	$ 477.94	$ 496.00	$ 611.44	$ 678.45	$ (133.50)	$ (182.45)
	New York	$ 636.42	$ 680.19	$ 1,018.49	$ 2,044.12	$ (382.07)	$ (1,363.93)
	North Carolina	$ 498.49	$ 538.05	$ 571.57	$ 646.02	$ (73.08)	$ (107.97)
	Ohio	$ 547.30	$ 602.31	$ 1,341.76	$ 1,398.12	$ (794.46)	$ (795.80)
	Vermont	$ 168.65	$ 532.84	$ 744.32	$ 915.51	$ (575.67)	$ (382.67)
	Washington	$ 585.58	$ 594.70	$ 617.66	$ 599.04	$ (32.08)	$ (4.34)
	Wisconsin	$ 518.02	$ 606.49	$ 1,719.40	$ 2,254.81	$ (1,201.38)	$ (1,648.33)
		$ 519.06	$ 556.48	$ 847.31	$ 973.75	$ (328.25)	$ (417.27)
Average All U.S. SVHs		$ 523.71	$ 569.52	$ 913.72	$ 1,092.37	$ (390.01)	$ (522.85)

Source: Publicly available Medicare cost report filings

Strategic initiatives considered by SVHs nationwide are mostly focused on adjustments to bed capacity and levels of care provided. In interviews, BerryDunn noted two trends. The first is to decrease bed capacity, which would in turn may increase per patient day reimbursement to the facilities. The second trend noted is to increase bed capacity, modernize facilities to provide more private rooms, and build new small-home, cottage-stye locations. In the comparison group, BerryDunn noted 4 of the 10 states had either just completed or were completing construction of new facilities.

Cost report data and inquiries of industry personnel show several SVHs decreasing or eliminating domiciliary care programs due to insufficient funding. In Maine, assisted living beds remain available to veterans at all six MVH locations, partially due to MaineCare coverage available through the state's PNMI residential care program. Other national SVHs strategic initiatives include implementing behavioral healthcare programs, implementing outpatient rehabilitation programs, exploring in-house pharmacy programs to reduce cost, and adding adult day care programs.

4.0 Demographic Demand Projection

The purpose of this portion of the engagement projected the demand, or need, for MVH beds for both nursing home and residential care components for each of the six MVH locations currently, and for the next two decades.

4.1 Work Performed

MVH and Maine DHHS engaged BerryDunn to develop nursing home and residential bed need demand projections for the MVH. Table 9 describes the approach, assumptions, and methods applied in the projection calculations and deliverables.

Table 9 – Work Performed

Report Area	Approach/Method	Deliverable
Bed need projections for each of the six MVH sites	Development of three forecasting models: a model based on MVH-specific patient days, a model based on source data from a report generated by the VA, and a model based on source data from a report generated by the General Accounting Office (GAO)	Findings include a quantitative analysis of proposed bed need by site Comparison of the projections using three forecasting methodologies Presentation of results at a stakeholder group meeting
Maine and national demand for nursing home beds	Population trends in the United States, Maine, and among Maine veterans Use of sources comparing national nursing home statistics and Maine-specific use of nursing facilities	Current and projected population trends Results comparing U.S. and Maine use rate of nursing homes from 2015 to 2022 Maine-specific use of nursing facilities and occupancy rates from 2015 to 2019

4.2 Methodology

BerryDunn used three different bed need methodologies to check for consistency and accuracy of calculations. The first method used 2022 actual MVH calendar year-to-date data as of July 2022 for each location and type of service (nursing home and residential care), projected to year-end. This information was trended forward to 2030 and 2040 taking into account geographic location and population of veterans age 65+ within each MVH facility's service area.

The second method used information from a survey that GAO conducted, published in 2019, that reported the number of veterans, nationally, who used SVHs, CNHs, and CLCs.

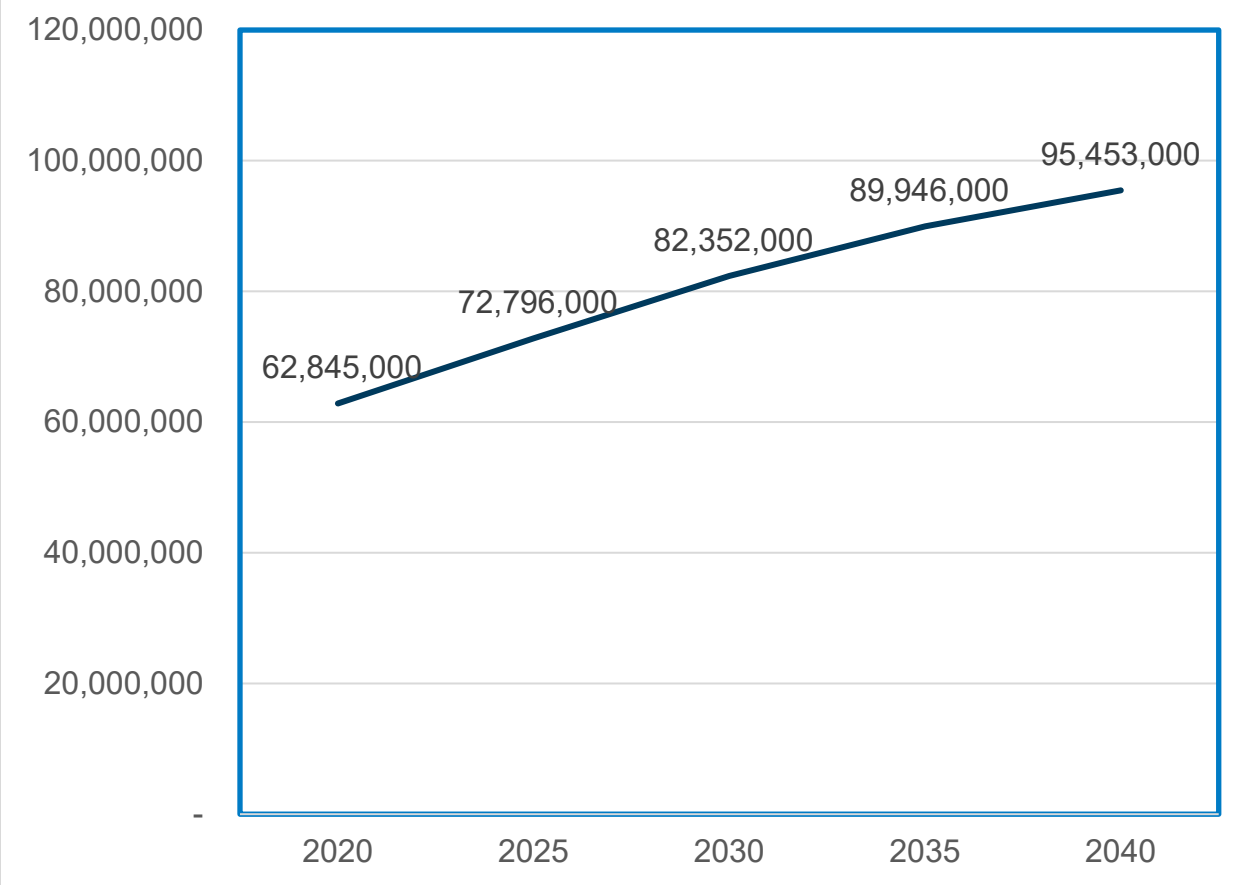
The third method used a VA-issued report first published in 2001 and recently amended, in which the VA authorized the number of nursing home and domicile living beds for each state, based on a rate per 10,000 veterans.

Appendix T provides information sources used for the demand projections.

4.3 National and Maine Population Trends

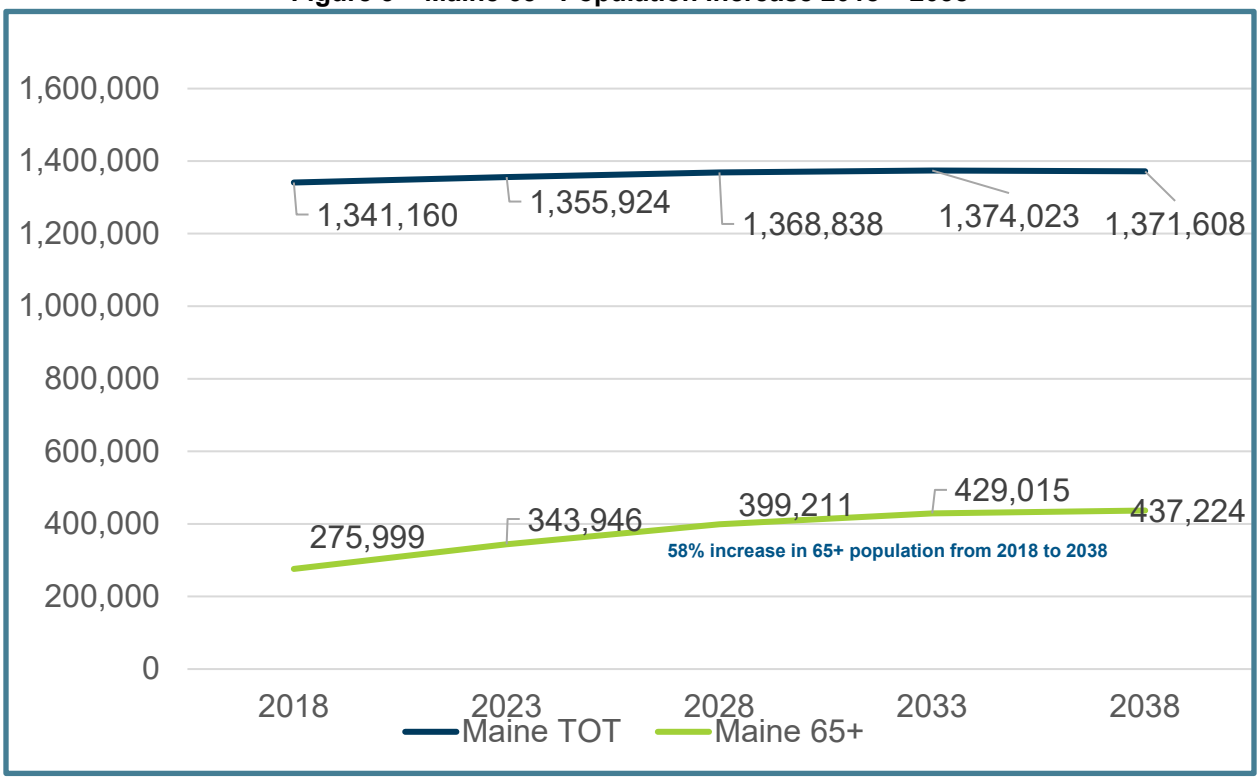
The 65+ population in the United States is expected to increase 51.9% from 2020 to 2040. (Figure 2). In fact, the U.S. Census projects that by 2034, older people will outnumber children for the first time in U.S. history. Within Maine, while the overall population is projected to increase 2.3% from 2018 to 2028, the 65+ population will increase 58.4% during that same period (Figure 3).

Figure 2 – U.S. 65+ Population Increasing from 2020 to 2040



https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

Figure 3 – Maine 65+ Population Increase 2018 – 2038



Sources:
https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inlinefiles/Maine%20Population%20Outlook%20to%202028%20-%20Corrected.pdf

https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/MaineStateCountyPopulationProjections2038.pdf

4.4 Use of Nursing Homes and Nursing Home Beds

Over the past few decades, as residential (assisted living) care, independent living facilities, and similar facilities proliferated for the older population, nursing home use changed. Nursing homes were once considered the sole solution for residents who could no longer live independently; however, individuals have more options today. For example, healthier residents might stay longer in an assisted living facility, might contract for at-home care, or might be part of a continuing care community that offers a full continuum of services from independent living to skilled nursing care.

In addition, reimbursement changes have forced hospitals to discharge patients sooner (or risk nonpayment) to less acute settings for short-term rehabilitation to recover until it is safe to return home. The reimbursement for short-term rehabilitation, which generally lasts 30 to 45 days (but can last longer under Medicare and private insurance with varying payment schedules), is favorable to the daily Medicaid rate for a nursing home bed. Thus, nursing homes might serve a different mix of patients from what the facilities served in the past. At MVH, the nursing home facilities are used both for those who need long-term care (ongoing assistance in daily living and management) and for patients receiving short-term rehabilitation.

The United States has seen a decreasing trend in nursing home use in most years (from 2015 to 2019), with a larger decrease in occupancy from 2020 to 2021, presumably driven by impacts from the COVID-19 pandemic. In 2022, there was a slight increase in nursing home use, but it was still far below the pre-pandemic use rate (see Table 10).

Table 10 – U.S. and Maine Use of Medicare-Certified Nursing Homes, 2015 – 2022
(Based on number of nursing facility users, total U.S. and Maine population)

Year	U.S. Nursing Home Rate	Maine Nursing Home Rate
2015	.427%	.467%
2016	.418%	.461%
2017	.413%	.451%
2018	.400%	.435%
2019	.405%	.438%

Sources: Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018, last census by July 1, 2020 and population statistics for Maine taken from: https://www.populationu.com/us/maine-population, taken from U.S. Census
https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/

Based on data from the Kaiser Family Foundation (KFF), in 2015, Maine exceeded the U.S. number of residents in nursing facilities by 10% and by 8% in 2019. The KFF data does not include residential care use. Although Maine exceeds the U.S. average number of residents in nursing facilities, numerous other states rank higher in nursing facility residents per 1,000, ages 75+. Based on the American Association of Retired Persons (AARP) Public Policy Institute's 2018 report, "Across the States," the highest nursing home use per 1,000, ages 75+ (based on 2016 data) is found in the states of North Dakota, Iowa, Rhode Island, South Dakota, and Louisiana. In this same report, Maine and New Hampshire rank sixth for nursing facility occupancy rate, trailing the District of Columbia (first place); South Dakota (second place); New York, North Dakota, and Rhode Island (tied in ranking for third).

Table 11 illustrates the downward trend of Mainers use of nursing homes from 2015 to 2019. This table also shows the number of available Maine nursing facility beds and residential care facility beds and their respective occupancy during the same period. While the number of beds in both types of facilities increased or decreased based on demand, the percent occupancy remained fairly constant: near or slightly under 90% for nursing homes and in the low 90% range for residential care.

Table 11 – Mainers' Use of In-State Residential Care Facilities, 2015 – 2022

Year	Using Nursing Homes*	% of Population	Number of Nursing Facility Beds in Maine**	% Nursing Home Occupancy in Maine **	Number of Residential Care Facility Beds in Maine**	% Residential Care Occupancy in Maine **
2015	6,208	.467%	8,746	90.53%	4,209	94.42%
2016	6,136	.461%	8,706	89.78%	4,287	93.11%
2017	6,023	.451%	8,599	88.36%	4,429	90.60%
2018	5,827	.435%	8,580	88.10%	4,643	92.58%
2019	5,874	.438%	8,207	89.55%	4,461	92.20%

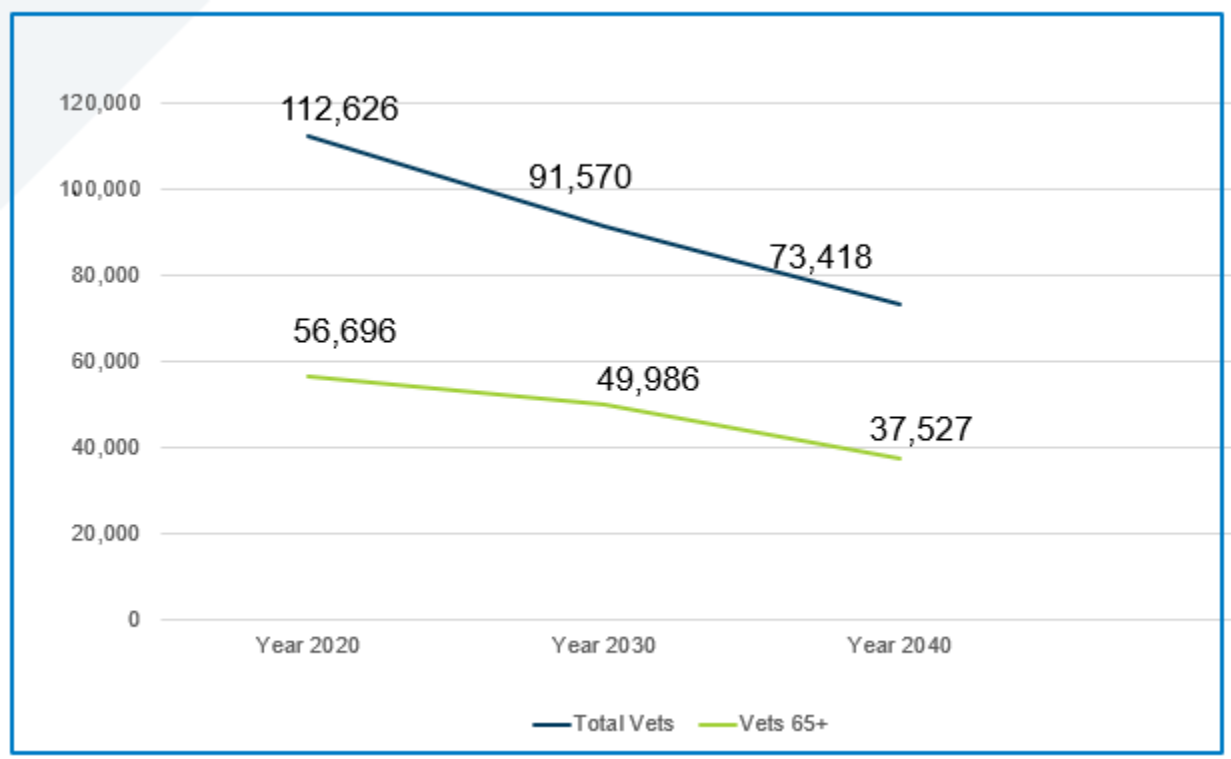
Sources: * Kaiser Family Foundation, Total Number of Residents in Certified Nursing Facilities, and ** BerryDunn database of Maine cost report data

4.5 Maine Veteran Population Trends

The blue line in Figure 4 shows the total number of Maine veterans in 2020, 2030, and 2040, as reported and projected by the VANCVAS. The green line represents the number of Maine veterans age 65+. Overall, there is a 35% projected decrease in the number of veterans in Maine from 2020 to 2040 and a 34% decrease of Maine veterans age 65+, exclusive of projected changes to in-migration assumptions

By decade, the number of Maine veterans is projected to decrease 19% from 2020 to 2030 and 20% from 2030 to 2040. Among the 65+ veteran population, a decline of 11.8% is projected from 2020 to 2030 and 25% from 2030 to 2040. In 2020, the 65+ population represented 50% of all veterans in Maine. In 2030, the 65+ veterans are projected to represent 55% of all veterans and in 2040, 51% (Figure 4).

Figure 4 – Maine Veterans Population 2020 – 2040



Source: https://www.va.gov/vetdata/veteran_population.asp

4.6 MVH Projected Bed Demand

As noted earlier, BerryDunn developed projections for MVH nursing home and residential bed need in three ways:

1. Using data from MVH patient days projected for each of MVH's sites
2. Using data from the GAO-generated report for SVHs use based on a 2018 survey
3. Using data from a VA report of veterans/10,000 authorized for nursing home and assisted living (domiciliary) beds in each state

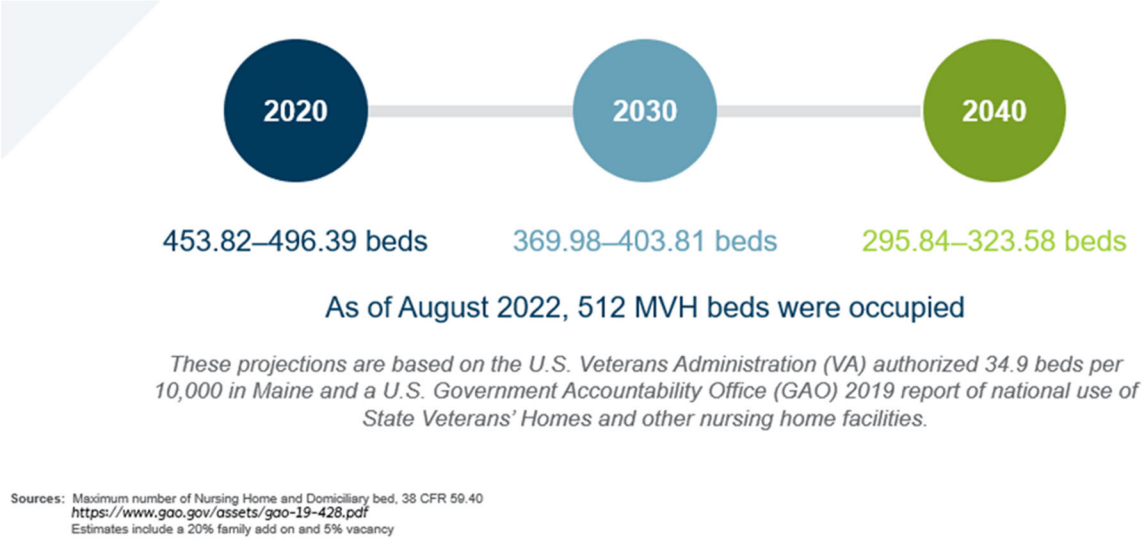
Each of the three methodologies is discussed in greater detail below.

4.7 Bed Need Projections Using GAO and VA Data

Figure 5 shows the range of beds calculated using GAO and VA data. The GAO selected six sites throughout the United States for a project to assess the quality of VA-affiliated nursing home care. The selection of the sites was based on specific criteria and projected veterans' use of SVHs, the use rate by veterans of community nursing facilities, and veterans' use of CLC. The GAO reported that, nationally, 49% of the veterans at the time the study was conducted were receiving care in SVHs, 28% in CNHs, and 23% in CLCs.

The VA projected that the number of VA-authorized nursing home and domiciliary (assisted living or residential care) beds in Maine is 34.9 beds per 10,000 veterans. These figures were used to calculate MVH bed demand. The first number in Figure 5, for each decade, is the GAO number based on 50% Maine veterans receiving care in SVHs; the second number is the VA estimate based on 34.9 per 10,000 veterans in Maine.

Figure 5 – Total Nursing Home and Residential Care Beds (based on GAO and VA statistics)



Comparing the GAO and VA projections to the actual observed occupancy at MVH in August 2022 shows that the GAO and VA projections have already been exceeded. As of that date, 512 beds were occupied.

4.8 Residential Bed Use and Other Factors Applied to Projections

Use of residential care or assisted living facilities in the United States is estimated to be 2% of the 65+ population (National Library of Medicine). An important caveat is that while there is data on use of assisted living facilities nationally, more robust data specific to Maine could not be found in the literature at the time BerryDunn conducted this study. Because the GAO projections did not include residential assisted living use, the 2% national residential care use rate was applied to that calculation. The VA and MVH patient day projections included this population. In addition, a 20% family inclusion and a vacancy factor (to allow for the turnover of beds) was applied to all projections. The numbers presented in Figure 5 and Table 12 reflect the result of adding these factors.

4.9 Bed Need Projections Using MVH Patient Days

The final projection method is the MVH patient day projection. MVH management provided patient ZIP Codes for each of the six MVH sites. Service areas were defined based on the patient origin of the residents at each location. The July 2022 nursing home and assisted living bed patient days were projected to calendar year-end by site and service. A 9% increase was applied to 2030 as the VA projected a substantial demand increase from 2019 to 2029

(projected prior to the pandemic in the VISN01 Far North Market report). In addition, a 20% family factor and 5% vacancy rate for the nursing home beds and 2% for the assisted living beds was applied.

The projection for each MVH site was weighted by the increase/decrease in the number of 65+ veterans expected in each service area from 2020 to 2030 and from 2030 to 2040. This formed the basis for the bed projections for each site as shown on the following pages. Further explanation of the service areas and population changes can be found in Appendix R.

4.10 Maine Veteran Population Bed Demand Comparisons

Table 12 compares the VA and GAO national statistics presented in Figure 5 to the actual observed patient day use of MVH in 2022 and projected to 2030 and 2040. This table shows the difference between the projections based on the VA and GAO statistics and the MVH patient day projections, by decade.

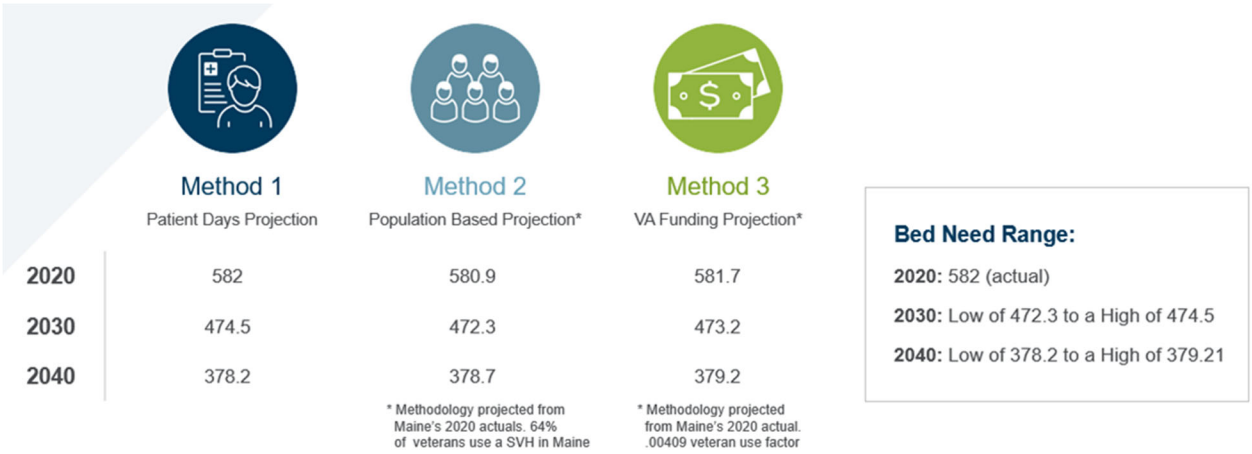
Table 12 – Projected Total MVH Bed Demand and Comparison Between National and Maine Projections

	2020	2030	2040
National Veteran Stats*	454–496	370–404	296–324
Maine Veteran Projections**	582	472–475	378–379
Difference	86–128 beds	71–105 beds	55–83 beds

Sources: *Maximum number of Nursing Home and Domiciliary bed, 38 CFR 59.40
https://www.gao.gov/products/gao-19-428
The sources did not include 20% family and vacancy factor; were added
** Maine estimates for 2030 and 2040 based off 2020 actual use.

Calculating a use rate using VA and GAO data underestimated the Maine veterans 65+ actual use of MVH as of 2020. Since the actual use of MVH in 2020 was known, the VA and GAO statistics were adjusted to reflect Maine's actual 2020 experience. When standardizing the 2020 bed demand rate across all three methodologies, the revised GAO SVHs use rate in Maine increased from the national figure of 50% of veterans using any SVH to a Maine-specific rate of 64%. The veterans/10,000 in Maine increased from 34.9/10,000 to 40.9/10,000. When the data was recalculated, the results, by decade, aligned as can be seen in Figure 6 below.

Figure 6 – Projected MVH Bed Need Using Three Different Methodologies Provided Similar Results



4.11 Bed Projections

Table 13 presents the bed demand from 2020 actuals, projected to 2030 and 2040. The patient days method was used, based on actual MVH 2022 bed use, and forecasted for both nursing home and residential assisted living beds. Table 14 goes one step further and provides the nursing home and residential bed demand by the six MVH sites for 2022, projected for 2030 and 2040 within each service area.

Table 13 – Total Projected Need for MVH Beds by Type and Year

	2020	2030	2040
Nursing Home (Skilled and Long-term Care)	**410**	**334**	**266**
Residential Care (Domiciliary Care or Assisted Living)	**171**	**140**	**112**
Total	**582**	**475**	**378**

Notes: At 95% occupancy for NH beds and 98% occupancy for residential beds
Currently MVH has 628 beds: 450 nursing home and 178 residential
Based on "patient days" (Method 1) methodology

Table 14 – Projected Bed Demand by MVH Site in 2020*, 2030, and 2040
(By Location, Year, and Bed Type)

Location	Skilled and long-term care (NH)			Residential care/assisted living (Res)		
	2020	2020–2030	2030–2040	2020	2020–2030	2030–2040
Augusta	103.20	81.98 (-21%)	61.98 (-24%)	29.10	26.47 (-9%)	20.01 (-24%)
	40% decline in NH and 31% decline in Res from 2020 to 2040					
Bangor	108.00	86.53 (-20%)	64.72 (-25%)	29.00	27.00 (-7%)	20.65 (-24%)
	40% decline in NH and 29% decline in Res from 2020 to 2040					
Caribou	35.70	31.61 (-11%)	26.90 (-15%)	28.20	21.44 (-24%)	18.25 (-15%)
	25% decline in NH and 35% decline in Res from 2020 to 2040					
Machias	N/A	N/A	N/A	29.40	21.54 (-27%)	16.35 (-24%)
	44% in Res from 2020 to 2040					
Scarborough	106.90	90.74 (-15%)	69.33 (-24%)	29.20	26.70 (-9%)	20.40 (-24%)
	35% decline in NH and 30% decline in Res from 2020 to 2040					
South Paris	56.36	43.40 (-23%)	42.87 (-1%)	26.45	17.12 (-35%)	16.76 (-2%)
	24% decline in NH and 37% decline in Res from 2020 to 2040					

2020 census numbers are actual annual bed use census at the MVH sites.

Table 14 presents the projections by site and the corresponding decline expected from the decade prior. This does not mean that individual veterans' *need* for services will decrease; the decrease is more likely a function of the *total decrease in number* of veterans in Maine, by service area, who are 65 years and older. Indeed, the percentage of veterans 65+ will increase in 2030 although the corresponding population 65+ will decrease. In addition, the declines within each decade may not be linear; in other words, MVH might experience an increase over the next several years as MVH recovers from the pandemic before a decline occurs.

An overall 18% decline in total bed demand is expected from 2020 to 2030, and a 20% decrease in bed demand is expected from 2030 to 2040, primarily due to the declining number of veterans in Maine during those periods.

Table 15 – Total Projected MVH Bed Need (By Type and Year)

	2020	2030	2040
Nursing Home (Skilled and Long-term Care)	410	334	266
Residential Care (Domiciliary Care or Assisted Living)	171	140	112
Total	**582**	**475**	**378**

Notes: At 95% occupancy for NH beds and 98% occupancy for Residential beds
Currently MVH has 628 beds: 450 NH and 178 Residential
Based on "patient days" (Method 1) methodology

4.12 Findings

Findings noted during the demand projection are as follows:

1. Based on actual KFF projections, up until the pandemic years, the number of Mainers (including veterans) using nursing facilities exceeded the U.S. average. This might be due to a variety of reasons, including:
    1. Average age of the Maine population, which is oldest in the nation with a median age of 45.1 years
    2. Large geographic rural footprint in the state, making it more difficult to access certain types of services and care
    3. Dispersion of family units within and outside the state, requiring care provided by non-family members
    4. Choice of living options after an individual can no longer live independently, which may be more limited due to the rural nature and size of the state
2. During the pandemic, use of nursing home beds in Maine decreased.
3. The GAO and VA statistics underestimated the use of MVH by Maine veterans and their families.
4. Comparing demand statistics from different geographic areas is difficult for several reasons, including:
    1. MVH might have more flexible admission criteria for use of its facilities than the national VA system
    2. There might be state-to-state variation in SVHs admissions criteria
    3. MVH allows certain eligible veteran family members admission to the facilities, up to 20% – 25% of its bed availability

4. The MVH skilled nursing units also service short-term rehab patients, an important segment of its resident population

5. MVH has experienced an occupancy increase from a low in 2021.

6. Veterans like to be around other veterans and enjoy the camaraderie.

7. Veterans view access to MVH facilities as an entitlement.

8. MVH offers high-quality care, according to the CMS' Nursing Home Compare website. All five MVH sites that provide nursing home services received a five-star (highest) rating.

9. This analysis estimates an overall 18% drop in MVH total bed demand from 2020 to 2030 and 20% from 2030 to 2040 based on the population of Maine veterans 65 years and older. The decline might not be linear; a right-sizing post-pandemic upswing could occur.

10. The population of Maine veterans 65 years and older is decreasing and is expected to decrease 34% from 2020 to 2040, and the number of all Maine veterans is expected to decrease 35%.

5.0 Workforce Analysis

This section provides information about how BerryDunn conducted work, actions taken, people involved, and information sources used to complete the workforce analysis.

5.1 Work Performed

The following work was performed by BerryDunn for the workforce analysis.

1. **Data Gathering** – BerryDunn compiled comparative workforce data from CMS Payroll Based Journal (PBJ) reporting, U.S. Bureau of Labor Statistics, Maine Department of Labor's Center for Workforce Research and Information, other SVHs, and cost-reporting data. BerryDunn compiled a summary of current Maine-based initiatives focused on improving access to healthcare workers, in particular workers needed in nursing homes and assisted living facilities.

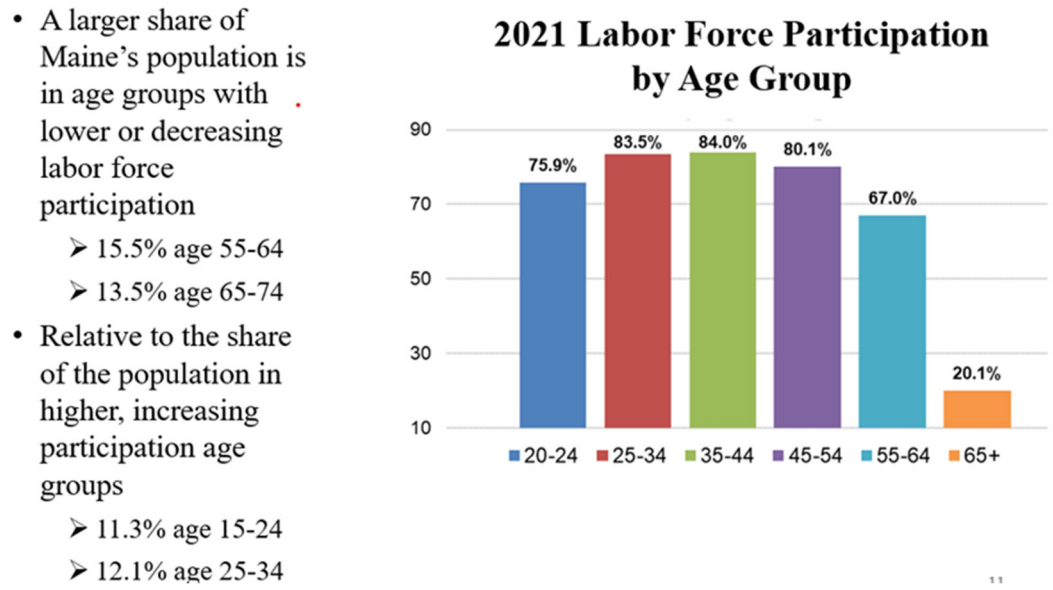
2. **Analysis** – BerryDunn compared workforce data gathered from external sources to current operations at MVH, such as direct care hours per patient day, staffing as a percent of total expenditures, and direct care staffing mix. In addition, BerryDunn conducted interviews and accumulated and examined the workforce data in conjunction with the demand projections and current workforce initiatives underway, to identify potential skill gaps between current and future workforce needs. The firm will present qualitative data regarding the impact current initiatives may have on the dynamic workforce environment.

3. **Summarization of Findings** – BerryDunn summarized the analysis for use by the stakeholder group. The firm presented this at the October stakeholder group meeting, answered questions and clarified points.

5.2 Analysis and Findings

In October 2020, the Maine Department of Labor's Center for Workforce Research and Information reported Maine workforce is projected to shrink by approximately 16,000 from 2020 to 2028 due to the number of Mainers reaching retirement age outpacing the number of young Mainers entering the workforce. As reported by Maine's Cabinet on Aging, a larger share of Maine's population is in age groups with lower or decreasing labor force participation; 29% of Maine's population is 55 – 74 years of age, while 23.4% is 15 – 34 years of age.

Figure 7 – Maine Demographics

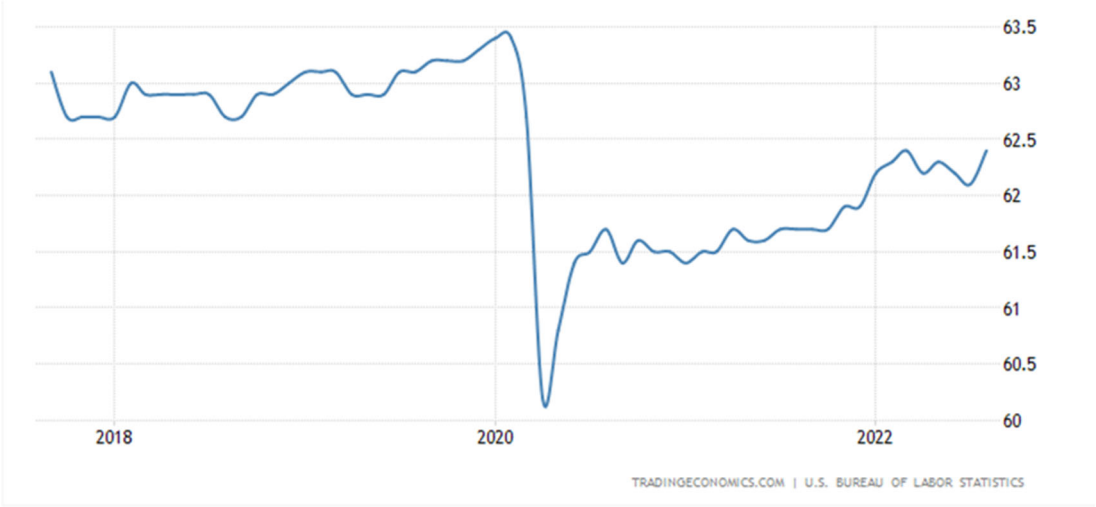


Source: Maine's Cabinet on Aging – July 28, 2022, meeting

The pandemic accelerated the expected shrinking labor force. The Portland Press Herald reported in its September 10, 2022, article "Not Working," a series on Maine's labor force crisis, "state economists estimate two-thirds of the 20,000 or so workers who have dropped out of the labor force since March 2020 were early retirees." The article reports that according to a Maine Department of Labor analysis, the number of people out of the labor force due to retirement rose from approximately 237,000 in 2019 to 267,000 in 2021.

The same trend can be seen at the national level. Prior to the pandemic, the labor force participation rate in the United States was at 63.5%. While the participation has rebounded somewhat in 2022, the percent was at 62.4% as of August 2022.

Figure 8 – National Labor Force Participation



What does this mean for SVHs, including MVH? A shortage of both clinical and non-clinical workers exists, resulting in fewer staff and higher wages.

Nationally, the U.S. Bureau of Labor Statistics reports nursing and residential care facility employment declined 5% from 2019 to 2020, and 5.7% from 2020 to 2021. Competition for workers resulted in noticeable wage increases—10.4% in 2020, and 5.6% in 2021. The first quarter of 2022 reveals a continuing reduction of employment coupled with continuing wage increases in the industry. The first quarter of 2022 showed an 11.4% increase in average weekly wage for nursing and residential care facilities over that same period in 2021. (The full report is included in Appendix M.)

According to the Maine Department of Labor's Center for Workforce Research and Information "Job Trends in Nursing and Residential Care – May 19, 2022", among the reduction in jobs that has occurred in healthcare and social assistance relative to 2019 levels as compared to 2021, about two out of three of the net reduction in jobs has happened in nursing and residential care facilities—about 1,725 employees lower compared to the 2019 average. The report notes that employers providing direct care services are struggling to meet their current staffing needs because of low compensation, a challenging work environment, high rates of turnover in direct care jobs, and health risks arising during the pandemic associated with these jobs.

Per BerryDunn's interview with Mark McInerney, director of Maine Department of Labor's Center for Workforce Research and Information, the current labor market is extremely competitive, with a 2.8% unemployment rate, making it harder for organizations to recruit and retain qualified staff. Out-of-state travel nursing agencies' total jobs (that include nursing occupations) averaged about 2,100 – 2,300 in 2018 through 2020 and increased to about 3,750 by the fourth quarter of 2021. The summary below also demonstrates a sharp increase in wages for agency (travel) nursing positions, specifically in Maine.

Figure 9 – Jobs and Wages – Travel Nursing Agencies

Source: Maine Center for Workforce Research and Information (CWRI) Job Trends in Nursing and Residential Care - May 19, 2022

5.3 Maine Workforce Initiatives

Many states, including Maine, are facilitating labor-related programs aimed at increasing and stabilizing the direct care labor pool, as well as considering waivers related to direct care staff certification and delegation of duties requirements.

In Maine, current workforce initiatives include:

1. The new website, CaringForMe.org, and a related social media campaign are designed to attract more workers to direct care professions in Maine. The website includes information on career pathways, training opportunities, job openings, testimonials, and events.

2. The Maine Workforce Development Compact is comprised of Maine businesses, associations, nonprofits, and municipalities that are committed to working together to solve Maine's workforce challenges. The Harold Alfond Center for the Advancement of Maine's Workforce has access to $60 million in grant funding. Planning to serve 24,000 Mainers with short-term training by 2025, the center provides financial support of up to $1,200 per frontline worker through December 2022, and a $1,200 match is available in 2023, 2024, and 2025. Maine community colleges experienced a greater number of applicants into the Licensed Practical Nurse program than expected and a greater number than the available spots.

DHHS, in partnership with the Department of Labor, created several healthcare-specific workforce initiatives; the overarching goal of the initiatives is to strengthen and grow Maine's healthcare workforce to help ensure a resilient and robust system of care across the state. The initiatives include a focus on training for frontline workers; creating pathways for advancement; helping to ensure staffing support at career centers; designing and implementing a multimedia campaign that promotes direct care worker jobs; and examining and expanding curriculum development.

Due to various initiatives in early phases of implementation, no data is available yet to forecast their impact on labor market or occupational projections.

5.4 Impact of Workforce Shortage on SVHs

Historically, many SVHs have generally been known for high quality care, which indirectly impacts workplace satisfaction. SVHs reported lower turnover, more favorable wages, and more generous care hours per patient day, frequently exceeding state minimum standards. Since the COVID-19 public health emergency, SVHs have reported new or increasing staffing shortages, an increased demand for higher wages to retain staff, and rapidly increasing nursing contract agency rates. Even at premium rates, the demand for nursing positions is so great that SVHs report needing to utilize various contract agencies to fill open positions.

Unlike many privately owned for-profit peers that outsource laundry, housekeeping, facilities maintenance, and dietary services, SVHs normally hire their own staff for all care and support

positions. With the staffing shortages affecting all departments and positions, SVHs report struggling to fill both clinical and non-clinical positions at record volumes.

The increased cost of labor is one of the major per diem cost-increase drivers for SVHs. Many rely on state Departments of Labor and Health and Human Services to provide relief through innovative programs tasked to increase worker supply and address shortages, such as retraining, licensing waivers, minimum staffing waivers, and other programs. The job outlook could not be forecasted with the effects of the new initiatives, as there is no data yet available on effectiveness of these programs.

BerryDunn's interviews with SVHs and other long-term care facilities revealed that a number of facilities had to suspend admissions due to limited or inadequate staffing levels. Due to the nature of services, mostly short-stay rehabilitation unit admissions are suspended. For the majority of facilities, short-stay revenue sources (such as Medicare) are more favorable and normally more profitable than revenue generated from long-term stays. The decrease in census drives the per diem costs up, and the loss of short-stay revenue continues to negatively impact the bottom line. Additionally, with a reduction of short-stay rehabilitation volume, some highly trained employees of the facilities (such as therapists, clinical directors, dieticians, and others) may be less utilized and potentially harder to retain.

COVID-19-related staff burnout, childcare or school schedule disruptions, infection control requirements, such as mandatory masking or vaccinations, and other factors resulted in a rapid reduction of clinical staff available for work. Additional factors, such as migration of clinical staff from facility-based employment to temporary contract agencies, may have also contributed to the reduction of workforce in clinical occupations. For example, in Vermont a single facility with 130 nursing beds and 8 domiciliary beds currently has 63 staff vacancies, of which 52 are clinical positions. Idaho's Boise location with 122 nursing beds and 36 domiciliary beds reported 30 CNA vacancies and 10 RN/LPN vacancies, which has prohibited new admissions.

5.5 Comparative SVHs Workforce Initiatives to Address Workforce Shortages

MVH is neither state owned or operated. However, a general theme seen across states whose SVHs are owned and operated by state governments was the challenge of being constrained by state government protocols to adjust to staffing needs dynamically and timely. Such facilities are not able to adjust pay scales or hire staff in an expeditious manner due to the need to follow state protocols and adhere to state pay scales. Despite the challenges, some initiatives in other comparative states are:

1. Kentucky – Raised caps on nurse training programs, making it easier to employ foreign nurses; implemented a reimbursement system for educational costs for clinical positions; and offered personal service contracts for nurses, which provide a higher wage with no benefits.
2. Idaho – Increased pay for critical staffing classifications (RN/LPN/CNA) by over 25%; and offered recruitment and retention bonuses, training, and tuition assistance.

3. Montana – Managed facilities have hired a marketing company to market for staffing.

5.6 Comparative Benchmarking

The pandemic contributed to the widening of the care cost shortfall, by decreasing the workforce pool through voluntary resignations and a demand for higher wages in addition to utility and supply cost increases. Additionally, contract nursing labor costs continues to increase nationwide.

Table 16 – SVHs Average Direct Care Labor Cost as Percent of Total Cost and Direct Care Cost per Patient Day

Nursing Facilities Group	State	Direct Care Labor Cost as Percent of Total Facility Cost		Direct Care Labor Cost per Patient Day	
		2020	2021	2020	2021
Maine					
	MVH	29.2%	29.1%	$ 108.90	$ 136.21
Comparison Group					
	Colorado	42.1%	43.0%	$ 141.21	$ 183.60
	Idaho	25.1%	27.1%	$ 93.57	$ 138.07
	Kansas	41.0%	42.8%	$ 176.42	$ 207.89
	Kentucky	18.6%	14.4%	$ 98.07	$ 93.61
	New York	36.8%	28.4%	$ 204.75	$ 262.62
	North Carolina	20.4%	19.3%	$ 129.74	$ 143.32
	Ohio	46.9%	45.3%	$ 166.47	$ 226.64
	Vermont	50.6%	47.8%	$ 283.94	$ 374.32
	Washington	53.9%	62.9%	$ 193.55	$ 273.88
	Wisconsin	29.3%	31.5%	$ 110.67	$ 139.36
		35.0%	33.7%	$ 153.09	$ 186.71
Average All U.S. SVHs		**34.7%**	**33.7%**	**$ 137.91**	**$ 171.71**

Source: HCRIS As Filed Medicare Cost Reports, 2020 – 2021

From 2020 to 2021, MVH average direct care costs increased by $27.31 per patient day.

Table 17 – Average Nursing Contract Labor Hours Per Resident Day, Utilization, and Cost, 2020 – 2021

Nursing Facilities Group	State	Average Contract Hours PPD		Contract Hours as Percent of Total Direct Care		Average Contract Agency Cost	
		2020	2021	2020	2021	2020	2021
Maine (per as filed MaineCare cost reports)							
	MVH	0.26	0.41	6.01%	8.38%	$ 520,521	$ 698,181
Comparison Group (per as filed Medicare cost reports)							
	Colorado	0.08	0.05	1.19%	0.34%	$ 95,804	$ 124,432
	Idaho	0.61	0.31	4.49%	5.41%	$ 762,959	$ 395,161
	Kansas	1.36	2.02	24.50%	33.40%	$ 1,104,853	$ 1,801,518
	New York	0.25	2.16	2.53%	4.13%	$ 475,323	$ 632,585
	Ohio	N/A	0.02	0.00%	0.15%	N/A	$ 23,460
	Vermont	0.74	1.39	12.38%	21.04%	$ 1,841,983	$ 2,968,484
	Washington	0.32	0.33	3.93%	5.29%	$ 414,274	$ 484,177
	Wisconsin	N/A	1.08	0.00%	6.77%	N/A	$ 1,411,403
		0.46	**1.07**	**3.49%**	**5.23%**	**$ 597,758**	**$ 831,198**
Average All U.S. SVHs		**0.56**	**0.82**	**3.68%**	**5.97%**	**$ 701,261**	**$ 770,463**

Table 18 – Case-Mix Adjusted Direct Care Hours per Patient/Resident Day, Nursing Facilities, Quarter 1, 2022

Nursing Facilities Group	State	Nurse Aide	LPN	RN	Total Direct Care
Maine					
	MVH	2.19	0.68	0.30	3.17
Comparison Group					
	Colorado	1.94	0.65	0.31	2.89
	Idaho	1.92	0.67	0.30	2.89
	Kansas	1.93	0.66	0.31	2.90
	Kentucky	2.04	0.66	0.30	3.00
	New York	2.12	0.69	0.33	3.13
	North Carolina	2.03	0.65	0.30	2.98
	Ohio	1.94	0.64	0.27	2.84
	Vermont	2.00	0.62	0.29	2.91
	Washington	1.98	0.66	0.29	2.94
	Wisconsin	1.85	0.67	0.30	2.82
		1.97	0.66	0.30	2.94
Average All U.S. SVHs		**1.95**	**0.65**	**0.30**	**2.90**

Source: CMS SNF Provider Information, May 2022

The case-mix adjusted direct care hours per resident day was obtained through the Payroll Based Journal reporting. The data is reported directly by the facilities, which may cause some variations in reporting. BerryDunn understands the low numbers in North Carolina are the result of an inability to report certain data. Based on the PBJ reporting, MVH has higher case-mix adjusted direct care hours for nurse aides than that of other states in the comparative data. LPN and RN positions are in line with the comparative state data.

Workforce shortages, which are contributing to higher labor costs, are stressing the financial operations of SVHs across the nation. SVHs are finding it increasingly difficult to support this increasing cost of operations from the revenues received from residents.

6.0 Focus Groups

This section presents the summarization of the results from the Caribou, Machias, and South Paris focus group sessions.

6.1 Work Performed

In order to conduct the focus group sessions in Caribou, Machias, and South Paris, BerryDunn assembled a planning team comprised of the following people:

1. BerryDunn – Dan Vogt, Tammy Brunetti, Jon Findlay
2. State of Maine – Commissioner Lambrew, Joe Marro
3. MVH – Kelley Kash, Rebecca Gagnon, Kevin Brooks

The group planned the focus groups for all three locations, including the desired breakout groups, duration of the focus groups, times of day, location, and the questions that would be asked of participants. This planning occurred during August and September. The State of Maine and MVH collaborated on the invitations for participation in the focus groups.

The focus groups were organized in the following way:

- Residents and family members[2]
- MVH staff and other community providers
- Civic and community leaders

The first two focus groups at each location were conducted without a Zoom link for public viewing. The third sessions with civic and community leaders were broadcast over Zoom for public viewing and recorded. Each group was provided a short background on MVH and on LD 2001 at the start of the session. Then each group was led through a series of questions used to facilitate discussion. The questions can be found in Appendix W of this report.

The sessions occurred on the following days:

1. Caribou on October 5, 2022
2. Machias on October 6, 2022
3. South Paris on October 20, 2022

In addition to participation in the discussion during the focus groups, participants were provided a paper feedback form that asked them to provide input into the attributes of healthcare in a

[2] With the exception of Machias, which was only family members, due to the focus on memory care in Machias and the inability for Machias residents to fully participate in a focus group session.

rank order exercise and a comment box to share information that did not come up in conversation. An example of this form can be found in Appendix X of this report.

Lastly, an electronic survey was available for public comment until November 28, 2022. Screenshots of this survey can be found in Appendix Y of this report.

6.2 Focus Group Summary of Feedback

This section summarizes the feedback received from the focus groups. BerryDunn organized this information by community and focus group. The following focus group sections are presented in the order in which they were facilitated and there are nine focus group sessions. This is followed by summarization of the comments received through the public comment survey.

Below are 20 themes identified from the focus group sessions.

1. The veterans' homes provide a place that supports the camaraderie and unique shared experiences of veterans.
2. There are few or no nursing home alternatives to MVH in the region or community.
3. The lack of transportation services is a barrier to aging at home.
4. MVH staff are proud of the work they do and value giving back to those who have served.
5. MVH has a high reputation and is a valued member of the community.
6. Residents benefit from being able to age in one facility that provides multiple levels of care to support them.
7. The services MVH provides keeps residents mentally and socially engaged and promotes a rich quality of life.
8. MVH's location in the community allows residents to maintain longstanding relationships with local healthcare providers.
9. Having family members living nearby MVH is important for visitation and enables family members to be part of the whole care team.
10. Family members value being engaged with MVH staff and part of the resident care team and having a voice in the MVH community.
11. Having to travel far for healthcare services and to visit resident family members is costly, takes time, and would reduce visit frequency.
12. MVH residents benefit from facilities being nearby to hospitals and other local community providers.
13. MVH is a safe place for veterans to age in the communities that are familiar to them.

14. The cleanliness and quality of the MVH facilities is better than that of other nursing facilities.
15. The housing stock in the community is not suited to the needs of the elderly and makes aging at home a challenge.
16. In-home support and care services are lacking in the community.
17. Veterans need guidance and advice regarding the benefits and services available to them.
18. Rural communities face a lack of bed availability for nursing home care.
19. The local workforce is small and an increase in competition for labor challenges employee recruitment and retention.
20. Finding people who are attracted to and committed to work and live in rural Maine communities is difficult.

6.3 Caribou Focus Group

Below is a summary of the feedback received from the focus groups held in Caribou on October 5, 2022. The feedback is organized into the three focus groups and the feedback forms. The information is presented in the way BerryDunn heard it shared. By design, the information is not attributed to specific people who shared the comments.

6.3.1 Residents and Family Members

Below is what was shared with BerryDunn during the residents and family members focus group in Caribou:

Question 1 – Why did you seek Maine Veterans' Homes as a care provider? What specifically attracted you to Maine Veterans' Homes?

1. MVH provides the only residential and dementia care in almost all of Aroostook County. No other facilities provide care and services at the level MVH does.
2. Caribou has been home for some residents for decades. Being home and connected to the community is important.
3. The MVH provides a community of veterans who share a personal bond.
4. Some aging and elderly residents are already confused enough. MVH provides care in the community that is familiar and feels safe to them.
5. My family member is the only female veteran remaining at MVH. Knowing that she was a veteran, it is important to us that she receives what has been promised to her as a veteran.
6. My father has been here for several years. The staff are more than just care workers; they are his family.

7. The services and care at MVH are impressive and the facility is clean and well-operated.
8. The MVH facility's close connection to Cary Medical Center allows quick transfer to the hospital and enables the receipt of intensive care in resident rooms at MVH. The number of services offered in one location in Caribou is a benefit.
9. There is not another facility in the area where my parent could have gone, and I do not know where we would have wound up without MVH.
10. The attractiveness of services when considering options at MVH were realized as true once my family member entered the home. MVH delivered on promises.
11. MVH employees respect the residents and veterans for whom they care. They are caring, thoughtful, and residents trust them.
12. People are grateful that family members are cared for nearby in Caribou. Keeping family members close is important for engagement and keeping the whole care team intact.

Question 2 – Describe your experience at Maine Veterans' Homes and with their services.

1. The care and experience at MVH are amazing and beyond what I have seen at other nursing homes. The facilities are clean, staff respect veterans and families, and there is a personal connection.
2. MVH staff listen to family members and go above and beyond to take care of problems or questions.
3. Prior to the pandemic, there was a family council at MVH where family members could provide input and perspective into what happens in the veterans' home.
4. Being able to feel like family members are a part of the veterans' home is a big deal.
5. Residents say that they feel safe at the MVH facility, which is very important to them.
6. MVH is dedicated to going the extra mile, making time and space for special events and anniversaries for veterans.
7. The standard and quality of food service at the MVH facility is good. Meals are important to residents and veterans.

Question 3 – What services could you not find at Maine Veterans' Homes or in the community?

1. Barber and beautician services are needed for residents. MVH has struggled to hire someone to provide these services.
2. MVH is willing to work with Northern Light Health. The van service made available to help with transportation to Presque Isle or for vision or specialty care is valuable.

Question 4 – How do you balance the choice of a local healthcare services versus traveling for healthcare services?

1. When weighing the choice of a nursing home in another area other than Caribou, having our parents cared for locally is very important to us.
2. In our rural area, local specialty services are already limited and are depended on. Traveling to Bangor can be a barrier.
3. The MVH Caribou facility is more than just "70 beds"; rather, it represents and supports "70 families in the community."
4. It is important to appreciate the needs and way of life of the rural communities served by MVH.
5. Wear and tear of traveling, inclement weather, and the cost of gasoline and lodging add up if having to travel far for services. Time is a limiting factor for the frequency of visitation to family members.
6. Dementia residents being placed too far from family is a concern. Aging in a familiar environment with family nearby is important.

Question 5 – What are your thoughts on telehealth services to help support yourself or a family member? Are you currently using telehealth services?

1. During the pandemic, we could not visit residents; however, the MVH staff were wonderful accommodating requests and setting up Zoom visits. It was important to be able to see resident family members.
2. It is a benefit to be able to have telehealth exams and specialist services with an RN in the room present to help set up an exam or visit.
3. Generally, residents and families are comfortable with and benefiting from telehealth services.
4. Families are invited to participate in telehealth conferences and be a part of the whole support team.
5. Family members are an extension of the MVH care team and vice versa.

Question 6 – If you had access to home healthcare and related support services, would your preference be to keep you family member at home?

1. I had a family member staying at home for several years with some in-home services used, but even if there were more services available, it didn't change the need for admission to the MVH.
2. Having had a parent with me for four years until admission to MVH, there was a lack of in-home care while working and caring for my parent.

3. My parent's income grew, and they were no longer eligible for home health or home care services.

Question 7 – Have you or your family member been impacted by the direct care labor market challenge and, if so, how?

1. Due to staffing challenges, sometimes activities and other events cannot be provided. The activities schedule has been inconsistent due to challenges finding someone to provide activities.
2. Currently, due to the pandemic, no volunteering is allowed, which also contributes to what MVH can provide to its veterans and residents.
3. MVH has been unable to find people to provide barber or beautician services.

6.3.2 MVH Staff and Other Community Providers

Below is what was shared with BerryDunn during the MVH staff and other community providers focus group in Caribou:

Question 1 – Do you feel residents of Maine Veterans' Homes value being at Maine Veterans' Homes? If so, why? For Maine Veterans' Homes staff, what benefits do you see residents receiving? For community providers, why do you refer to or collaborate with Maine Veterans' Homes for your patients?

1. MVH staff members observe that residents receive high-quality care and assistance with their daily needs. There is a belief that residents feel valued, and that staff know the residents well and are able to personalize care to each resident.
2. Military personnel are important to our country and sacrifice for our freedoms. There is a need for both urban and rural areas to provide veterans services. It is not reasonable for rural veterans to travel to veterans' homes in Bangor or Augusta or elsewhere.
3. The shared story and past experiences, new acquaintances made, and strong cohort of veterans at MVH is powerful.
4. Our staff's care for veterans reflects our core values of honesty, integrity, respect, teamwork, and leading the way.
5. The quality and beauty of the MVH Caribou facility is valued by staff and residents.
6. The VA and MVH are separate entities, and it was prudent that the Maine legislature saw the need for MVH long-term care services not provided by the VA.
7. The sacrifice and experience of our veterans leaves a long-term impact. Employees need to have an understanding and appreciation of this to adequately provide care. Caring for our veterans is not as easy as caring for non-veterans.
8. The number of healthcare beds in Aroostook County is decreasing. The emergency room is becoming a catch-all when there is not sufficient capacity or alternative care settings.

9. In-home health, there is a need for safe and effective transition of care. Not everyone can stay home, and taking away options and choice hurts people.

10. Visitation for residents is important to them and families, and MVH's Caribou location provides this.

Question 2 – What specific services and benefits are Maine Veterans' Homes residents most benefiting from?

1. Residents benefit from MVH's basic nursing functions and support with activities of daily living.

2. There is value in the ability to transition between levels of care (residential care, memory care) all in one location.

3. Cary Medical Center's presence adjacent to the MVH campus is a benefit to resident care.

4. MVH has a streamlined admissions and placement of care process.

5. Maine has the oldest demographic in the country, and Aroostook County has the oldest demographic in Maine. The aging trend of the population is going to increase demand for MVH services.

Question 3 – What services are not currently offered, but are needed in the community?

1. There are several patients occupying hospital beds who should instead be receiving care in a nursing home. The lack of available nursing home beds crowds out other hospital patient admissions. Removing the MVH facility would increase the bed shortage and introduce risk to the lives of patients served in our community.

2. We have not been above 90% occupancy at the MVH Caribou facility due to staffing shortages. In some cases, staff find easier work and equal or greater pay at non-healthcare employers in the community.

3. CNA compensation is too low. If the system were better funded, the staffing shortage might be less challenging, and more beds could be staffed.

4. Prejudice or ageism against the elderly may be a contributing factor.

5. Across the country, governors and governments can pay less than what it takes to provide quality care while still satisfying regulations and compliance.

6. More adult day care would be a useful service in our community.

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

1. There is limited to no planning or coordination of care for veterans or non-veterans.
2. In the past, a bureau of planning verified that there was adequate service throughout Maine; however, the bureau was abolished, and no one has since been tasked with the responsibility of planning for long-term care services.
3. Hospitals have been required on a regular basis to plan with other community members and providers; however, a veteran representative(s) has historically not been involved.
4. Planning has been relatively siloed in the home health space with limited connection or collaboration with other providers.
5. The VA will offer some home services, but it is disorganized and not provided in coordination with MVH.

Question 5 – What are barriers to aging at home in this community, if any?

1. The lack of available transportation services is a large barrier to aging at home. Winter weather can impact ability to travel and safety.
2. Family support and availability of financial resources can be a barrier to accessing services needed to age at home.
3. Regions and communities with lower populations typically lack the general support services needed to age at home. There is a lack of caregivers who provide at-home and home health services.
4. The structure and layout of the homes in which the elderly are living do not accommodate the shifting needs of individuals as they age.
5. Veterans can be soft spoken and hesitant to voice their concerns or needs regarding services and support.
6. We observe younger veterans and community members dying at a young age with multiple comorbidities. General public health awareness and education on the importance of promoting healthy lifestyles for younger Americans and veterans is important on the impact of health and care needs later in life.

Question 6 – How does geography play into where you refer residents to for services?

1. It is a benefit to have veterans close to their families. This community is where they were born and raised, and family visitation is important to veteran well-being.
2. The financial cost of traveling for care can be a barrier for residents and families.
3. There are more healthcare organizations and services in central and southern Maine; however, we do have great healthcare organizations in Aroostook County and a transfer

to elsewhere in Maine isn't always needed. Maintaining MVH's presence in Caribou in the future is important.

Question 7 – Why did you seek out Maine Veterans' Homes as an employer?

1. I joined MVH to serve and care for our veterans and to support MVH's mission.
2. I have served in the military. Several members of my family have served in the military, and working at MVH is my way of giving back.
3. I was attracted to MVH's CNA program and MVH offered to pay for me to become a CNA.
4. Working at MVH, I am able to give back to the veterans and the people who grew up and live here.
5. Working at MVH is a way for me to contribute and to honor veterans' sacrifice despite not having served in the armed forces myself.

Question 8 – What are the biggest challenges for recruiting and retaining employees?

1. We have a smaller group of staff carrying the weight of what would normally be the burden of a larger care team. Some staff are on the edge of burnout, but they don't say much and keep pushing forward.
2. How can we better sell and market the MVH mission to help drive recruiting and retention?
3. Sometimes, staff are only able to get a few days off and can't fully rest and recover, which wears on them over time. Work/life balance can be a challenge. Sometimes employees leave because they can get similar pay elsewhere with less stress and burnout.
4. The work at MVH is rewarding but can be emotionally draining depending on the day.
5. There is a mismatch between the workforce available and the number of people who need care.
6. Government social programs and benefits have an influence on workforce participation. Individuals weigh the impact of changes in income level and eligibility for benefits.
7. I've observed a shift in work ethic with recent applicants compared to several years ago.
8. It is challenging to compete with non-direct care employers who can offer their employees the flexibility that comes with hybrid or remote work environments.

6.3.3 Civic and Community Leaders

Below is what was shared with BerryDunn during the civic and community leaders focus group in Caribou:

Question 1 – Do you view Maine Veterans' Homes as a valuable member of this community and if so, why?

1. Our elderly and veteran population in Caribou is important, and MVH is an important part of caring for and treasuring them.
2. I applaud MVH for establishing the Caribou facility in the first place. It is a feasible location for residents and families and accommodates frequent visitation, which is so important to residents and families.
3. The individuals for whom MVH cares lived here and were a part of the community and, though no longer living at home, MVH provides a place for them to live and continue to be a member of our community.
4. This veterans' home provides a lot of work opportunities in the community, and its presence and services extend beyond the facility into the broader community.
5. There is strong concern about the potential closure of this facility. It is important that we find a way for the financial needs to be met so that care for residents at this facility can continue.

Question 2 – As members of this community, what long-term support services are veterans and members of the community seeking?

1. MVH is a logical member of the community. We have an active veteran population and organizations including the VA, veterans center, VFW, American Legion, and cemetery.
2. Speaking to many veterans who still live in the community, many retired and come back to this community where they desire to age and spend the rest of their lives.
3. It is important to veterans that they are able to receive care and services from people who specialize in working with veterans.
4. Individuals can transition between residential, skilled, and memory care all at one MVH location without need for transfer to other facilities.
5. People are upset at the idea of having to travel far for care and the barriers to family and resident visitation that distance and travel would create.
6. Veterans served our country, and this is a community of veterans and their spouses. Veteran experience is important, and MVH provides a community for veterans. The care provided at MVH is excellent.
7. Veteran camaraderie at MVH is important, and veterans feel safe talking about their personal experiences.

8. The MVH staff understand and appreciate the veteran life experiences. This is not something I have seen as much in other long-term care facilities.

9. A lot of services are available of which veterans might not be aware. There is a need for a central, one-stop shop where veterans can receive guidance regarding the services and resources available to them.

10. The neighboring presence of Cary Medical Center and its wide range of services on campus is a benefit to the MVH facility and veterans.

Question 3 – What services are not offered and are needed in the community?

1. Public transportation is a challenge for veterans and the elderly, given the rural nature and the size of Aroostook County. This includes transportation for housing, to the hospital, or for errands.

2. Veterans who live at home do not have access to transportation and feel isolated.

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

1. Regionally, issues are discussed informally between various parties, but problem solving is difficult.

2. There is a desire to collaborate and help the elderly and veterans remain in our community.

3. There is competition in the healthcare field, such as for staffing and patients, which can be a barrier to regional planning.

4. I do not see healthcare organizations in the region working together to plan for veteran care coordination.

5. Funding mechanisms influence what each entity chooses to focus on.

6. When speaking to veterans' groups, I hear passionate concerns. Veterans need a single point of contact who can help steer them in the direction they need for services or care.

Question 5 – Are there barriers to aging at home in this community? If so, what are they?

1. Lack of transportation continues to be a barrier to aging at home in our community.

2. It can be challenging for elderly couples to help each other get by at home in situations where each person takes turns with the responsibilities of caring for each other. Both individuals have needs, and it can be challenging to work as a team.

3. There are economic barriers to aging at home regarding monthly income and ability to afford expenses, taxes, bills, and insurances.

4. Some elderly community members have no family in the region, no one to help clean the home or provide general assistance.

5. Some elderly individuals living at home do not meet the eligibility requirements to get the help they need.

6. We are a community that looks out for its neighbors. Sometimes police conduct wellness checks because no one else is, and people share that some community members haven't been heard from or seen. There is a volunteering need for well-being checks.

7. People are concerned with being taken out of their homes, which they view as a last resort.

Question 6 – What are the biggest challenges for recruiting and retaining healthcare employees in this geographical market? What suggestions do you have that would improve the ability to recruit and retain healthcare employees?

1. There are good programs in continued and higher education in the region, and employers have worked hard to try to retain workers.

2. MVH has done well with its CNA training program as a staffing source.

3. Our rural setting is challenge for retaining young people, and the population has declined significantly in the last 20 years.

4. Cultural diversity in the region is lacking and can be a challenge to retaining foreign-born providers who work in the community for a few years while paying off loans before leaving.

5. We compete locally, statewide, and nationwide for workers, and we need to adapt.

6. Hospitals and other larger healthcare providers go after clinical workers intensely. This is an art form that some healthcare organizations have figured out while others have not.

7. There are new Mainers coming from away who exist all over Maine. How do we attract them to the County?

8. Nursing is a mentally and physically draining profession. Is enough being done to support nurses? We need to focus on staff well-being and compensation, including financial support, childcare support, making people feel welcome, and paying staff accordingly.

Question 7 – What type of support does this community need to attract more services or facilities to serve the needs of its aging population?

1. We need to create a plan regarding what veterans and the elderly need in our community instead of different organizations and entities providing different components individually. Perhaps 10-year planning with ongoing adjustments for evolving conditions.

6.4 Machias Focus Group

Below is a summary of the feedback received from the focus groups held in Machias on October 6, 2022. The feedback is organized into the three focus groups and the feedback forms. The information is presented in the way BerryDunn heard it shared. By design, the information is not attributed to specific people who shared the comments.

6.4.1 Residents and Family Members

Below is what was shared with BerryDunn during the residents and family members focus group in Machias:

Question 1 – Why did you seek Maine Veterans' Homes as a care provider? What specifically attracted you to Maine Veterans' Homes?

1. My parent shared that MVH was her choice because her peers had lived there and she was aware of the high quality and conditions of the facility. Having a private room was also important. There were limited alternatives in the Machias region, and it was heartening to have a facility that focused on memory and dementia care. The location being close was important to being a part of my mom's experience and care team.
2. MVH's Machias home has a good reputation. The facility is clean, the staff take care of the residents, and the quality of the food is above and beyond. My parent loves it and it's a great place.
3. I knew of the MVH facility's reputation, cleanliness, beauty of the facility, and I knew that I could trust the facility and employees to take care of my parent's healthcare needs.
4. There is no one else who can do what MVH does for someone who is high functioning in assisted living but who needs dementia care.
5. The level of care and love that the staff show to residents: "that is what I wanted." The feeling of no longer having to worry. MVH Machias has been a blessing for family members.
6. For us, MVH was "THE choice" – there was no other option, it was MVH, or my father was moving in with me.
7. MVH Machias is in a good location, provides availability, has great staff, great food, and provides residents with the benefits of a private room.
8. The MVH facility was perfect for my dad. He knows everyone's name and knows all the workers.

Question 2 – Describe your experience at Maine Veterans' Homes and with their services.

1. The activities and social services are top-notch. There are many activities that help drive mental and social stimulation rather than staring out a window or at a TV for extended periods of time. These MVH programs contribute to a richness of quality of life.

2. My mother in a different facility has nothing compared to what my father experiences at MVH.

3. MVH's treatment of families is great. Staff are happy to hear from family and promptly address any questions or concerns. Staff are right on top of everything and keep family members apprised of updates.

4. I value the human, family touch of the MVH staff. The people who work here want to work here and are happy to be here. Staff were devastated about the potential for the facility to close.

Question 3 – What services could you not find at Maine Veterans' Homes or in the community?

1. Specialized care for memory care was not available anywhere else, and travel to Bangor would have been required. Traveling two hours is not "in my community."

2. For other nursing homes in the area, you can only get a private room if you are a private pay resident, and here at MVH that is different.

3. The MVH facility's activities program is a better experience than what is offered at other nursing homes.

4. Home health services are limited in the area due to staffing challenges.

5. Community health and counseling resources try to provide families with the resources they need, but there are limits to what they can do. It is challenging to get a nurse to visit an individual at home and take care of basic needs on a daily basis. Availability of resources is limited and inconsistent.

6. There are no cardiac specialty providers in the Machias area.

7. Travel to Bangor is required for audiology care from the VA, though MVH is able to provide transportation round trip.

Question 4 – How do you balance the choice of a local healthcare services versus traveling for healthcare services?

1. The most important location aspect for me is being near to the resident's primary care provider. At this stage of the resident's life, familiarity and being present and involved with the provider is important.

2. My mother was approved to be at MVH with my father but must reside in Ellsworth because there is not sufficient cardiac care in the Machias region.

3. My parent needed diabetic shoes, and MVH was able to coordinate with a local healthcare center to get shoes delivered so that we did not need to travel to the Togus VA facility.

4. It is important for my parent to maintain a good relationship with the psychiatric nurse at the VA facility in Bangor through a mix of transportation and telehealth. MVH makes sure

to accommodate residents and allow residents to keep the doctors they've seen historically.

Question 5 – What are your thoughts on telehealth services to help support yourself or a family member? Are you currently using telehealth services?

1. I have used telehealth in the past, but after a while it was no longer offered, though I think it would serve this area well.
2. I've heard that funding for telehealth may be a challenge.
3. When dealing with memory-impaired residents, diagnosis and communication can be challenging through telehealth; however, the staff at MVH seem well suited to support residents with telehealth.

Question 6 – If you had access to home healthcare and related support services, would your preference be to keep you family member at home?

1. I would have kept my family member at home if the home could be retrofitted to meet the needs of a 90+ year old individual.
2. Given that there were not support services available and because my mother knew of the good standing and quality of services at MVH, we decided to move into MVH.
3. My parent lived with me for an extended period of time with support resources coming into the home two days per week. The mental stimulation experienced at MVH could not be provided at home and my parent's mental acuity has improved while living at MVH.
4. Even with sufficient at-home support, I would still prefer to have my family member at MVH. For various reasons, my family member needed 24-hour care and support.
5. Having private bedrooms and bathrooms is highly valued by residents.

Question 7 – Have you or your family member been impacted by the direct care labor market challenge and, if so, how?

1. Labor challenges have impacted availability of specialty care such as for hearing or eye appointments.
2. It can be difficult to find dental care appointment availability.
3. Quality of life is important. When hearing is a challenge and an appointment cannot be found for months, there is a big impact.
4. It can be challenging to get direct care staff to take on a job or career and move to the Machias region.
5. Some of the providers in the area are in the final stages of their education and need to serve in rural healthcare, but when they are finished, they leave and do not return.
6. I've experienced wait times for psychiatry treatment for over a year.

7. Washington County technical schools with healthcare tracks for CNAs could provide an opportunity to have students do practicums at MVH through a partnership. These students are people who will potentially stay in the Machias region.

6.4.2 MVH Staff and Other Community Providers

Below is what was shared with BerryDunn during the MVH staff and other community providers focus group in Machias:

Question 1 – Do you feel residents of Maine Veterans' Homes value being at Maine Veterans' Homes? If so, why? For Maine Veterans' Homes staff, what benefits do you see residents receiving? For community providers, why do you refer to or collaborate with Maine Veterans' Homes for your patients?

1. Residents tell me almost daily that they are glad to be here and that the care they receive is high quality.
2. Residents value how staff communicate with them. A resident shared that once they joined the Machias facility that it was above and beyond what they anticipated.
3. During talk of closing the facility, residents were asking "why do I need to leave my home?" Residents and veterans do not deserve this.
4. The staff in Machias are the best trained of any facility in which I have worked. They are good resident advocates and treat the residents with dignity.
5. MVH is an important community member. MVH Machias is known for going above and beyond among community members.
6. MVH Machias is unique in that it is the only veterans' home in the state that is connected to a hospital.
7. We (the hospital) made 14 offers to staff at MVH in the event that the facility closed, because the MVH staff are so good at what they do.

Question 2– What specific services and benefits are Maine Veterans' Homes residents most benefiting from?

1. Regardless of the ask or need, resident and veteran advocacy at MVH is a priority.
2. It is important that residents can maintain their longstanding community provider/doctor and local support network.
3. We support veteran choice where we are able to. We help with transportation and accommodating care coordination for the veteran for external care services.

Question 3 – What services are not currently offered, but are needed in the community?

1. There is a need for more geriatric psychiatry services and resources in the community. Some patients at the local hospital have stays that last for months while waiting for psychiatric bed availability in the state. Veterans who have geriatric psychiatry-related

needs express the feeling that they cannot be supported by existing community care resources.

2. There are not enough mental health services.
3. I would like to see MVH Machias eligibility broadened; for example, someone who needs assisted living care, not because of cognitive impairment but for mobility reasons or having multiple comorbidities that need to be managed. Veterans have been turned away in the past because they did not have dementia.
4. There are homeless veterans in the community, some of whom are staying in the woods. This is a service gap that needs to be met.
5. The future needs of veterans from different conflicts will be different and will require new approaches to care. MVH will need to rethink care needs, and more training will be needed.

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

1. We are a caring community and strive to provide services in-home as long as possible.
2. The community has lost some services, including transportation and nursing homes in Cooper and Lubec.
3. It is not clear if regional planning and coordination of care is happening in the region. If it is happening, I have not heard about it.

Question 5 – What are barriers to aging at home in this community, if any?

1. Isolation, geography, and transportation.
2. Lack of a workforce – we cannot get consistent workers for in-home care services. It is challenging to find CNAs or other staff to help veterans or disabled individuals in their homes.
3. Public health mandates during the pandemic have impacted the workforce.
4. Medication adherence and not having in-home help is a barrier to aging at home.

Question 6 – How does geography play into where you refer residents to for services?

1. We are using floor staff to transport residents for trips or care appointments. Current staffing levels make long-distance appointments difficult, due to limited staff and volunteers.
2. Geography and transportation needs mean the MVH team must juggle transportation and care.
3. External providers try to consolidate appointments into a single time block to gain efficiency for travel and care.

Question 7 – Why did you seek out Maine Veterans' Homes as an employer?

1. My father was here as a resident and fell in love with the facility and the environment – "this is exactly where I want to be." Residents give back to the MVH staff, too.
2. I had heard great things about MVH, and it has exceeded my expectations including the managers, coworkers, and residents.
3. The facility is beautiful and clean, and it is better than where I worked before. The friendliness at the facility is a benefit.
4. The MVH facility has a high reputation in the community.
5. I worked outside of the healthcare sector, but as soon as I started working on the unit, I knew this was where I wanted to be.

Question 8 – What are the biggest challenges for recruiting and retaining employees?

1. A lot of people come through MVH because they are in school. For students, the facility is more of a steppingstone in their career, which impacts retention.
2. Public health mandates and exemption rules had an impact on staff retention.
3. There is a shrinking local availability of workers across the clinical worker spectrum.
4. It is challenging to compete with travel agencies as smaller, more rural providers have funding challenges.
5. A smaller scope of clinical services in the region is a challenge to attracting clinical staff.
6. The pandemic has changed things—organizations once not seen as competitors in the labor market are now competitors. There is a shrinking pool of labor with increased competition.
7. It can be hard for current staff who are working alongside agency staff who are compensated a greater wage.
8. We do not have enough licensed day care, which means more people work per diem instead of full time.

6.4.3 Civic and Community Leaders

Below is what was shared with BerryDunn during the civic and community leaders focus group in Machias:

Question 1 – Do you view Maine Veterans' Homes as a valuable member of this community and if so, why?

1. Veterans are everything to us, and it is important that MVH facilities remain open.
2. I have gotten to know a lot of veterans, and it is important to preserve their stories.
3. This is a good facility. This facility has the top rating for MVH year after year.

4. Residents love this place and find comfort here.
5. For the sacrifice and price paid by our veterans, we need this facility to remain open. There is no greater facility for the veterans.
6. Taking the veterans out of their home is not okay, and traveling to Bangor for healthcare is difficult.
7. People who have worked at other healthcare facilities have found their passion at MVH caring for veterans.
8. The MVH facility provides three areas of quantifiable value in the community: 1) economic value through jobs, careers, opportunity, housing, and increasing the tax base, 2) quality of life through keeping families and care teams together where veterans have spent their entire lives, and 3) cultural value – Machias is veteran friendly, which is a badge that the community wears, and MVH is the headquarters of that badge.

Question 2 – As members of this community, what long-term support services are veterans and members of the community seeking?

1. There may be a declining veteran population, but I believe there are a lot of veterans who are unaware of the services available to them. There is a need for greater awareness and engagement.
2. Funding should be provided to support the veterans' homes. What does the future hold in terms of funding beyond what is allocated in LD 2001?
3. Qualified workers left when the notice to close the home was announced. Can we make a rebound? Can we provide incentives to pay them?
4. It would be nice to see more enlisted military personnel on the MVH board alongside officers as well as more representation from rural Maine.
5. There are needs for more veteran housing in Washington County.
6. Initially, it was challenging to get admitted to MVH Machias, but now there are empty beds, and people are afraid to commit to the facility if it might close.
7. The facility is clean, and residents are well taken care of. Employees are responsive and there is a high quality of care compared to other long-term care options.

Question 3 – What services are not offered and are needed in the community?

1. There is a need for more information from the MVH facility that it exists and about what services it can provide. Education to veterans on the benefits available to them.
2. Can the MVH facility change its licensure and eligibility criteria so that it can provide services and care to a wider range of elderly veterans?

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

3. Most municipalities in the Washington County area are conducting planning. There is some regional planning on some topics, but I am unaware of regional planning specific to veterans' healthcare services.
4. The American Legion has a buddy check system throughout the state with designated representatives checking in on veterans in their homes.
5. In the last few years, Washington County has had a lack of certified planners. Communities need to take advantage of grants. Our communities are aware of the problem and multiple NFPs are trying to sort out the issue.

Question 5 – Are there barriers to aging at home in this community? If so, what are they?

1. There are limited inbound services to the home available in Washington County, such as Uber, taxies, or grocery and restaurant delivery.
2. Increased cost of living is challenging to veterans who are on fixed incomes.
3. The VA can be slow helping an aging veteran who is still living at home. For example, if a veteran is only 50% service-connected, it can be difficult to get services.
4. Agencies are desperate for employees. There is a shortage of in-home healthcare aids. Having in-home services that support aging at home is even more vital in rural areas like Washington County.
5. Housing infrastructure is old and not always suited toward mobility and the needs of the elderly.
6. Winter weather and rural geography present barriers to aging at home.
7. Veterans who have no family are relying on friends to meet their needs. They want to stay home and do not want to go to a facility.

Question 6 – What are the biggest challenges for recruiting and retaining healthcare employees in this geographical market? What suggestions do you have that would improve the ability to recruit and retain healthcare employees?

1. Funding and ability to offer higher wages is a challenge.
2. MVH is competing against a lot of other facilities and employers.
3. The staff at MVH deserve to be paid more. They are proud of the work they do and should be paid commensurate to that—rewarded for the level of effort.
4. There is only a certain segment of the population that wants to live the way people in our community do. It is not as convenient to live in a rural part of the state.
5. There are people who want to work and live here but who cannot find housing and end up leaving.

6. Some people in the area have left the healthcare field due to public health measures and pandemic protocols.
7. Washington County does not have as many training resources for nurses and CNAs compared to places like Bangor. People travel to get training and end up staying there.
8. There are lots of advertised jobs for the MVH facility but not enough qualified people to fill them.
9. Could there be more collaboration for workforce training across all of MVH's facilities?

Question 7 – What type of support does this community need to attract more services or facilities to serve the needs of its aging population?

1. Funding and staffing have been hard and contributed to nursing home closures.
2. We need a single resource of veterans where they can go to understand the resources, support, and benefits that are available to them.
3. It is unclear if the broader community understands the needs of veterans in the community.
4. Rotating physicians are not accustomed or attracted to the Downeast lifestyle.
5. It would be nice if there was a place for senior citizens to go to regularly for socialization and activities. As people grow older, they sometimes think there is nothing to do. Engagement is important to staying sharp. Connectivity is key for the aging population.
6. This county needs planning services and grant-writing services.

6.5 South Paris Focus Group

Below is a summary of the feedback received from the focus groups held in South Paris on October 20, 2022. The feedback is organized into the three focus groups and the feedback forms. The information is presented in the way BerryDunn heard it shared. By design, the information is not attributed to specific people who shared the comments.

6.5.1 Residents and Family Members

Below is what was shared with BerryDunn during the residents and family members focus group in South Paris:

Question 1 – Why did you seek Maine Veterans' Homes as a care provider? What specifically attracted you to Maine Veterans' Homes?

1. The MVH facility is closer to family and those who live in the area, located centrally as a hub for the surrounding towns. It is nice knowing that veterans can be close to their family members.

2. We visited the facility before deciding to admit my family member. We were very impressed with the cleanliness of the facility and the quality of care residents receive. MVH South Paris is a very nice, open facility. They meet my family member's needs.
3. The facility is geared toward veterans. The service and care provided is a way of giving back to and thanking veterans for their service to our country.
4. Since becoming a resident at MVH, my family member's overall health has improved, transitioning from hospice care to residential care.
5. As an EMT, the MVH facility is different compared to any other facility I have visited.
6. When I came to MVH, I was impressed by the facility and the staff. I value the culture of veteran camaraderie and the feeling of family and being made to feel like I am at home.

Question 2 – Describe your experience at Maine Veterans' Homes and with their services.

1. Any time we have a concern, we can call the staff at MVH and get it addressed in a timely manner.
2. The welfare of the resident is the number-one priority at MVH.
3. MVH staff are very nice, and the quality of care is good.
4. The activities department works hard and keeps residents active and engaged.
5. My family has nothing but good things to say. MVH listens intently to what my family members asked about me.
6. MVH is very good about making sure that I am able to get to my appointments. There are people available to help with transportation.

Question 3 – What services could you not find at Maine Veterans' Homes or in the community?

1. With nursing home closures in the area, there are not a lot of options for family members in the area if they cannot join the MVH facility.
2. There is a lack of resources to care for veterans while they wait to be admitted to MVH.
3. There may be gaps in terms of who MVH can serve and care for based on eligibility requirements.

Question 4 – How do you balance the choice of a local healthcare services versus traveling for healthcare services?

1. There is a preference to receive services closer to home and the community when possible.
2. The opening of the Lewiston VA facility lessened travel to Togus for appointments.
3. There are services in South Paris and Lewiston and providers who have contracts with the VA. Generally, there are more VA and external providers in this area.

Question 5 – What are your thoughts on telehealth services to help support yourself or a family member? Are you currently using telehealth services?

1. I use telehealth to meet with several providers, which alleviates the need for travel. Telehealth has been helpful meeting needs in most cases and provides access to care and services not immediately available in the community.
2. Telehealth is a good option under the right circumstances, but I still prefer an in-person visit, and veterans deserve it.

Question 6 – If you had access to home healthcare and related support services, would your preference be to keep you family member at home?

1. Absolutely. I am at the MVH facility because there is a lack of resources to provide support in the home. I had nurses coming into the home in the past, but eventually needed more care than was available.
2. If more care was available, I would stay home. I was not able to find the level of home services I needed.

Question 7 – Have you or your family member been impacted by the direct care labor market challenge and, if so, how?

1. MVH staff sometimes have limited time to spend with residents, which impacts relationships with residents. The staff are good people, but they are stretched thin. Nurses say they are tired.
2. Sometimes resident or family requests take longer to fulfill because staff are so busy. The weekends in particular can be a challenge.
3. It is difficult to find anyone who is able to come into the home and look after you for eight hours each day.
4. I cannot go several days without home care, and there were not enough options or CNAs.
5. What can be done to generate interest in CNA and nursing programs? Can we engage young people when they are considering careers? We should emphasize the rewarding aspects of a career in nursing and caring for residents and veterans with rich lives and experiences.

6.5.2 MVH Staff and Other Community Providers

Below is what was shared with BerryDunn during the MVH staff and other community providers focus group in South Paris:

Question 1 – Do you feel residents of Maine Veterans' Homes value being at Maine Veterans' Homes? If so, why? For Maine Veterans' Homes staff, what benefits do you see residents receiving? For community providers, why do you refer to or collaborate with Maine Veterans' Homes for your patients?

1. The staff at MVH value and honor the veterans, and veterans feel and know it.
2. Veterans appreciate being with other veterans and the experiences they have shared. Veterans feel welcome and that MVH is their home.
3. MVH has a history of being connected to community members such as the VFW, schools, fundraisers, and motorcycle and car clubs. The community comes to MVH and vice versa.
4. MVH has a strong reputation. The cleanliness and quality at the facility are good and unlike other facilities.
5. Veterans are able to age in place at one facility, remaining in their "home" across the care continuum.
6. As a non-MVH healthcare worker, walking in the door you feel the respect, warm welcome, and service from the MVH staff.
7. The skillsets of MVH staff are strong.
8. I refer patients to MVH for skilled and respite care. The staff are welcoming, and there is a family-like atmosphere that stands out from other nursing homes.

Question 2 – What specific services and benefits are Maine Veterans' Homes residents most benefiting from?

1. The activities department works hard to center activities around the veteran experience. It provides a safe place to speak.
2. Most of our homes have therapy services in-house. We understand how the veterans function and can help them at every level.
3. Residents benefit from our holistic, individualized approach to caring for veterans across multiple teams and disciplines.
4. I noticed immediately that there is an expectation in the facility for a high standard of care. Staff push each other to provide high-quality care. It is better than other facilities, and veterans deserve it.

Question 3 – What services are not currently offered, but are needed in the community?

1. Mental health support services are needed in the community and especially for veterans. When veterans come to the hospital, their mental health needs stand out.
2. There are not enough geriatric psychiatry beds in the community or statewide. It is challenging to meet veteran needs in the emergency room and it exacerbates provision of care.
3. The way different entities and organizations view assisted living impacts what veterans qualify for. Veterans need guidance to understand the conflicting availability of benefits.

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

1. I am not aware of much planning related to coordination of veteran care. There has not been a focus on veteran needs and how to plan and coordinate around them.
2. Some local providers can be accessed by veterans through existing agreements.
3. There is a group at Stephens Memorial Hospital that includes long-term care facilities in the community. The group provides a forum for sharing ideas and resources.

Question 5 – What are barriers to aging at home in this community, if any?

1. The staffing shortage for in-home care or transportation services. There is a lack of Meals on Wheels programs.
2. Family care team burnout.
3. Internet access can be a barrier to accessing services veterans need or telemedicine.
4. Wages in the community are low in comparison to cost of living.
5. Staff consistency at MVH is important. Familiarity helps drive adequate care for certain veterans.
6. Decreased access to primary care has led to people being diagnosed with advanced conditions because they have not seen a provider.
7. There are insufficient resources to conduct house visits.
8. MVH is a great care partner to care for veterans and their unique needs. “Thank goodness we have them as a partner in our community.”

Question 6 – How does geography play into where you refer residents to for services?

1. We accept residents from all over the state, sometimes from other MVH facilities.
2. I see that veterans want to live in a veterans’ home instead of a nursing home.
3. Families and loved ones want veterans to be close when they join MVH. Visitation is important.
4. In hospice care, location is important as it influences the time and travel burden for care.
5. We try to support our local community as much as we can by referring to local community providers and always try to give veterans a choice.

Question 7 – Why did you seek out Maine Veterans’ Homes as an employer?

1. I come from a family with a long history of military service.
2. The quality of the MVH facility was like nothing I had seen before. There is no greater honor than to care for our veterans.

3. Staff longevity and retention at MVH demonstrates the passion and pride staff share in their care of veterans.

4. The people at MVH are some of the most hardworking people I have met.

Question 8– What are the biggest challenges for recruiting and retaining employees?

1. I have observed foundational knowledge gaps (math and reading) in some of our applicants. Lack of these skills makes training difficult. Local availability of the education needed to enter the nursing workforce is a gap.

2. Nursing is already a challenging career, and COVID-19 has made it more so. We are trying to do more with less due to new policies and regulations.

3. Some newer staff are overwhelmed after experiencing what the job requires and they leave.

4. Competition for labor in the communities is a challenge. It gets to a point where we cannot raise wages higher than competitors, including non-healthcare employers.

5. Younger people are placing more emphasis on their personal time versus their work life compared to other generations.

6. Can early retirees be engaged and motivated to rejoin the workforce? Even part time?

6.5.3 Civic and Community Leaders

Below is what was shared with BerryDunn during the civic and community leaders focus group in South Paris:

Question 1 – Do you view Maine Veterans' Homes as a valuable member of this community and if so, why?

1. It is very important to have the veterans' home in this community and statewide. Veterans need the essential care and services MVH can provide them.

2. Some veterans are not safe at home even if they had at-home support resources. MVH provides a safe community for them.

3. Veteran connection is important. At MVH, veterans have a shared experience, which helps create and sustain relationships.

4. There is a lot of community support for the veterans' home. It is important to recognize those who have served in the military. Some MVH veterans remain active in the community.

5. The different levels of care provided at MVH is a benefit to residents and veterans.

Question 2 – As members of this community, what long-term support services are veterans and members of the community seeking?

1. It is important for the MVH facility to have sufficient staffing levels so that it can maximize capacity.
2. Some prospective residents/family members experience longer wait times because of a lack of veterans' home bed availability.
3. It is important to increase awareness to community members of the support and resources available to them.

Question 3 – What services are not offered and are needed in the community?

1. Reliable and consistent transportation services are lacking. This presents a challenge to getting to appointments.
2. There is a lack of services to support the homeless, and emergency shelters in Oxford County are scarce.
3. More resources are needed for volunteer groups.
4. Individuals in the community are not always aware of resources available to them; for example, attaining funding from the VA for home modifications.

Question 4 – Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?

1. I have not seen any planning on a regional basis.
2. It would be great if there was a central point of contact for veterans to gain access to the services or support they need.
3. There are pockets of people who can be called, but lack of awareness can be a barrier. People don't know what is available to them in the community.

Question 5 – Are there barriers to aging at home in this community? If so, what are they?

1. Individuals want to remain in their homes but think they can't because they don't believe they can get the necessary help or resources.
2. There is not adequate in-home help in the community due to a lack of funding to employ people to provide in-home services.
3. Residents and veterans need legal advice and services to help navigate decisions related to remaining at home or joining MVH.
4. The affordability of living at home and receiving in-home support service is a challenge.
5. The older housing stock in the area is not consistently suited to meet the needs of the elderly.

Question 6 – What are the biggest challenges for recruiting and retaining healthcare employees in this geographical market? What suggestions do you have that would improve the ability to recruit and retain healthcare employees?

1. The tight labor market and demand for greater compensation.
2. Workers seek strong benefits too, such as affordable housing and healthcare. Let's draw people into the workforce with the right incentives.
3. There needs to be more promotion and marketing of the healthcare field in high schools and other educational institutions.
4. Can subsidization of training and education help with workforce challenges?
5. Workers consider the local wage market and eligibility for and availability of welfare and other benefits.

Question 7 – What type of support does this community need to attract more services or facilities to serve the needs of its aging population?

1. A centralized senior center that can provide care, advisory and resource guidance, meals, and social and community events. There is nothing in the area like this.
2. There is a need for more volunteers.

6.5.4 Feedback Forms

The following comments were provided on feedback forms distributed at the end of each focus group session. The forms provided participants an opportunity to share open-ended additional comments and feedback.

1. The MVH staff are respectful to resident families. Family members are able to participate in the care of their loved ones. Staff always try to accommodate family wishes and asks.
2. Knowing my family member is taken care of 24 hours each day is a relief for me.
3. MVH staff are knowledgeable, kind, empathetic, and patient.
4. I love having my parent here. Resident care quality is good. I do not have to worry. My family is very happy with the home.
5. The veterans' home is the best opportunity for my family member to live a high quality of life.
6. A veteran-specific facility is the cherry on top for our veteran population.
7. There are many veterans in this region who need this facility.
8. I enjoy working at MVH.
9. I have found a job I enjoy and want to continue giving the best care to these residents.
10. The home is proactive with resident care.

11. Cost and location are big factors for people living in rural areas of Maine.
12. If my family member were to move further away, I worry that his care would be much more difficult, and it would take a toll on me as his caretaker.
13. Some low-income individuals forgo care because they cannot afford it.
14. Generating awareness of available services is important. Having accessible, available resources on a regular basis matter.
15. I value the cleanliness and high quality of the facility.
16. Quality should always come first but not at the expense of availability.
17. Do veterans have healthcare and whole-life coordinators and advocates in the community?
18. How can the community help to support MVH activities, and how will needs be communicated to the community?

Additionally, focus group participants completed a rank order exercise to assign priority of five attributes of healthcare including quality, location, availability/wait time, veteran specific experience, and cost. An assigned rank of 1 indicates highest priority and a rank of 5 indicates lowest priority. Table 19 includes the average rank for each attribute and the frequency of first-, second-, third-, fourth-, and fifth-rank choices for each attribute.

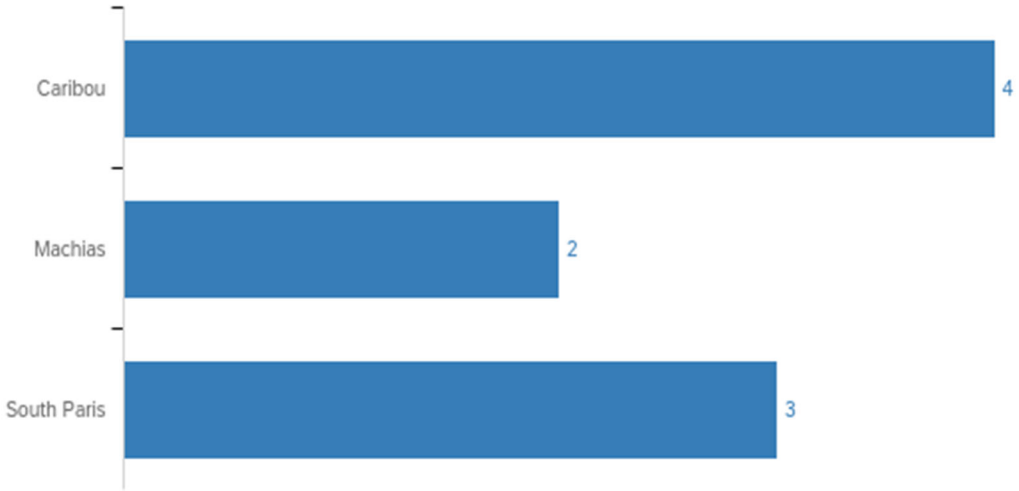
Table 19 – Ranked Order Exercise

Summary of Rank Order Exercise Responses					
	Attribute of Healthcare				
	Quality	Location	Availability /Wait Time	Veteran Specific Experience	Cost
Average Score	1.8	2.3	3.2	3.4	4.0
# of times ranked 1st	26	17	6	2	2
# of times ranked 2nd	15	17	6	11	4
# of times ranked 3rd	8	6	14	13	12
# of times ranked 4th	2	9	20	15	7
# of times ranked 5th	2	4	7	12	28

6.6 Public Comment via Electronic Survey

BerryDunn provided an online survey for public comment, which was kept open through November 28, 2022. Nine responses were received, with three comments provided. Below shows the distribution of the nine responses and the three comments.

Figure 10 – Distribution of Number of Public Comments



Below are the three comments received in the responses:

1. Machias – As the State Senator representing all of Washington County and 16 communities in Eastern Hancock County, I am quite concerned about the lack of long-term services and supports being available to our elderly and our veterans. Through the years we have seen a number of nursing facilities close due to the high costs of staying in business; thus, this important population has been forced to move out of the County to receive much needed care. The MVH Machias facility is a very critical facility caring for

our well deserving veterans, keeping them close to their loved ones. I feel the plan should do everything it can to continue funding for this very important facility!

2. Caribou – Could Maine bring back the Homeward Bound program or something similar? We need more options for people to stay home where the quality of their lives would be much better with a bit of support. Funding for family caregivers? This would be much less than cost for nursing home or assisted living. Here are a couple facts from Alzheimer's Association: More than 11 million Americans provide unpaid care for people with Alzheimer's or other dementias. In 2021, these caregivers provided more than 16 billion hours of care valued at nearly $272 billion. We have no nursing homes in the County, that I know of, that specialize in care for those with dementia. We need to focus on helping our elderly who choose to live at home. Thank you.

3. South Paris – There is a huge need in this community for long term services and support of all kinds. There are not many facilities, and when veterans or their spouses have to wait, or have to go to facilities that are a significant distance away, it makes it very hard on them and their family. The facility in South Paris is needed, and if possible really could be expanded.

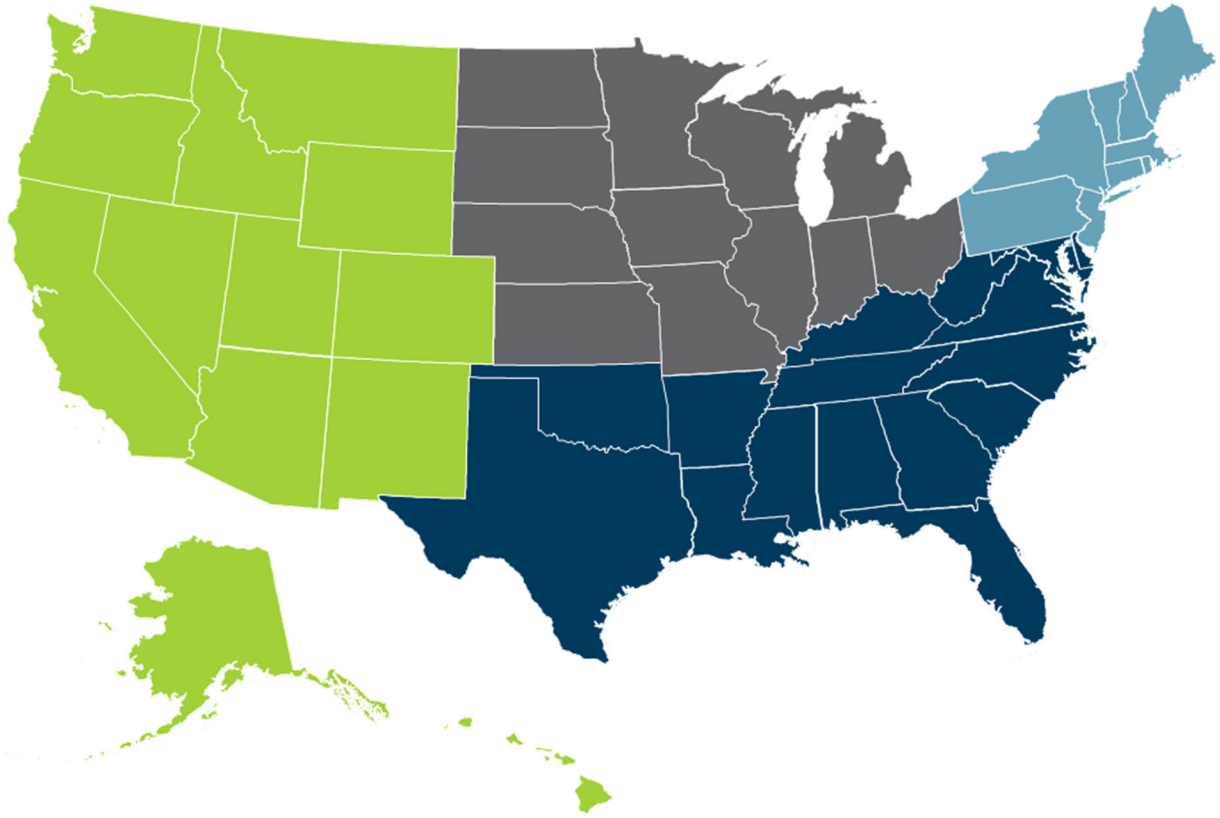
7.0 Appendices

Appendix A (Comparative Study) – Summarization of Findings

CMS SNF Medicare cost reports 2019 – 2021	**Medicare certified skilled nursing facilities** file an annual full utilization cost report if their Medicare utilization is over established threshold. *Notes 1, 2*
The Bureau of Labor Statistics reports, 2019 – 2021	**The Bureau of Labor Statistics** measures labor market activity, working conditions, price changes, and productivity in the U.S. economy to support public and private decision making.
CMS Payroll Based Journal reporting data 2019 – 2022	**All Medicare and Medicaid certified skilled nursing and long-term care facilities** are required to report certain labor and resident census statistics. This data is submitted by facilities and summarized by CMS quarterly. Due to COVID-19, facilities had filing waivers through a portion of calendar year 2020. *Note 1*
CMS Provider Information - Care Compare 2021 – 2022	**General information on currently active nursing homes**, including number of certified beds, quality measure scores, staffing and other information used in the Five-Star Rating System. Data are presented at the facility level, and is updated quarterly. *Note 1*
National Center for Veterans Analysis and Statistics Data	**National Center for Veterans Analysis and Statistics,** accumulates and summarizes Veteran data and statistics, and develops estimates and projections on Veteran populations.

Note 1: BerryDunn removes data outliers

Note 2: Data is updated regularly, potentially resulting in data summary changes due to cost report audits, provider cost report amendments, and late filing submissions



West	South		Midwest	Northeast
Alaska	Alabama	North Carolina	Illinois	Connecticut
Arizona	Arkansas	Oklahoma	Indiana	Maine
California	Delaware	South Carolina	Iowa	Massachusetts
Colorado	Florida	Tennessee	Kansas	New Hampshire
Hawaii	Georgia	Texas	Michigan	New Jersey
Idaho	Kentucky	Virginia	Minnesota	New York
Montana	Louisiana	Washington D.C.	Missouri	Pennsylvania
Nevada	Maryland	West Virginia	Nebraska	Rhode Island
New Mexico	Mississippi		North Dakota	Vermont
Oregon			Ohio	
Utah			South Dakota	
Washington			Wisconsin	
Wyoming				

Region	State	Number of Facilities	Total Number of Certified Beds	Average Number Residents per Day
Midwest				
	Indiana	1	284	114
	Iowa	1	702	356
	Kansas	2	153	50
	Michigan	3	337	33
	Minnesota	4	615	119
	North Dakota	1	52	46
	Ohio	2	595	157
	South Dakota	1	71	66
	Wisconsin	5	751	105
		20	**3,560**	**105**
Northeast				
	Maine	5	462	69
	Massachusetts	1	88	44
	New Jersey	3	964	211
	New York	6	1,372	144
	Pennsylvania	6	1,205	126
	Vermont	1	177	94
		22	**4,268**	**124**
South				
	Arkansas	2	186	77
	Delaware	1	144	51
	Florida	6	720	79
	Kentucky	4	681	67
	Louisiana	5	631	6
	Maryland	1	286	211
	North Carolina	4	449	85
	Oklahoma	1	170	New facility – data excluded
	South Carolina	2	440	175

Region	State	Number of Facilities	Total Number of Certified Beds	Average Number Residents per Day
	Tennessee	4	528	94
	Texas	10	1,278	103
	Virginia	2	380	148
		42	**5,893**	**87**
West				
	Arizona	2	320	92
	California	6	1,093	137
	Colorado	5	554	67
	Hawaii	2	115	33
	Idaho	3	254	57
	Montana	3	245	48
	Nevada	2	276	124
	New Mexico	2	335	89
	Oregon	2	305	115
	Utah	4	417	95
	Washington	4	517	100
		35	**4,431**	**90**
United States		**119**	**18,152**	**98**

Appendix B (Comparative Study) – Definitions per 38 CFR Part 51

Adult day healthcare means a therapeutic outpatient care program that includes one or more of the following services, based on patient care needs: medical services, rehabilitation, therapeutic activities, socialization, and nutrition. Services are provided in a congregate setting.

Domiciliary care means the furnishing of a home to a veteran, including the furnishing of shelter, food, and other comforts of home, and necessary medical services as defined in this part. For purposes of the definition of *domiciliary care*, the phrase *necessary medical services* means the medical services subpart E of this part requires the state home to provide.

Eligible veteran means a veteran whose care in a state home may serve as a basis for per diem payments to the state. The requirements that an eligible veteran must meet are set forth in 38 CFR Part 51 §§ 51.50 (nursing home care), 51.51 (domiciliary care), and 51.52 (adult day healthcare).

Nursing home care means the accommodation of convalescents or other people who are not acutely ill and not in need of hospital care but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, people duly licensed to provide such care. The term includes services furnished in skilled nursing care facilities, in intermediate care facilities, and in combined facilities. It does not include domiciliary care.

Resident means an individual receiving nursing home or domiciliary care.

State home means a home recognized and, to the extent required by this part, certified pursuant to this part that a state established primarily for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. A state home must provide at least one program of care (i.e., domiciliary care, nursing home care, or adult day healthcare).

VA means the U.S. Department of Veterans Affairs.

Veteran means a veteran under 38 U.S.C. 101.

Appendix C (Comparative Study) – VA Long-Term Care Service Locations, by Type and State

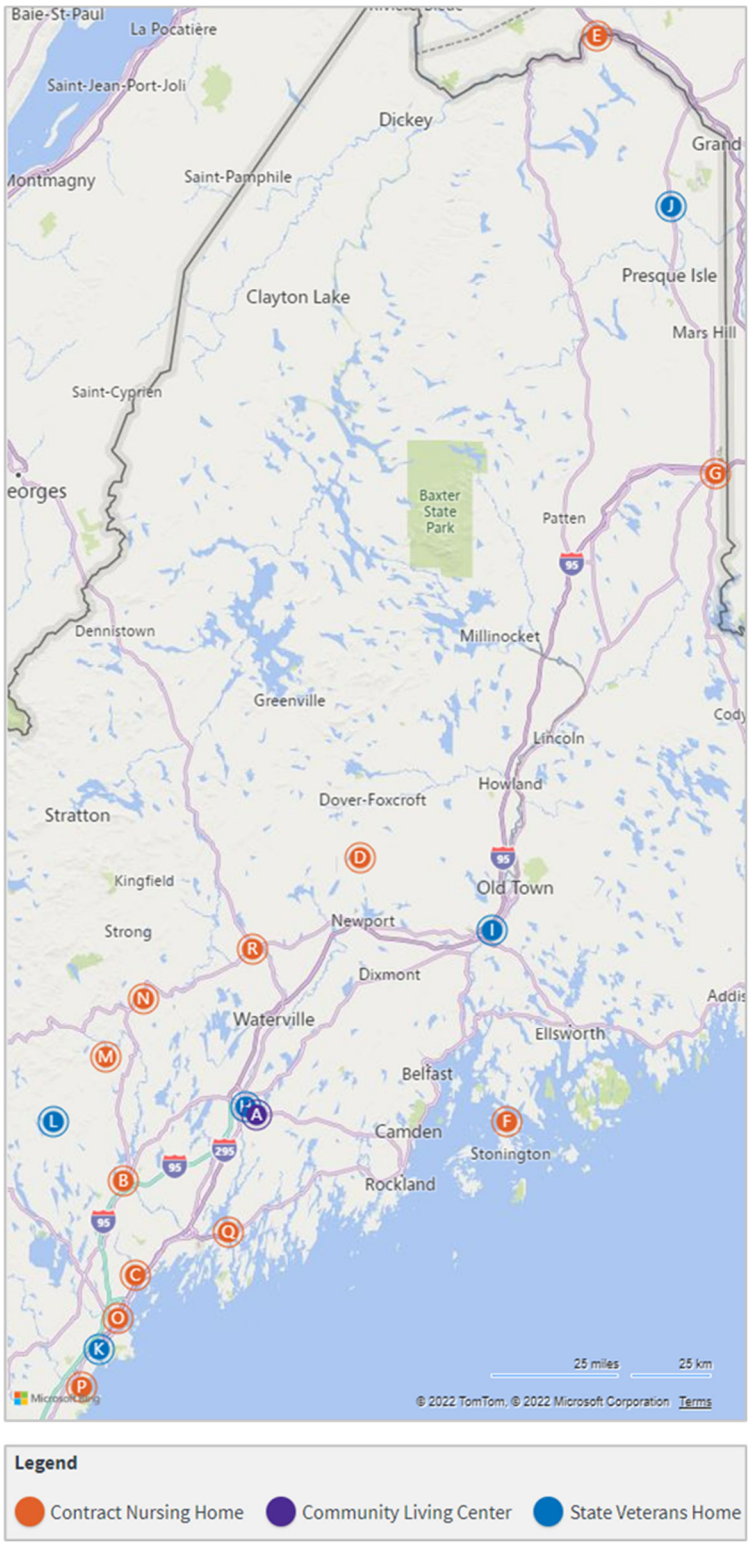
Region/State	CLCs	SVHs	CNHs
Midwest			
Illinois	5	4	69
Indiana	1	1	93
Iowa	1	1	31
Kansas	3	2	27
Michigan	5	2	65
Minnesota	2	4	36
Missouri	3	7	52
Nebraska	1	4	26
North Dakota	1	1	15
Ohio	4	2	244
South Dakota	3	1	22
Wisconsin	3	5	58
	32	**34**	**738**
Northeast			
Connecticut	1	1	11
Maine	**1**	**5**	**12**
Massachusetts	3	2	50
New Hampshire	1	1	28
New Jersey	1	3	51
New York	11	5	72
Pennsylvania	8	6	150
Rhode Island	None	1	11
Vermont	None	1	15
	26	**25**	**400**
South			
Alabama	2	4	58
Arkansas	1	1	25

Region/State	CLCs	SVHs	CNHs
Delaware	1	1	12
Florida	7	6	168
Georgia	4	2	63
Kentucky	1	4	46
Louisiana	2	5	44
Maryland	2	1	60
Mississippi	2	4	26
North Carolina	4	4	78
Oklahoma	1	6	52
South Carolina	2	3	32
Tennessee	2	4	155
Texas	9	9	159
Virginia	3	2	58
Washington D.C.	1	None	None
West Virginia	3	1	48
	47	**57**	**1,084**
West			
Alaska	None	1	5
Arizona	3	2	35
California	11	6	142
Colorado	2	5	37
Hawaii	1	1	5
Idaho	1	3	18
Montana	1	2	17
Nevada	1	2	7
New Mexico	1	2	14
Oregon	1	2	59
Utah	None	4	26
Washington	4	4	27
Wyoming	2	None	5
	28	**34**	**397**

Region/State	CLCs	SVHs	CNHs
Unincorporated			
Puerto Rico	1	1	1
Total	**134**	**151**	**2,620**

Source: https://www.accesstocare.va.gov/.

Appendix D (Comparative Study) – Long-Term Care for Veterans in Maine – Facility Types and Locations



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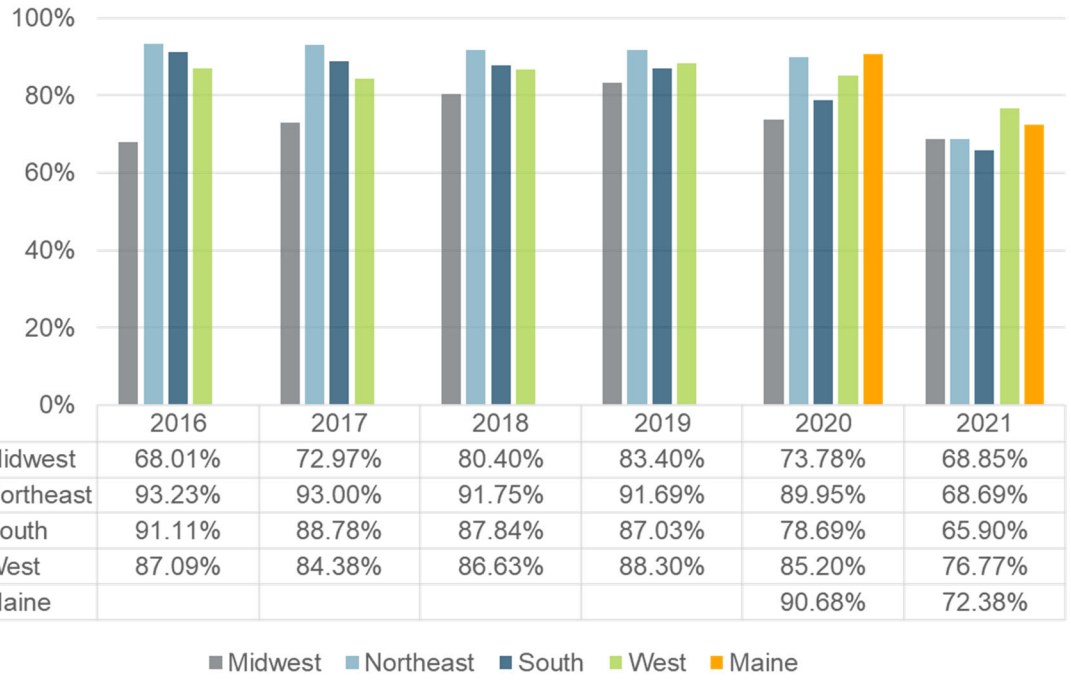
Appendix E (Comparative Study) – Levels of Care and Licensed Beds

	NF-Only Facilities	NF-AL Facilities	AL-Only Facilities	Total Facilities	NF Beds	AL/DOM Beds	Total Beds
Midwest							
Illinois	3	2		5	1,266	100	1,366
Indiana		1		1	337	80	417
Iowa		1		1	447	113	560
Kansas		2		2	228	213	441
Michigan	1	2		3	742	162	904
Minnesota	3	1		4	574	250	824
Missouri	7			7	1,350		1,350
Nebraska		4		4	455	189	644
North Dakota		1		1	52	98	150
Ohio	1	1		2	595	205	800
South Dakota		1		1	76	24	100
Wisconsin	2	1		3	951	40	991
	17	**17**		**34**	**7,073**	**1,474**	**8,547**
Northeast							
Connecticut		1		1	125	428	553
Maine		**5**	**1**	**6**	**450**	**178**	**628**
Massachusetts	1	1		2	472	30	502
New Hampshire	1			1	250		250
New Jersey	3			3	948		948
New York	5			5	1,220		1,220
Pennsylvania	2	4		6	1,287	375	1,662
Rhode Island		1		1	250	36	286
Vermont		1		1	130	8	138
	12	**13**	**1**	**26**	**5,132**	**1,055**	**6,187**
South							
Alabama	3	1		4	624	80	704
Arkansas	2			2	204		204

	NF-Only Facilities	NF-AL Facilities	AL-Only Facilities	Total Facilities	NF Beds	AL/DOM Beds	Total Beds
Delaware		1		1	150	30	180
Florida	6			6	720	149	869
Georgia	1	1		2	564	120	684
Kentucky	4			4	681		681
Louisiana	5			5	816		816
Maryland		1		1	286	168	454
Mississippi	4			4	600		600
North Carolina	4			4	499		499
Oklahoma	7			7	1,423		1,423
South Carolina	4			4	796		796
Tennessee	4			4	528		528
Texas	9			9	1,330		1,330
Virginia	1	1		2	380	60	440
West Virginia	1		1	2	120	150	270
	55	**5**	**1**	**61**	**9,721**	**757**	**10,478**
West							
Alaska			1	1		79	79
Arizona	2			2	344		344
California		6		6	1,104	1,599	2,703
Colorado	4	1		5	574	50	624
Hawaii	1			1	95		95
Idaho	2	1		3	254	36	290
Montana	2	1		3	245	12	257
Nevada	2			2	276		276
New Mexico	1	1		2	182	10	192
Oregon	2			2	305		305
Utah	4			4	417		417
Washington	3	1		4	517	28	545
Wyoming			1	1		116	116
	23	**11**	**2**	**36**	**4,313**	**1,930**	**6,243**

	NF-Only Facilities	NF-AL Facilities	AL-Only Facilities	Total Facilities	NF Beds	AL/DOM Beds	Total Beds
Unincorporated							
Puerto Rico		1		1	120	120	240
Total	**107**	**47**	**4**	**158**	**26,359**	**5,336**	**31,695**

Appendix F (Comparative Study/Workforce Analysis) – SVHs Average Facility Occupancy



	2016	2017	2018	2019	2020	2021
Midwest	68.01%	72.97%	80.40%	83.40%	73.78%	68.85%
Northeast	93.23%	93.00%	91.75%	91.69%	89.95%	68.69%
South	91.11%	88.78%	87.84%	87.03%	78.69%	65.90%
West	87.09%	84.38%	86.63%	88.30%	85.20%	76.77%
Maine					90.68%	72.38%

$$\frac{\textit{Total facility patient days}}{\textit{Total facility available days}}$$

Average facility occupancy is calculated by dividing total patient days by the total facility available bed days as reported on Medicare cost report Worksheet S-3, Part I, and includes SNF, NF, ICF/MR, and other long term care units, such as assisted living or domiciliary.

Occupancy has been declining nationwide since 2019, driven by both diminishing referrals (infection control concerns, reduction of elective procedures, such as joint replacements, and hospital capacity limitations), and facilities' ability to accept patients (suspension of admissions due to inadequate staffing).

Maine Veterans' Homes (Medicare-certified facilities) show strong average occupancy as compared to their peers in Northeast states and nationally.

Higher occupancy helps lower per patient day costs for building-related and administrative expenses not related to occupancy levels.

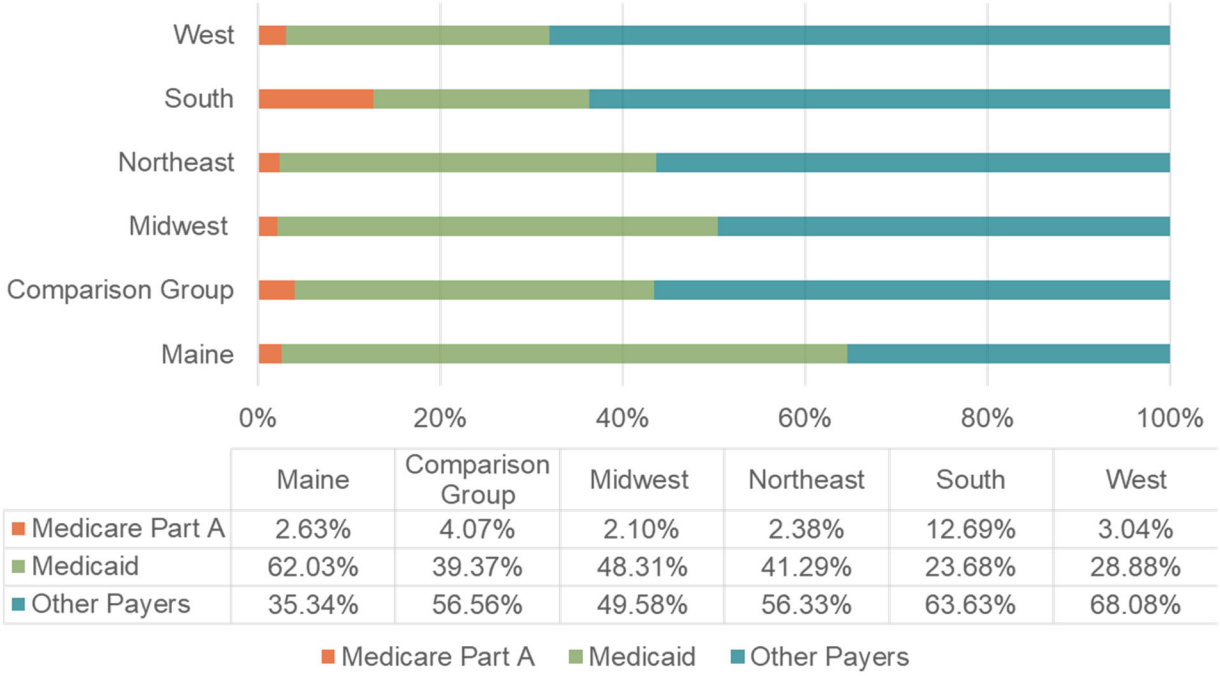
As Filed Medicare Cost Reports, HCRIS, 2016 – 2021 Trending

	2019			2020			2021		
Comparison Group State	Avg. SNF Occupancy	Avg. DOM Occupancy	Avg. Total Occupancy	Avg. SNF Occupancy	Avg. DOM Occupancy	Avg. Total Occupancy	Avg. SNF Occupancy	Avg. DOM Occupancy	Avg. Total Occupancy
Maine				89.0%	95.9%	90.7%	71.4%	78.4%	72.4%
Comparison Group									
Colorado	No Data	No Data	No Data	80.8%		80.8%	62.0%		62.0%
Idaho	No Data	No Data	No Data	81.8%	52.0%	79.3%	65.9%	39.5%	63.9%
Kansas	No Data	No Data	No Data	71.2%		71.2%	70.6%		70.6%
Kentucky	No Data	No Data	No Data	68.1%		68.1%	50.9%		52.2%
New York	99.6%		99.6%	85.9%		85.9%	47.6%		47.6%
North Carolina	No Data	No Data	No Data	90.7%		90.7%	79.0%		79.0%
Ohio	No Data	No Data	No Data	90.6%		90.6%	62.1%		62.1%
Vermont	No Data	No Data	No Data	92.5%	80.7%	91.9%	76.5%	70.0%	76.2%
Washington	No Data	No Data	No Data	93.4%		93.4%	88.1%		88.1%
Wisconsin	No Data	No Data	No Data	89.5%		89.5%	83.1%		83.1%
Comparison Group Average	99.6%		99.6%	83.9%	66.4%	83.7%	66.5%	54.8%	66.4%
Other SVHs									
Arizona	No Data	No Data	No Data	79.6%	97.6%	86.3%	75.4%	76.7%	76.5%
Arkansas	No Data	No Data	No Data	83.0%		83.0%	82.6%		82.6%
California	No Data	No Data	No Data	95.6%	96.4%	96.5%	80.4%	77.0%	76.9%
Delaware	No Data	No Data	No Data	39.2%		39.2%	39.7%		39.7%
Florida	No Data	No Data	No Data	91.6%		91.6%	65.5%		65.5%
Hawaii	93.5%		93.5%	79.4%		79.4%			
Indiana	No Data	No Data	No Data	47.7%	26.0%	43.5%	41.1%	9.1%	34.3%
Louisiana	No Data	No Data	No Data	45.3%	96.5%	87.4%	17.7%	79.8%	66.3%
Maryland	97.7%	75.9%	89.6%	87.7%	66.6%	79.9%	74.3%	53.3%	66.5%
Michigan	No Data	No Data	No Data	85.8%		85.8%	49.8%		49.8%
Nevada	No Data	No Data	No Data	72.3%		72.3%	81.2%		81.2%
New Jersey	No Data	No Data	No Data	87.9%		87.9%	64.2%		64.2%
New Mexico	No Data	No Data	No Data	64.9%		64.9%	66.0%		66.0%
Oregon	92.3%		92.3%	87.9%		87.9%	70.0%		70.0%
South Carolina	No Data	No Data	No Data	97.2%		97.2%	82.2%		82.2%
Tennessee	No Data	No Data	No Data	90.5%		90.5%	69.0%		69.0%

	2019			2020			2021		
Comparison Group State	**Avg. SNF Occupancy**	**Avg. DOM Occupancy**	**Avg. Total Occupancy**	**Avg. SNF Occupancy**	**Avg. DOM Occupancy**	**Avg. Total Occupancy**	**Avg. SNF Occupancy**	**Avg. DOM Occupancy**	**Avg. Total Occupancy**
Texas	50.6%		50.6%	78.8%		78.8%	72.6%		72.6%
Utah	97.9%		97.9%	92.0%		92.0%	92.1%		92.1%
Virginia	No Data	No Data	No Data	90.4%	43.2%	85.2%	75.6%	36.0%	71.5%
Other SVHs Average	88.9%	75.9%	87.7%	80.5%	86.3%	85.1%	67.7%	69.1%	70.9%
All SVHs Average	**90.2%**	**75.9%**	**89.2%**	**82.2%**	**86.7%**	**84.9%**	**67.5%**	**69.9%**	**69.5%**

Appendix G (Comparative Study/Workforce Analysis) – SVHs SNF/NF Unit Average Payer

As Filed Medicare Cost Reports, HCRIS, 2021



	Maine	Comparison Group	Midwest	Northeast	South	West
Medicare Part A	2.63%	4.07%	2.10%	2.38%	12.69%	3.04%
Medicaid	62.03%	39.37%	48.31%	41.29%	23.68%	28.88%
Other Payers	35.34%	56.56%	49.58%	56.33%	63.63%	68.08%

$$\frac{\textit{Total SNF/NF Payer Category Days}}{\textit{Total SNF/NF Census}}$$

Average payer mix is calculated by dividing total applicable Skilled Nursing and Long-Term Care units payer days by total nursing unit days, as reported on Worksheet S-3, Part I.

This calculation does not include domiciliary or assisted living units.

Due to significant variations in Medicaid reimbursement for SVHs, payer mix has to be considered in the context of each state's reimbursement rules and methodologies.
For example, some states reimburse SVH facilities based on reported allowable costs, and others have cost caps.

Different payers have different payment rules and compliance guidelines. Understanding a facility's payer mix is critical to successful goal setting, budgeting, and revenue cycle tasks such as collections.

Payer Group		Medicare		Medicaid		All Other Payers	
	State	2020	2021	2020	2021	2020	2021
Maine		4.6%	2.6%	55.9%	62.0%	39.5%	35.3%
Comparison Group	Colorado	2.4%	2.0%	53.5%	45.0%	44.1%	52.9%
	Idaho	2.5%	3.5%	46.2%	42.6%	51.3%	53.9%
	Kansas	2.5%	3.7%	34.8%	31.7%	62.7%	64.5%
	Kentucky	1.0%	1.1%	36.0%	40.3%	63.0%	58.7%
	New York	2.5%	1.8%	36.5%	51.1%	61.1%	47.1%
	North Carolina	13.4%	13.5%	39.1%	40.4%	47.5%	46.0%
	Ohio	0.5%	0.9%	0.0%	0.0%	99.5%	99.1%
	Vermont	0.3%	0.9%	47.0%	51.7%	52.6%	47.4%
	Washington	2.4%	2.8%	37.7%	38.9%	59.9%	58.3%
	Wisconsin	1.9%	1.7%	60.2%	58.4%	37.9%	39.9%
SVHs Comparison Group Average		3.6%	4.1%	38.6%	39.4%	57.8%	56.6%
Other SVHs	Arizona	1.0%	2.2%	20.6%	17.1%	78.4%	80.7%
	Arkansas	1.9%	1.7%	36.0%	34.1%	62.1%	64.2%
	California	1.8%	2.5%	0.0%	0.0%	98.2%	97.5%
	Delaware	No Data	No Data	No Data	No Data	No Data	No Data
	Florida	2.5%	3.6%	27.2%	26.7%	70.2%	69.7%
	Hawaii	5.2%	No Data	42.1%	No Data	52.7%	No Data
	Indiana	0.6%	1.8%	69.9%	82.7%	29.5%	15.4%
	Louisiana	61.2%	80.2%	0.0%	0.0%	38.8%	19.8%
	Maryland	3.1%	4.3%	49.9%	48.5%	47.0%	47.2%
	Michigan	No Data	No Data	No Data	26.9%	No Data	No Data
	Nevada	15.0%	5.6%	29.4%	30.2%	55.7%	64.1%
	New Jersey	2.9%	2.6%	0.0%	0.0%	97.1%	97.4%
	New Mexico	2.0%	1.5%	85.6%	73.1%	12.4%	25.3%
	Oregon	1.0%	2.7%	40.6%	39.1%	58.4%	58.3%
	South Carolina	0.7%	0.2%	8.0%	7.3%	91.4%	92.4%
	Tennessee	4.5%	5.3%	7.3%	29.1%	88.1%	65.6%

Payer Group	Medicare		Medicaid		All Other Payers	
State	2020	2021	2020	2021	2020	2021
Texas	4.3%	2.2%	8.5%	13.9%	87.2%	84.0%
Utah	3.9%	4.5%	6.1%	5.8%	90.0%	89.7%
Virginia	5.3%	5.6%	42.2%	40.1%	52.5%	54.3%
Other SVHs – Average	9.8%	9.6%	17.9%	20.3%	72.3%	70.2%
All SVHs – Average	**7.3%**	**7.4%**	**27.6%**	**29.0%**	**65.1%**	**63.6%**

As Filed Medicare Cost Reports, HCRIS, 2020 – 2021

Appendix H (Comparative Study/Workforce Analysis) – SVHs Program: FY2022 Per Diem Rates for Selected Veterans Under Pub. L. 112-154, Section 105

Region/State	Urban Counties		Rural Counties	
	Number of SVHs	Average Facility Rate, FY2022	Number of SVHs	Average Facility Rate, FY2022
Midwest				
Illinois	1	$437.65	3	$418.58
Indiana	1	$473.10		
Iowa			1	$411.05
Kansas			2	$401.68
Michigan	1	$438.57	1	$418.28
Minnesota	2	$485.03	2	$440.45
Missouri	3	$441.60	4	$395.50
Nebraska	1	$458.19	3	$427.09
North Dakota			1	$420.54
Ohio	1	$454.44	1	$408.56
South Dakota			1	$401.32
Wisconsin	2	$473.33	1	$437.70
	12	**$458.62**	**20**	**$415.04**
Northeast				
Connecticut	1	$503.95		
Maine	2	$457.09	3	$414.68
Massachusetts	2	$497.42		
New Hampshire			1	$473.46
New Jersey	3	$554.55		
New York	3	$579.07	2	$422.31
Pennsylvania	6	$439.41		
Rhode Island	1	$482.10		
Vermont			1	$455.68
	18	**$496.25**	**7**	**$431.11**

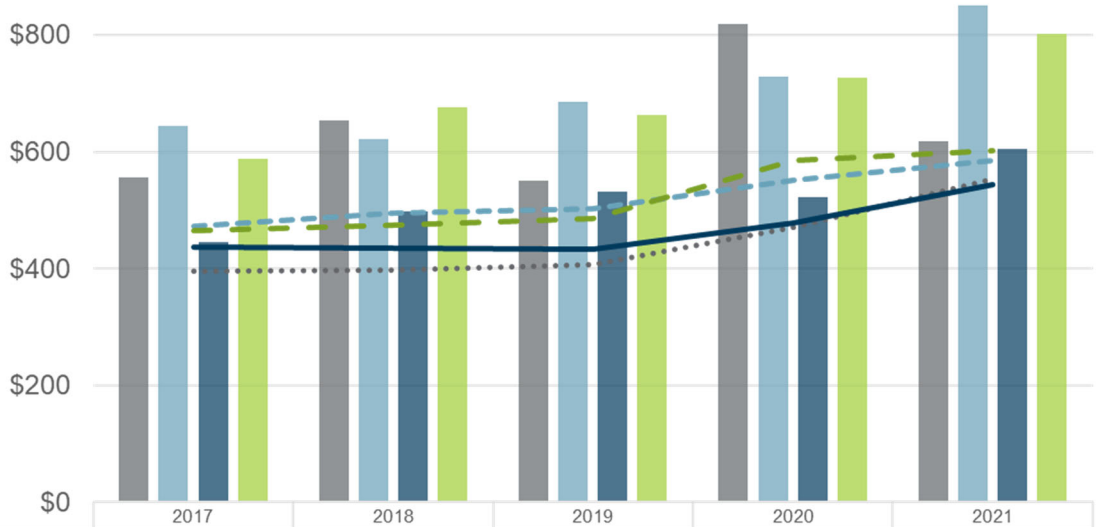
Region/State	Urban Counties		Rural Counties	
	Number of SVHs	Average Facility Rate, FY2022	Number of SVHs	Average Facility Rate, FY2022
South				
Alabama	3	$401.30	1	$357.61
Arkansas	2	$416.83		
Delaware	1	$447.74		
Florida	6	$431.26		
Georgia	1	$428.33	1	$390.29
Kentucky	2	$415.77	2	$404.50
Louisiana	5	$404.67		
Maryland	1	$480.09		
Mississippi	2	$400.90	2	$382.59
North Carolina	3	$435.46	1	$406.10
Oklahoma	3	$408.84	4	$397.82
South Carolina	2	$431.64	1	$412.23
Tennessee	4	$395.92		
Texas	7	$426.68	2	$411.60
Virginia	2	$439.09		
West Virginia	1	$423.43	1	$378.80
	45	**$420.14**	**15**	**$395.58**
West				
Alaska	1	$547.07		
Arizona	2	$445.02		
California	6	$573.93		
Colorado	1	$471.49	4	$470.25
Hawaii			1	$544.38
Idaho	3	$436.04		
Montana			2	$438.06
Nevada	2	$492.07		
New Mexico			2	$430.10
Oregon	1	$497.09	1	$485.21

Region/State	Urban Counties		Rural Counties	
	Number of SVHs	Average Facility Rate, FY2022	Number of SVHs	Average Facility Rate, FY2022
Utah	4	$458.81		
Washington	4	$511.20		
Wyoming			1	$448.96
	24	**$500.90**	**11**	**$463.26**
Unincorporated				
Puerto Rico	1	$269.06		
U.S. SVHs Average	**100**	**$456.33**	**53**	**$421.66**

Appendix I (Comparative Study/Workforce Analysis) – SVHs Average

Medicare per Patient Day Revenue and Cost Trending | 2016 – 2021

As Filed Medicare Cost Reports, HCRIS, 2017 – 2021



	2017	2018	2019	2020	2021
Midwest - cost	$555.93	$654.18	$550.25	$818.58	$618.40
Northeast - cost	$644.53	$620.82	$684.63	$727.75	$851.23
South - cost	$446.22	$497.59	$531.31	$521.75	$604.35
West - cost	$587.26	$676.17	$662.95	$726.40	$801.70
Midwest - revenue	$394.73	$396.82	$406.27	$471.44	$552.37
Northeast - revenue	$471.69	$494.72	$502.58	$551.28	$584.50
South - revenue	$437.60	$435.22	$433.25	$477.32	$544.27
West - revenue	$465.19	$475.04	$484.90	$585.91	$602.59

A deep understanding of Medicare Part A consolidated billing rules and periodic vendor contract reviews may help with SNF program expense management. A facility's ability to manage more complex patient needs may favorably impact revenues and increase overall program profitability.

Medicare Part A profitability is driven by the complexity of patient needs and the related cost of providing services, including labor, ancillary services, and facility costs.

State Veterans' Homes normally have lower traditional Medicare A skilled care utilization rates than peers, presenting a noticeable challenge in keeping Medicare services profitable.

Appendix J (Comparative Study/Workforce Analysis) – Average SVHs Medicare Revenue, Cost and Shortfall Per Patient Day

As Filed Medicare Cost Reports, HCRIS, 2020 – 2021

Comparison Group	State	Medicare Revenue PPD		Medicare Cost PPD		Medicare Shortfall PPD	
		2020	2021	2020	2021	2020	2021
Maine							
	MVH	$ 527.08	$ 538.33	$ 627.45	$ 791.36	$ (100.36)	$ (253.03)
Comparison Group							
	Colorado	$ 531.26	$ 536.26	$ 830.53	$ 910.27	$ (299.28)	$ (374.01)
	Idaho	$ 523.38	$ 518.07	$ 592.93	$ 751.86	$ (69.56)	$ (233.78)
	Kansas	$ 462.78	$ 558.73	$ 972.73	$ 495.05	$ (509.95)	$ 63.68
	Kentucky	$ 477.94	$ 496.00	$ 611.44	$ 678.45	$ (133.50)	$ (182.45)
	New York	$ 636.42	$ 680.19	$ 1,018.49	$ 2,044.12	$ (382.07)	$ (1,363.93)
	North Carolina	$ 498.49	$ 538.05	$ 571.57	$ 646.02	$ (73.08)	$ (107.97)
	Ohio	$ 547.30	$ 602.31	$ 1,341.76	$ 1,398.12	$ (794.46)	$ (795.80)
	Vermont	$ 168.65	$ 532.84	$ 744.32	$ 915.51	$ (575.67)	$ (382.67)
	Washington	$ 585.58	$ 594.70	$ 617.66	$ 599.04	$ (32.08)	$ (4.34)
	Wisconsin	$ 518.02	$ 606.49	$ 1,719.40	$ 2,254.81	$ (1,201.38)	$ (1,648.33)
		$ 519.06	**$ 556.48**	**$ 847.31**	**$ 973.75**	**$ (328.25)**	**$ (417.27)**
Average All US SVH		**$ 523.71**	**$ 569.52**	**$ 913.72**	**$ 1,092.37**	**$ (390.01)**	**$ (522.85)**

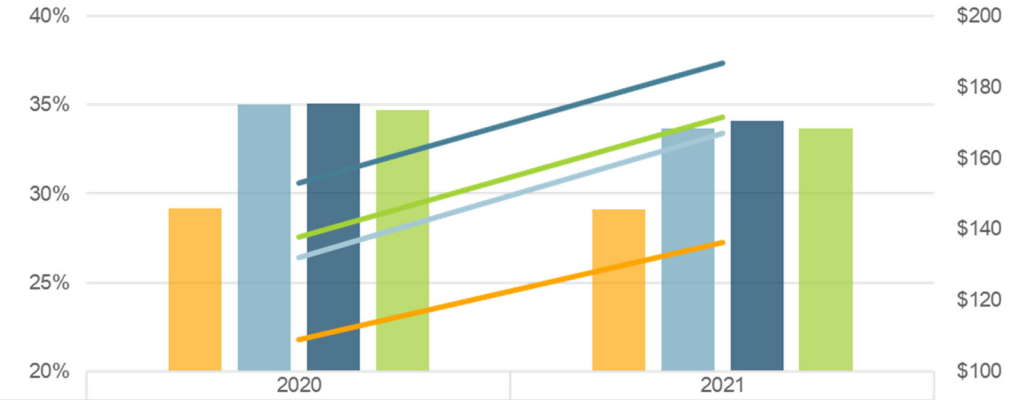
Medicare Part A reimbursement for skilled nursing facility care and services is subject to the **consolidated billing** rules. In addition to room and board costs, all patient medical needs and services, (with a few exceptions) including nursing labor, physician visits, transportation, medications, therapy services, laboratory and imaging services are covered by one per diem rate based on patient assessment data.

In some instances, just the cost of prescribed medication may exceed the daily rate reimbursed by Medicare.

Privately owned facilities frequently emphasize carefully pre-screening patients prior to making admission decisions and coordinating care during short stays. Due to their commitment to serving veterans and their families, SVHs may not have equal patient pre-admission screening practices.

Appendix K (Workforce Analysis) – SVHs Average Direct Care Labor Cost

As Filed Medicare Cost Reports, HCRIS, 2020 – 2021



	2020	2021
Maine	29.20%	29.10%
Comparison Group	35.00%	33.70%
All Other SVHs	35.10%	34.10%
SVHs Average	34.70%	33.70%
Maine - Cost	$108.90	$136.21
Comparison Group - Cost	$153.09	$186.71
All Other SVHs - Cost	$132.00	$167.05
SVHs Average - Cost	$137.91	$171.71

Labor is the largest expense for senior living facilities. In this calculation, direct labor cost includes wages and fringe benefits of the facility-based direct care employees and contract labor expense (registered nurses, licensed practical nurses and aides providing care to residents).

Many facilities are experiencing **increased staffing agency use** to fill nursing vacancies, resulting in labor cost increase.

Some states, counties or municipalities experienced a significant change in minimum wage requirements during 2020 – 2021. Wages also include COVID-related employee wages and bonus pay.

Understanding and managing labor statistics may help facilities improve the bottom line, both short and long term, by aligning costs and revenue trends. Labor budgets and schedules adjusted for both census and patient needs can help facilities have the right people in the right places at the right time.

It should be noted, however, that VA requirements for minimum staffing may exceed state-specific minimum staffing requirements.

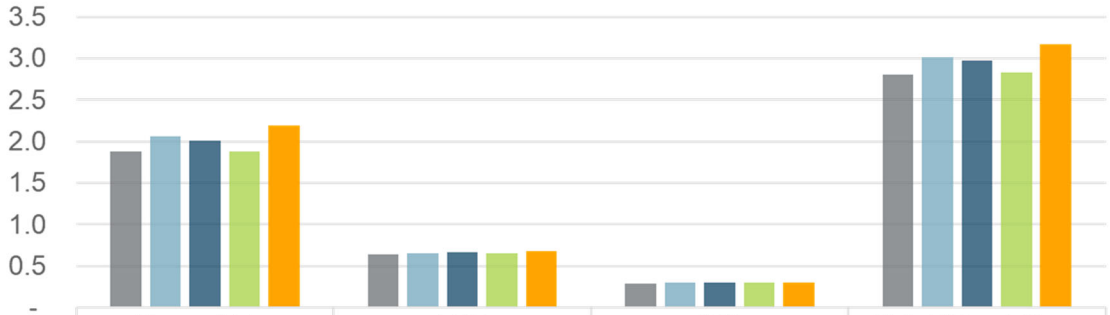
Direct labor hours should be considered in conjunction with case mix index (indicator of resident needs and clinical complexities), requiring different staff time to meet varying resident care needs.

As Filed Medicare Cost Reports, HCRIS, 2020 – 2021

Nursing Facilities Group	State	Direct Care Labor Cost as Percent of Total Facility Cost		Direct Care Labor Cost PPD	
		2020	2021	2020	2021
Maine					
	MVH	29.2%	29.1%	$ 108.90	$ 136.21
Comparison Group					
	Colorado	42.1%	43.0%	$ 141.21	$ 183.60
	Idaho	25.1%	27.1%	$ 93.57	$ 138.07
	Kansas	41.0%	42.8%	$ 176.42	$ 207.89
	Kentucky	18.6%	14.4%	$ 98.07	$ 93.61
	New York	36.8%	28.4%	$ 204.75	$ 262.62
	North Carolina	20.4%	19.3%	$ 129.74	$ 143.32
	Ohio	46.9%	45.3%	$ 166.47	$ 226.64
	Vermont	50.6%	47.8%	$ 283.94	$ 374.32
	Washington	53.9%	62.9%	$ 193.55	$ 273.88
	Wisconsin	29.3%	31.5%	$ 110.67	$ 139.36
		35.0%	**33.7%**	**$ 153.09**	**$ 186.71**
Average All US SVH		**34.7%**	**33.7%**	**$ 137.91**	**$ 171.71**

Appendix L (Workforce Analysis) – SVHs Average

Case-Mix Adjusted Direct Care Hours Per Patient Day | 1st Quarter 2022



	Nurse Aide	LPN	RN	Total Direct Care
Midwest	1.88	0.64	0.28	2.80
Northeast	2.06	0.66	0.30	3.01
South	2.01	0.66	0.30	2.98
West	1.88	0.65	0.30	2.83
Maine	2.19	0.68	0.3	3.17

Case-Mix Index (CMI) is a numerical representation of a resident's care needs complexity, calculated by Minimum Data Set (MDS) assessment. Patients requiring more staff assistance have a higher score. Adjusting hours by CMI allows for comparison of efficiency between facilities with varying patient demographics.

CMS adjusts facility-reported payroll-based journal (PBJ) staffing ratios for case-mix, using the scoring of Resource Utilization Group (RUG-IV) case-mix system.

To find out more about CMS methodology, go to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

Facilities require adequate staffing to meet patient needs. Industry best practice is to adjust staffing based on census and the needs of patients, as excessive staffing may lead to lost productivity, drive cost, and result in diminishing margins.

Minimum staffing levels are mandated by VA and state licensing agencies.

Consistent with CMS 5-Star average rating for staffing, MVH provides more direct care hours per resident per day than peers.

Facilities are required to report this data to CMS (payroll-based journal reports).

Case-Mix Adjusted Direct Care Hours Per Patient Day | 1st Quarter 2022

Region	State	Nurse Aide	LPN	RN	Total Direct Care
Midwest					
	Indiana	1.89	0.65	0.29	2.83
	Iowa	1.70	0.61	0.27	2.58
	Kansas	1.93	0.66	0.31	2.90
	Michigan	1.94	0.60	0.28	2.82
	Minnesota	1.97	0.63	0.27	2.87
	North Dakota	1.74	0.61	0.26	2.61
	Ohio	1.94	0.64	0.27	2.84
	South Dakota	1.61	0.60	0.27	2.49
	Wisconsin	1.85	0.67	0.30	2.82
		1.88	**0.64**	**0.28**	**2.80**
Northeast					
	Maine	2.19	0.68	0.30	3.17
	Massachusetts	Not reported	Not reported	Not reported	Not reported
	New Jersey	1.89	0.63	0.28	2.79
	New York	2.12	0.69	0.33	3.13
	Pennsylvania	1.99	0.63	0.28	2.90
	Vermont	2.00	0.62	0.29	2.91
		2.06	**0.66**	**0.30**	**3.01**
South					
	Arkansas	1.75	0.60	0.27	2.62
	Delaware	2.20	0.60	0.27	3.07
	Florida	2.07	0.68	0.32	3.08
	Kentucky	2.04	0.66	0.30	3.00
	Louisiana	Not reported	Not reported	Not reported	Not reported
	Maryland	2.09	0.67	0.30	3.06
	North Carolina	2.03	0.65	0.30	2.98
	Oklahoma	Not reported	Not reported	Not reported	Not reported
	South Carolina	1.95	0.61	0.26	2.82
	Tennessee	2.07	0.72	0.33	3.13
	Texas	1.96	0.66	0.30	2.92
	Virginia	1.95	0.65	0.30	2.90
		2.01	**0.66**	**0.30**	**2.98**
West					
	Arizona	1.92	0.67	0.31	2.89
	California	1.67	0.60	0.27	2.54
	Colorado	1.94	0.65	0.31	2.89
	Hawaii	1.91	0.63	0.30	2.84
	Idaho	1.92	0.67	0.30	2.89
	Montana	1.79	0.67	0.32	2.78
	Nevada	1.95	0.66	0.29	2.90
	New Mexico	1.87	0.64	0.31	2.82
	Oregon	2.05	0.65	0.28	2.98
	Utah	1.98	0.69	0.34	3.01
	Washington	1.98	0.66	0.29	2.94
		1.88	**0.65**	**0.30**	**2.83**
United States		**1.95**	**0.65**	**0.30**	**2.90**

Appendix M (Workforce Analysis) – U.S. Nursing and Residential Facility Employment and Wages

2019 - 2021

U.S. BUREAU OF LABOR STATISTICS

Bureau of Labor Statistics > Data Tools > Charts and Applications

Quarterly Census of Employment and Wages

Employment and Wages Data Viewer

Private, NAICS 623 Nursing and residential care facilities, U.S. TOTAL
Annual averages 2019 - 2021 , All establishment sizes
Source: Quarterly Census of Employment and Wages - Bureau of Labor Statistics

Summary Change Table Hide

From: 2019 To: 2021	Annual Establishments	Annual Average Employment	Total Annual Wages	Annual Average Weekly Wage	Annual Wages per Employee
2019 Levels	82,413	3,360,911	112,705,133,682	$645	$33,534
2021 Levels	85,697	3,011,110	117,680,926,037	$752	$39,082
Level Change From 2019 to 2021	3,284	-349,801	4,975,792,355	$107	$5,548
Percent Change From 2019 to 2021	4.0%	-10.4%	4.4%	16.6%	16.5%

Table Filter: (Filter Value) Apply Clear Page 1 of 1 < >

Download Source Data Build Another Table Display 75 rows per page

Year	Annual Establishments	Annual Average Employment	Annual Average Weekly Wage	Annual Average Employment Location Quotient	Annual Average Weekly Wage Location Quotient	Annual Average Employment Change Over the Year	Annual Average Employment % Change Over the Year	Annual Average Weekly Wage Change Over the Year	Annual Average Weekly Wage % Change Over the Year
2019	82,413	3,360,911	$645	1.00	1.00	16,003	0.5%	$24	3.9%
2020	83,807	3,192,406	712	1.00	1.00	-168,505	-5.0%	67	10.4%
2021	85,697	3,011,110	752	1.00	1.00	-181,296	-5.7%	40	5.6%

Employment and Wages Data Viewer

Private, NAICS 623 Nursing and residential care facilities, National
2021 - 2022 First Quarter, All establishment sizes
Source: Quarterly Census of Employment and Wages - Bureau of Labor Statistics

Summary Change Table Hide

From: Q1 2021 To: Q1 2022	Quarterly Establishments	First Month Employment	Second Month Employment	Third Month Employment	Total Quarterly Wages	Average Weekly Wage
Q1 2021 Levels	84,686	3,069,815	3,058,408	3,053,578	$27,513,923,768	$692
Q1 2022 Levels	86,411	2,921,613	2,934,377	2,941,511	$29,397,116,112	$771
Level Change From Q1 2021 to Q1 2022	1,725	-148,202	-124,031	-112,067	$1,883,192,344	$79
Percent Change From Q1 2021 to Q1 2022	2.0%	-4.8%	-4.1%	-3.7%	6.8%	11.4%

Nationwide, nursing and residential facility employment has been on a decline, 5% from 2019 to 2020, and further 5.7% from 2020 to 2021. Competition for workers resulted in noticeable wage increases, 10.4% in 2020, and 5.6% in 2021.

First quarter of 2022 shows continuing reduction of employment and increase in wages.

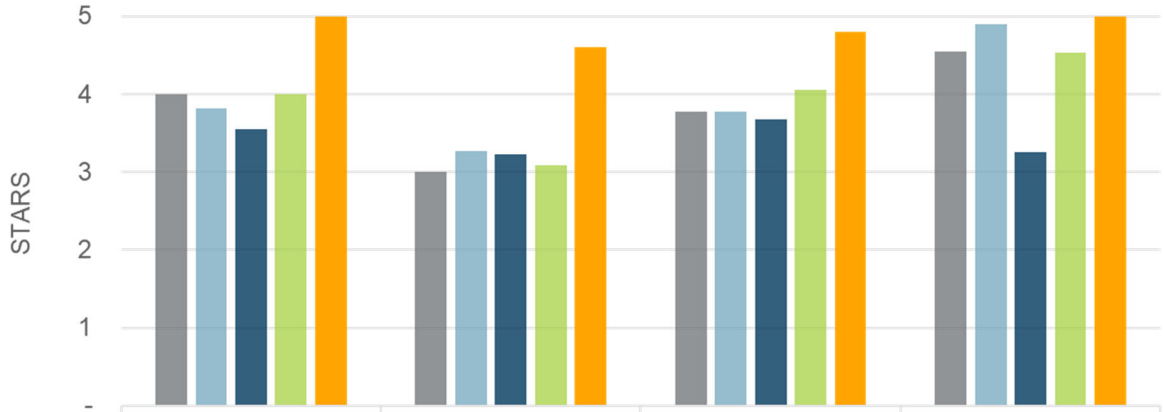
Appendix N (Workforce Analysis) – SVHs Average Nursing Contract Labor

Hours per Resident Day, Utilization, and Cost, 2020 - 2021

Nursing Facilities Group	State	Average Contract Hours PPD		Contract Hours as Percent of Total Direct Care		Average Contract Agency Cost	
		2020	2021	2020	2021	2020	2021
Maine (per as filed MaineCare cost reports)							
	MVH	0.26	0.41	6.01%	8.38%	$ 520,521	$ 698,181
Comparison Group (per as filed Medicare cost reports)							
	Colorado	0.08	0.05	1.19%	0.34%	$ 95,804	$ 124,432
	Idaho	0.61	0.31	4.49%	5.41%	$ 762,959	$ 395,161
	Kansas	1.36	2.02	24.50%	33.40%	$ 1,104,853	$ 1,801,518
	New York	0.25	2.16	2.53%	4.13%	$ 475,323	$ 632,585
	Ohio	Not reported	0.02	0.00%	0.15%	Not reported	$ 23,460
	Vermont	0.74	1.39	12.38%	21.04%	$ 1,841,983	$ 2,968,484
	Washington	0.32	0.33	3.93%	5.29%	$ 414,274	$ 484,177
	Wisconsin	Not reported	1.08	0.00%	6.77%	Not reported	$ 1,411,403
		0.46	**1.07**	**3.49%**	**5.23%**	**$ 597,758**	**$ 831,198**
Average All US SVH		**0.56**	**0.82**	**3.68%**	**5.97%**	**$ 701,261**	**$ 770,463**

Appendix O (Workforce Analysis) – SVHs Average Star Ratings

CMS Provider Information, May 1, 2022, Update



	Overall Rating	Health Inspection Rating	QM Rating	Staffing Rating
Midwest	4.00	3.00	3.78	4.56
Northeast	3.82	3.27	3.77	4.90
South	3.55	3.23	3.68	3.26
West	4.00	3.09	4.06	4.53
Maine	5.00	4.60	4.80	5.00

The highest score a facility can achieve is **five stars**. Higher score is favorable.

MVH have very favorable quality ratings, higher than their peer groups in all regions, in all categories, indicating focus on quality care and quality outcomes.

Providers and consumers are able to access and compare CMS Star ratings by facility location.

Other information available includes detail on quality measures and recent health inspections and surveys.

Appendix P (Workforce Analysis) – SVHs Average Star Ratings by Region and State

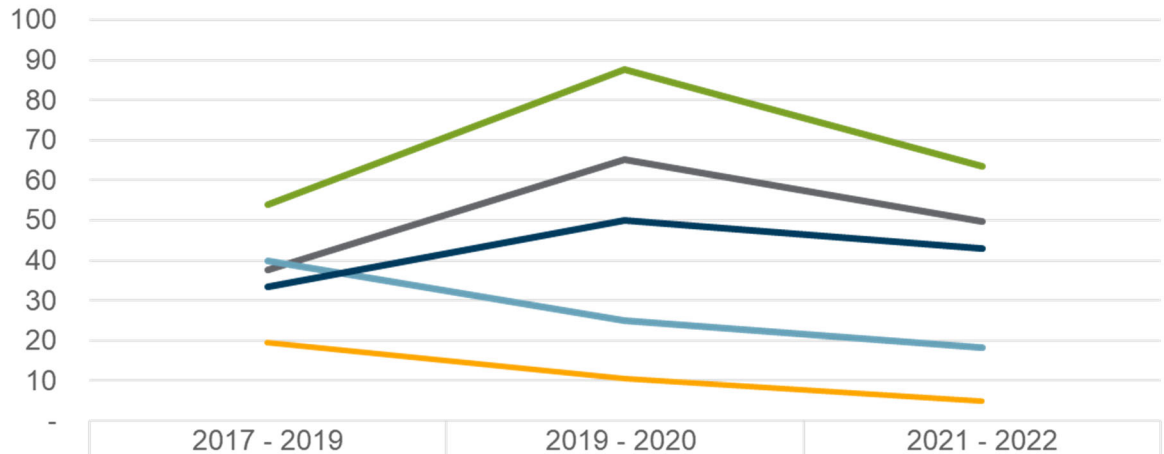
CMS Provider Information, May 1, 2022, Update

Region	State	Overall Rating	Health Inspection Rating	Quality Measures Rating	Staffing Rating
Midwest					
	Indiana	3.00	2.00	2.00	4.00
	Iowa	5.00	4.00	5.00	4.00
	Kansas	3.00	2.00	2.00	5.00
	Michigan	4.00	2.00	5.00	5.00
	Minnesota	4.50	3.25	4.00	5.00
	North Dakota	5.00	5.00	3.00	5.00
	Ohio	4.00	3.00	4.50	4.00
	South Dakota	3.00	4.00	3.00	1.00
	Wisconsin	4.00	2.80	4.20	5.00
		4.00	**3.00**	**3.78**	**4.56**
Northeast					
	Maine	5.00	4.60	4.80	5.00
	Massachusetts	3.00	2.00	5.00	Not reported
	New Jersey	3.00	2.00	4.00	5.00
	New York	3.67	3.50	3.50	4.60
	Pennsylvania	3.67	3.00	3.17	5.00
	Vermont	3.00	2.00	2.00	5.00
		3.82	**3.27**	**3.77**	**4.90**
South					
	Arkansas	2.50	1.50	4.00	2.50
	Delaware	4.00	2.00	5.00	5.00
	Florida	3.67	3.33	3.17	4.67
	Kentucky	5.00	4.50	4.00	5.00
	Louisiana	4.00	5.00	1.00	1.00
	Maryland	2.00	2.00	3.00	2.00
	North Carolina	2.75	2.75	4.00	2.00
	Oklahoma		New facility – ratings not available		
	South Carolina	4.00	3.00	3.50	4.00
	Tennessee	4.50	3.50	3.75	4.25
	Texas	2.89	2.56	4.22	2.22
	Virginia	3.00	2.50	3.50	4.00
		3.55	**3.23**	**3.68**	**3.26**
West					
	Arizona	3.50	3.00	3.50	4.00
	California	4.33	3.33	4.17	5.00
	Colorado	4.40	3.20	3.80	5.00
	Hawaii	3.00	2.00	4.50	5.00
	Idaho	4.00	3.00	4.67	5.00
	Montana	4.50	3.50	4.00	5.00
	Nevada	4.50	3.00	5.00	5.00
	New Mexico	2.50	2.00	3.00	3.00
	Oregon	4.00	2.50	4.00	4.50
	Utah	4.75	4.25	5.00	4.00
	Washington	3.25	2.75	3.00	3.75
		4.00	**3.09**	**4.06**	**4.53**
United States		**3.81**	**3.16**	**3.83**	**4.16**

Appendix Q (Workforce Analysis) – SVHs Average

Health Score Trending, Annual Surveys | 2017 – 2022

CMS Provider Information, May 1, 2022, Update



	2017 - 2019	2019 - 2020	2021 - 2022
Midwest	37.56	65.11	49.83
Northeast	39.95	25.09	18.36
South	33.38	49.88	42.95
West	53.88	87.71	63.44
Maine	19.6	10.4	4.8

Midwest Northeast South West Maine

CMS calculates ratings for the health inspections based on the number, scope, and severity of deficiencies identified during the annual inspection surveys. All deficiency findings are weighted by scope and severity. More serious, widespread deficiencies receive more points. **Lower numbers are favorable**, indicating fewer or less severe findings. Life safety surveys are not included in this calculation.

MVH have been consistently demonstrating strong regulatory compliance based on annual health survey scoring.

To find out more about CMS methodology, go to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

Health Score Trending, Annual Surveys, by State | 2017 – 2022

CMS Provider Information, May 1, 2022, Update

Region	State	2017 – 2019	2019 - 2020	2021 - 2022
Midwest				
	Indiana	32.00	64.00	80.00
	Iowa	36.00	8.00	Not reported
	Kansas	110.00	74.00	47.50
	Michigan	28.00	194.00	119.00
	Minnesota	49.00	83.00	14.00
	North Dakota	4.00	Not reported	16.00
	Ohio	28.00	8.00	70.00
	South Dakota	4.00	24.00	20.00
	Wisconsin	20.00	77.20	74.20
		37.56	**65.11**	**49.83**
Northeast				
	Maine	19.60	10.40	4.80
	Massachusetts	32.00	64.00	60.00
	New Jersey	104.33	22.67	14.67
	New York	22.67	16.67	13.33
	Pennsylvania	46.67	44.67	24.00
	Vermont	20.00	Not reported	52.00
		39.95	**25.09**	**18.36**
South				
	Arkansas	128.00	115.00	97.50
	Delaware	96.00	148.00	96.00
	Florida	18.67	52.83	26.00
	Kentucky	9.00	14.00	7.00
	Louisiana	4.80	3.20	Not reported
	Maryland	24.00	68.00	131.00
	North Carolina	40.75	14.00	57.00
	Oklahoma		N/A - New Facility	Not reported
	South Carolina	14.00	40.00	32.00
	Tennessee	11.00	7.00	19.00
	Texas	54.22	94.22	57.56
	Virginia	32.00	74.00	113.00
		33.38	**49.88**	**42.95**
West				
	Arizona	32.00	50.00	40.00
	California	48.00	80.00	53.83
	Colorado	48.80	52.80	35.20
	Hawaii	138.00	231.00	40.00
	Idaho	28.00	116.67	198.00
	Montana	68.00	36.00	24.00
	Nevada	20.00	32.00	42.00
	New Mexico	110.00	179.50	88.00
	Oregon	22.00	104.50	58.00
	Utah	14.00	16.00	27.00
	Washington	85.00	139.50	93.00
		53.88	**87.71**	**63.44**
United States		**41.20**	**58.78**	**45.40**

Appendix R (Demographic Demand Projection) – Percent Change in Veterans 65+ From Decade to Decade

Location	Number of Veterans 65+ Served Within Service Area Population			Percentage decrease from Prior Decade	
				2030	2040
	2020	2030	2040		
Augusta	23195	20522	15524	-11.5%	-24.4%
Bangor	11301	9738	7280	-13.8%	-25.2%
Caribou	5480	4740	4034	-13.5%	-14.9%
Machias	11917	10628	8070	-10.8%	-24.1%
Scarborough	17539	15797	12067	-9.9%	-23.6%
South Paris	19352	13605	13324	-29.7%	-2.1%

Source: https://www.va.gov/vetdata/veteran_population.asp

Appendix S (Demographic Demand Projection) – Service Area Definitions, Veterans 65+

SERVICE AREA DEFINITIONS, VETERANS 65+		
Year: 2022 (Jan-July)		
Augusta		104 Patients
Primary	56%	Kennebec
Secondary	39%	Lincoln, Waldo, Sagadahoc, Penobscot, Piscataquis, Knox, Hancock,
		Somerset, Franklin, Cumberland, York, Androscoggin, Oxford
Out of State	5%	N=4
Bangor		115 Patients
Primary	75%	Penobscot
Secondary	23%	Cumberland, Piscataquis, Hancock, Waldo, Washington, Knox,
		Kennebec, Somerset
Out of State	2%	
Caribou		52 Patients
Primary	81%	Aroostook
Secondary	13%	Penobscot, Franklin, Waldo, Somerset
Out of State	8%	
Machias		26 Patients
Primary	61%	Washington
Secondary	19%	Kennebec, Hancock, York, Penobscot, Cumberland
Out of State	15%	
Scarborough		120 Patients
Primary	61%	Cumberland
Secondary	31%	Androscoggin, York, Oxford, Sagadahoc, Kennebec, Knox, Waldo
Out of State	18%	
South Paris		78 Patients
Primary	45%	Oxford
Secondary	49%	Somerset, Cumberland, Androscoggin, York, Kennebec, Lincoln, Washington,
Out of State	6%	
Source:	https://www.va.gov/vetdata/veteran_population.asp	

Appendix T (Demographic Demand Projection) – Information Sources

Sources used for this study include the following:

1. AARP Public Policy Institute, "Across the States Profiles of Long-Term Services and Supports, 2018. https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf
2. CDC study of national long-term care providers: https://www.cdc.gov/nchs/npals/Survey-methodology-document03152021.pdf
3. Census and Maine population data:
    1. https://www.multpl.com/united-states-population/table/by-year
    2. https://www.populationu.com/us/maine-population
4. Anticipated demand for nursing home beds 2019 – 2029:
    1. va.gov/AIRCommissionReport, Vol II: Market Recommendations VISN 01 Far North Market, p. 22 based on VA's Enrollee Health Care Projection Model in bed days of care
5. CMS' Nursing Home Compare Website, https://www.medicare.gov/care-compare/results?searchType=NursingHome&page=4&state=ME&sort=alpha
6. 2019 GAO report: https://www.gao.gov/assets/gao-19-428.pdf
7. Internal data from BerryDunn archives
8. Internal data from MVH
9. KFF, Projections of Nursing Home Use 2015 – 2022, https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?activeTab=graph&currentTimeframe=0&startTimeframe=7&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
10. Maine Office of State Economist
    1. https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/MaineStateCountyPopulationProjections2038.pdf
    2. https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/Maine%20Population%20Outlook%20to%202028%20-%20Corrected.pdf
11. National Library of Medicine, Use of residential/assisted living beds nationally: https://www.ncbi.nlm.nih.gov/books/NBK51841/

12. Veterans 65 – 84 and 85+ by County 2020 – 2040, https://www.va.gov/vetdata/veteran_population.asp

13. Veterans Population Tables, https://www.va.gov/vetdata/veteran_population.asp

Appendix U (Demographic Demand Projection) – Number of Veterans by State, 2022

Region/State	Number of Veterans	Veterans per Capita
Midwest		
Illinois	553,593	4,322
Indiana	372,074	5,435
Iowa	178,481	5,544
Kansas	172,750	5,846
Michigan	532,394	5,263
Minnesota	291,453	5,036
Missouri	391,513	6,327
Nebraska	113,567	5,711
North Dakota	46,288	5,783
Ohio	685,905	5,787
South Dakota	55,969	6,211
Wisconsin	319,280	5,380
	3,713,267	**66,645**
Northeast		
Connecticut	160,142	4,433
Maine	101,652	7,424
Massachusetts	290,648	4,078
New Hampshire	93,326	6,715
New Jersey	313,928	3,344
New York	676,295	3,321
Pennsylvania	731,411	5,599
Rhode Island	52,128	4,712
Vermont	34,915	5,400
	2,454,445	**45,027**
South		
Alabama	324,857	6,403
Arkansas	191,786	6,328

Region/State		Number of Veterans	Veterans per Capita
	Delaware	65,065	6,453
	Florida	1,416,472	6,414
	Georgia	625,251	5,727
	Kentucky	257,452	5,672
	Louisiana	239,881	5,123
	Maryland	357,261	5,709
	Mississippi	164,687	5,564
	North Carolina	654,365	6,162
	Oklahoma	266,895	6,671
	South Carolina	360,355	6,907
	Tennessee	428,519	6,101
	Texas	1,435,527	4,794
	Virginia	674,242	7,699
	West Virginia	125,084	7,020
		7,587,699	**98,746**
West			
	Alaska	64,765	8,775
	Arizona	491,239	6,726
	California	1,525,746	3,815
	Colorado	370,677	6,259
	Hawaii	97,478	6,612
	Idaho	115,549	6,103
	Montana	85,401	7,741
	Nevada	205,659	6,456
	New Mexico	141,558	6,648
	Oregon	273,946	6,344
	Utah	120,198	3,563
	Washington	517,912	6,555
	Wyoming	44,403	7,662
		4,054,531	**83,260**
Total		**17,809,942**	**293,678**

Appendix V (Demographic Demand Projection) – SVHs Beds Availability and Veteran Population Statistics

Region/State	Number of SVHs	Number of SVHs beds	Average Number of Veterans, Age 65+	VA Maximum Number of SVHs beds, FY2022	Average Number of Aged Veterans per SVHs bed
Midwest					
Illinois	5	1,366	287,237	1,754	445
Indiana	1	417	186,775	1,216	975
Iowa	1	560	95,667	578	346
Kansas	2	441	88,416	518	443
Michigan	3	904	289,578	1,786	622
Minnesota	4	824	161,942	1,058	381
Missouri	7	1,350	196,216	1,257	308
Nebraska	4	644	57,477	371	195
North Dakota	1	150	21,977	137	355
Ohio	2	800	346,283	2,143	912
South Dakota	1	100	29,170	179	654
Wisconsin	3	991	176,175	1,062	353
	34	**8,547**	**161,409**	**12,059**	**499**
Northeast					
Connecticut	1	553	88,719	559	311
Maine	6	628	56,696	362	179
Massachusetts	2	502	159,139	944	616
New Hampshire	1	250	49,803	361	405
New Jersey	3	948	177,796	992	357
New York	5	1,220	372,702	2,209	612
Pennsylvania	6	1,662	397,410	2,336	463
Rhode Island	1	286	30,930	157	218
Vermont	1	138	20,699	142	305
	26	**6,187**	**150,433**	**8,062**	**385**
South					
Alabama	4	704	153,196	1,007	511

Region/State	Number of SVHs	Number of SVHs beds	Average Number of Veterans, Age 65+	VA Maximum Number of SVHs beds, FY2022	Average Number of Aged Veterans per SVHs bed
Arkansas	2	204	96,809	653	1,034
Delaware	1	180	36,535	207	394
Florida	6	869	756,009	4,049	1,720
Georgia	2	684	267,654	1,975	1,009
Kentucky	4	681	124,302	818	415
Louisiana	5	816	117,060	638	342
Maryland	1	454	153,126	1,102	821
Mississippi	4	600	74,813	480	312
North Carolina	4	499	301,843	1,900	1,409
Oklahoma	7	1,423	129,009	766	205
South Carolina	4	796	174,875	1,089	495
Tennessee	4	528	205,317	1,311	859
Texas	9	1,330	615,116	4,119	1,178
Virginia	2	440	264,148	1,903	1,608
Washington D.C.	0		11,651	83	
West Virginia	2	270	66,207	406	501
	61	**10,478**	**208,687**	**22,506**	**801**
West					
Alaska	1	79	22,775	179	904
Arizona	2	344	254,878	1,520	1,477
California	6	2,703	773,973	4,363	608
Colorado	5	624	160,183	1,114	618
Hawaii	1	95	45,509	268	1,186
Idaho	3	290	62,413	394	440
Montana	3	257	41,953	281	347
Nevada	2	276	100,401	649	796
New Mexico	2	192	71,706	417	780
Oregon	2	305	142,419	907	932
Utah	4	417	58,945	426	319

Region/State	Number of SVHs	Number of SVHs beds	Average Number of Veterans, Age 65+	VA Maximum Number of SVHs beds, FY2022	Average Number of Aged Veterans per SVHs bed
Washington	4	545	247,262	1,687	1,012
Wyoming	1	116	21,254	154	404
	36	**6,243**	**154,128**	**12,359**	**756**
Unincorporated					
Puerto Rico	1	240	47,364	288	339
U.S. SVHs	**158**	**31,695**	**170,952**	**55,274**	**636**

Appendix W (Focus Groups) – Focus Group Questions

Below are the questions used for the focus groups. These are organized into the three focus groups conducted. The same questions were used across focus groups conducted in Caribou, Machias, and South Paris.

Residents and Family Members

1. Why did you seek Maine Veterans' Homes as a care provider? What specifically attracted you to Maine Veterans' Homes?
2. Describe your experience at Maine Veterans' Homes and with their services.
3. What services could you not find at Maine Veterans' Homes or in the community?
4. How do you balance the choice of a local healthcare services versus traveling for healthcare services?
5. What are your thoughts on telehealth services to help support yourself or a family member? Are you currently using telehealth services?
6. If you had access to home healthcare and related support services, would your preference be to keep you family member at home?
7. Have you or your family member been impacted by the direct care labor market challenge and, if so, how?

MVH Staff and Other Community Providers

1. Do you feel residents of Maine Veterans' Homes value being at Maine Veterans' Homes? If so, why? For Maine Veterans' Homes staff, what benefits do you see residents receiving? For community providers, why do you refer to or collaborate with Maine Veterans' Homes for your patients?
2. What specific services and benefits are Maine Veterans' Homes residents most benefiting from?
3. What services are not currently offered, but are needed in the community?
4. Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?
5. What are barriers to aging at home in this community, if any?
6. How does geography play into where you refer residents to for services?
7. Why did you seek out Maine Veterans' Homes as an employer?
8. What are the biggest challenges for recruiting and retaining employees?

Civic and Community Leaders

1. Do you view Maine Veterans' Homes as a valuable member of this community and if so, why?
2. As members of this community, what long-term support services are veterans and members of the community seeking?
3. What services are not offered and are needed in the community?
4. Is regional planning and coordination of care for veteran services and long-term support services occurring in the community? If so, to what extent?
5. Are there barriers to aging at home in this community? If so, what are they?
6. What are the biggest challenges for recruiting and retaining healthcare employees in this geographical market? What suggestions do you have that would improve the ability to recruit and retain healthcare employees?
7. What type of support does this community need to attract more services or facilities to serve the needs of its aging population?

Appendix X (Focus Groups) – Example of Feedback Form

Below is the feedback form BerryDunn provided to the nine focus groups. This allowed feedback on different attributes of healthcare as well as additional comments that did not come up during the focus group discussion.

Focus Group Session

Rank Order Exercise

Please rank the following attributes of healthcare in order from 1 to 5. With 1 being the most important and 5 the least. Use each number only once.

Rank	Attribute of Healthcare
	Location
	Availability / Wait Time
	Quality
	Veteran specific experience
	Cost

Additional Comments

1

Appendix Y (Focus Groups) – Public Comment Survey

Below is the electronic survey BerryDunn provided for public comment. This was available and open until November 28, 2022. It was shared via public advertisement in local newspapers in the three communities of focus.