Island Nursing Home Task Force

Executive Summary & Appended Reports

The following Executive Summary and appended reports are presented to the Board of the Island Nursing Home by the Island Nursing Home Task Force on

December 16, 2021

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EXECUTIVE SUMMARY

The Island Nursing Home Task Force was created by the Board of INH in September 2021 to review nursing home regulations and establish time oriented goals for the future of INH. The Task Force adopted as its mission:

> *To evaluate and recommend to the Board a long-term sustainable plan for reopening the INH facility to serve seniors from the Island and the Blue Hill Peninsula.*

Consistent with this mission statement, the goal of the task force was to define a sustainable mix of skilled nursing, long-term care, residential, and rehabilitation services for seniors that could be implemented at INH as soon as possible. Regulatory restrictions on INH's operating license require a restart of nursing home services as early as October 2022 and no later than February 2023, absent any extensions of those dates.

The Task Force has met weekly since its creation. It divided its focus on the three structural cornerstones that are the foundations for reopening of INH: staffing, housing, and management. To that end, three subcommittees of the Task Force were created: Recruitment and Retention, Affordable Housing, and Operations and Management. These subcommittees have met at least weekly for the past two months. Their members have interviewed or met with representatives of staffing agencies, builders, real estate agents, media, and representatives from other nursing home facilities to independently verify and build on information shared by INH's Board, management, staff, accountants and attorneys.

CONSULTANT

After consideration of other options and possible affiliations, the Management and Operations subcommittee concluded that professional consulting services were needed to advise the Task Force and the Board on developing a viable plan for reopening INH. The Board agreed and recently entered into an agreement engaging Covenant Health System as its consultant. Members of the Task Force and the Board have had many conversations with Covenant including a recent joint meeting with Philip Hickey, System Vice President of Covenant, who will be its hands-on representative for INH, as well as his boss, Gerard Foley, President of Covenant. Covenant has recently toured the facility and met key retained INH personnel. It is hoped by all that Covenant will find reopening to be a viable alternative and that it and the INH Board can proceed with Covenant's taking on an advisory role in the reopening. It is intended that the INH Board will continue to maintain its role in any advisory/management agreement. The relationship with Covenant can bring access to staffing solutions, joint buying of supplies and equipment and support for INH management and advisory services that was so in need when INH was relying on its own resources. If a viable plan for reopening is developed, the Board can then decide the form a continuing relationship with Covenant might take.

HOUSING

The one important area in which Covenant cannot be helpful is in the critical need for affordable housing. Access to affordable housing for INH staff is an area where the communities on the

Island and Peninsula must come together, surface existing housing resources and ultimately plan, finance and construct affordable housing to be available for INH staff. The creation of new housing could be under the auspices of the INH Board if it should acquire the housing development and management expertise, but is probably better handled through an experienced developer such as Island Workforce Housing or a private housing developer. After reviewing staffing requirements presented by the Recruitment and Retention subcommittee, the Affordable Housing subcommittee recommends development of as many as 20 new housing units. A reopening capital campaign should include not less than $2 million for construction of new housing representing approximately 35% of the total estimated cost. The balance, or an additional $3.5 million, hopefully can be financed by obtaining a long- term amortizing loan secured by the project. Such a project is likely to take two to three years to complete. The interim staff housing needs must be filled using existing housing resources from the communities. Some indication of local availability of housing for such a period has come forward and hopefully more will follow.

GOVERNANCE

A strong INH Board is critically important in the reopening of the nursing home. Engagement with the consultant, developing new management and staffing, and getting the support of the communities to raise the capital necessary to fund the reopening and needed housing objectives require a strong committed Board. Through the travails of the past few months, the Board has lost some members and recently added some new members. **Continuity of membership and purpose are essential for the Board to attract the community support necessary for a plan to reopen**. The Task Force recommends that the Board engage a consultant to assist the Board in organization and governance and in focusing on the need to add additional knowledgeable community members to provide expertise in development, housing and community relations. The strength and commitment of the Board will be a key consideration in Covenant's conclusions as to the viability of INH for the future. The Island and Peninsula communities definitely believe INH is a treasure, but will look to the leadership of the Board to show that it is worthy of their support.

RECRUITMENT AND STAFFING

The numbers and qualifications of staff needed for a reopened INH are dependent on the mix of skilled nursing, long-term care, residential and rehabilitation services that the Board, in concert with the Consultant and the management team, determines to be the most viable combination. Staffing requirements would be smaller initially as INH reopens, but would ramp up quickly as more beds and services and resident count increased. Based on discussions with retained staff, the Recruitment and Retention subcommittee estimates that staffing needs other than direct care can be recruited locally. Nursing and direct care staff (RNs, LPNs, CNAs, CNA-Ms, and PSS/CRMAs) will require a combination of locally recruited staffing and long-term contract staffing. Hopefully, a number of former direct care staff can be brought back to INH and that should constitute a recruitment priority. Based on staffing ratios over the past three years, contracted staff have made up as much as two-thirds of direct care staff. Discussions with Covenant and Infinity Care Partners indicate that nursing staff are available from qualified Filipino nurses who come fully licensed with 3-year minimum contracts. Some direct care staff other than nurses may be sourced from abroad as well. Plans are underway to expand the CNA

students in the Island Adult education program to attract more local candidates. Other concerns discussed by the subcommittee in its full report include consideration of wage and benefit packages (including affordable housing support), and scheduling. A critical concern expressed by former staff involves being forced to take double shifts when employee child care wasn't available for scheduled staff or illness created absences. The Covid 19 pandemic has definitely placed increased burdens on INH staff in this regard. Staff communication with management and the Board have created additional issues that must be addressed in any reopening plan. INH has traditionally had a strong feeling of teamwork and "family." It is important to bring that atmosphere back to the facility.

CRITICAL ISSUES FOR IMMEDIATE ATTENTION

The Task Force believes that certain cornerstones must be laid in the next 45-60 days as prerequisites to any reopening plan:

1. The Board and retained staff must work closely with Covenant to provide it with necessary historical information and show Covenant the strength of community support of the Board and of a plan to reopen INH.
2. The Board must come together as a cohesive group dedicated to reopening INH and convince the Island and Blue Hill Peninsula communities of its ability, focus and commitment to do so.
3. The Board, Covenant and retained staff must develop a plan for reopening INH including a timetable for staffing, resident mix, licensing and operations.
4. The Board needs to develop an operating and capital fund raising plan for reopening in the range of $1 million and seek the support of key major donors to be included in the process.
5. The Board must review potential affordable housing building sites, select a developer, research needs and plan a fund raising campaign for as much as $2 million for affordable housing for INH staff. Key potential donors should be identified and included in the planning.
6. Continued solicitation by Board and retained staff of community housing resources is necessary to bridge the 2 to 3 year gap before new housing can be constructed and becomes available.
7. Plans for bringing nurses from the Philippines need to be finalized and related contracts and deposits signed and made.
8. INH needs to work with the CNA training programs to recruit and finance participants and remain in contact with former employees and keep them involved in reopening plans.

THE INH TASK FORCE

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Genevieve McDonald, Vice Chair	Roberta Greenlaw Johnson	Gail Senecal
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Ronda Dodge	Peter Roth	

Attachments: A. Report of Management and Operations subcommittee
B. Report of Staffing Recruitment and Retention subcommittee
C. Report of Affordable Housing subcommittee

ATTACHMENT A

Island Nursing Home Task Force
Management and Operations Subcommittee
Final Report and Recommendations
December 14, 2021

1. Assessment of Long Term Viability

Financial Condition

The Island Nursing Home (INH) faces many of the same challenges being experienced by many of the country's small, rural, independent Long Term Care (LTC) facilities. Largely supported by Medicaid reimbursement, these facilities struggle to balance revenue and expenses while at the same time trying to attract and retain staff from an ever-tightening pool of qualified care givers. The recent national shocks provided by Covid and a local shortage of affordable staff housing have pushed many LTC facilities to the brink of closing -- or actual closing, as is the case with INH.

Prior to the emergence of Covid and the staffing crisis, INH had been largely able to balance its revenues and expenses. This situation was made possible by (1) careful financial and operational management, (2) stable patient and resident activity, (3) no long-term debt service, (4) generous community support, and (5) some success in providing additional and more highly reimbursed skilled nursing and therapy services. The recent staffing crisis has of course changed this situation and led to the INH closure. Having reviewed the financial statements and operational trends of INH beginning with Fiscal Year 2018 and continuing through September 2021, it is the assessment of the subcommittee that financial viability continues to be a possibility if adequate staffing can be obtained and effective strategic, financial and operational management continues. The subcommittee recommends that this preliminary assessment should be confirmed by a far more rigorous review undertaken by the INH Board together with a firm specializing and knowledgeable in regional LTC matters.

Service Needs Assessment

As mentioned above, Patient and resident activity at INH has been stable for the preceding several years, and the population needing and seeking INH services appears likely to remain at least stable going forward. There are always swings in healthcare trends, but the ongoing shortage of community LTC beds continues to affect the timely discharge of patients in acute care settings. Acute care hospitals cite this fact as a key limiting factor in their bed availability. Careful investments in staff and facilities might allow INH to resume meeting the needs for skilled nursing and rehabilitation services in the community.

Although there are new senior facilities opening throughout the State which offer the complete array of services, from independent living -- to assisted living -- to LTC, most such facilities do

not serve the principal population of residents and patients that has been served by INH. INH serves largely a Medicaid patient/resident population, with a more limited short term Medicare skilled nursing/therapy population. In contrast, these newer senior facilities do not normally accept Medicaid patients.

The subcommittee also recognizes that demographics support the continued viability and importance of INH's mission to serve its local senior population. Maine has one of the country's oldest average aged populations and Hancock County has one of the oldest aged populations in Maine.

Longer term, there have been discussions nationally about additional federal financial support for LTC. Given the huge potential cost involved in making LTC more available for the general population, this federal program no doubt would receive significant review before ever going forward. If it did, it would benefit INH. From a state perspective, it is also unlikely that there will be a significant amount of additional Medicaid LTC resources being made available in the near future, although such additional state Medicaid resources could benefit INH as well if available.

Historic Patient and Resident Satisfaction

The subcommittee did not review any formal patient or resident satisfaction data for INH, although the Task Force as a whole has reached out to the community for its input in multiple ways. The Task Force held meetings with both the Stonington and Deer Isle Selectmen/Town Managers, convened a discussion with former INH employees, and conducted a community wide zoom meeting with over 50 area residents. These discussions have been wide ranging on a number of topics. Patient and resident satisfaction has not been raised as an issue at any of these meetings. Additionally, given the small size of the communities being served, and the sensitivity of adverse satisfaction data, the lack of discussion around these issues gives the subcommittee some degree of comfort that the community has been satisfied with the care at INH and that this issue does not currently threaten the long-term viability of INH.

Philanthropy

The financial assessment revealed the strength of past community support for INH. Endowment, capital, and annual appeals campaigns have provided INH with generous support and no long-term debt. Looking forward to a possible re-opening, there will be significant costs incurred prior to re-opening as (i) staff is hired and trained, and (ii) facilities are prepared, for the re-opening. These pre-opening costs likely will not be reimbursed from future income and, depending on the phasing of the bed complement's re-opening, these costs could well exceed $500,000. During the subcommittee's investigations, one LTC financial professional projected that these costs could surpass one million dollars if a large number of beds were opened initially. Additionally, once beds are re-opened and billings begin for services provided, there will be a lag time from when services rendered until payments are received. This lag time will require short-term financing until service payments are received.

The accompanying Housing Subcommittee report has evaluated interim and long-term options for providing housing which the INH staff can afford. In addition to long term debt financing for

any affordable housing project, there will also likely be a need for an accompanying capital fundraising campaign approaching $2,000,000. These funds will be critical to ensuring INH's long-term viability.

There appears to be strong community support for a re-opening of INH. Philanthropy would be a perfect source for the funding of both the unreimbursed costs relating to re-opening as well as the costs relating to staff housing development and rental support. The INH board should strongly consider mounting a community fundraising campaign as soon as the re-opening and housing development budgets are finalized. INH's current viability has in part resulted from past and generous community support. Hopefully this good fortune can be repeated.
In addition to philanthropy, INH should also pursue any federal or state Covid or non-Covid related funding which might be available to support re-opening of needed LTC facilities.

Staff Morale and the Ability to Attract and Retain Employees

A staffing crisis resulted in the closure of INH. A solution to this staffing crisis is the key determinant to LTC's long-term viability. The Recruitment and Retention Subcommittee is focused on this issue. It is mentioned here only to insure that this topic is always front and center with any discussion regarding INH's long term viability.

2. Management and Governance Options

Assessment of Current Management and Governance Structure

INH is currently structured as an independent, non-profit organization dedicated to serving the needs of the local senior population. This has been the common model for most small rural LTC facilities. The INH Board hires an administrator to (1) provide assistance in the development of strategic plans and objectives, (2) implement those strategic plans, and (3) manage day-to-day operations.

This independent governance and management model allows for maximum local control over the affairs of INH. Policies, procedures, and priorities can be customized to best meet the community's needs. On the flip side, the Board must be constantly appraising the national and regional LTC environment for future challenges which it must successfully face. Likewise, the Board must attract and retain an experienced and capable administrator able to garner the respect and support of INH staff. Ideally this person could also be an important INH interface with the community for general support as well as philanthropy. As is the case with its clinical staff, attracting such an individual given INH's size and remote location can be very difficult. These challenges facing the Board could be eased via alternative governance and management structures that the subcommittee believes the Board should consider. Attracting qualified leadership may be easier if INH is in some way affiliated with a larger regional network of providers.

Alternative Structures

There are several alternatives for consideration. At one extreme would be a sale of INH to a national or regional network of healthcare facilities on the condition that the INH continues to serve the needs of the Island and the Peninsula. The purchasing entity could be either a non-profit or a for-profit network. There are multiple advantages for INH's membership in a regional network. Most significant would be INH's access to the expertise, services, economies of scale and capital provided by its membership in a larger network. The loss of financial autonomy and local community control are the most obvious disadvantages.

Another alternative for consideration would be membership in a regional network without the loss of financial autonomy and community control. Such an arrangement would allow INH to remain completely autonomous as an independent non-profit community organization. As an independent organization, INH would be joining a network of other LTC facilities -- some independently owned and operated like INH, as well as some owned and operated by the company organizing the network. Membership in such a network usually requires an annual membership fee as well as one-time and/or ongoing expenses for additional services sub-contracted from the network. Such additional services might include access to master contracts for US and overseas contracted labor, beneficial group purchasing arrangements, and the provision of an administrator, director of nursing, or other key management staff. Access to shared electronic medical records or billing systems are types of services that might be sub-contracted.

A third alternative would be to not join a regional network but to rather seek specific expertise and services on an as-needed basis from appropriate consulting organizations. These consulting organizations can often be subsidiaries of the same regional networks. This final alternative allows for a high degree of local autonomy, but also requires more independent expertise and involvement on the part of the Board.

The subcommittee's recommendation on the advisability of an alternative governance and management structure is provided after the following discussion of potential regional partners below.

Potential Regional Partners and Recommendations

The Subcommittee considered three regional networks for possible affiliation. They were Northern Light, North Country Associates, and Covenant Health. Neither Northern Light nor North Country Associates were in a position to consider any form of affiliation or consulting arrangements with INH. North Country Associates, the largest LTC network in Maine, currently is in the process of closing two of its facilities due to similar staffing problems as those INH faced, and a third facility is undergoing a major management realignment which is currently North Country Associates' first priority for consulting services. In addition, North Country Associates is looking forward strategically to focus its energies and resources in LTC facilities closer to urban areas where staff recruitment and retention may well be more successful. So it is not pursuing rural locations at this point.

Northern Light's LTC division, like INH and North Country Associates, is also struggling with staffing issues and these challenges make it impossible for them to consider affiliation arrangements with INH at this time.

The response from Covenant Health was far more open to working with INH. The Covenant network has 20 facilities in New England and Pennsylvania. Four of these facilities are in Maine. Facilities either join the network as independently-owned members availing themselves of the services and expertise available from network membership or they sell their assets to Covenant and are owned and operated by Covenant. One of the Maine facilities, in Bangor, has recently moved from being an independently-owned member to being owned by Covenant. The other three Maine facilities are independently-owned members.

Our conversations with Philip Hickey, Covenant Health System's Vice President for Post-Acute Care-Maine and President of d'Youville Pavilion (a 210-bed facility in Lewiston), were wide ranging and productive. We found him to be very experienced, positive and creative in his approach to problem solving, and flexible in how INH might affiliate with Covenant. Importantly, given the still small size of the Covenant network in Maine, Mr. Hickey would be the principal involved in working with INH. We believe his personal involvement would be a major plus.

After a review of INH's situation we concluded that a phased approach would be the best recommendation for an INH affiliation with Covenant. We suggested, and Mr. Hickey agreed, that an initial phase of work might be a short-term consulting engagement with INH where he first performed a more comprehensive review and determination of the long term viability of INH. If he concluded that INH could be viable given staffing availability, he would then prepare a reopening plan and associated budget for INH.

Assuming INH and Covenant are satisfied with the outcome of this consulting engagement, the two organizations could then explore an affiliation agreement. This agreement could take many different forms but would probably have INH becoming an independently-owned member (Affiliate Member) taking advantage of specific services from Covenant. We are hopeful that, over the near term, the current administrator-in-training will continue to develop as the potential INH administrator. However, if this is not the case, INH and Covenant might consider alternative arrangements whereby Covenant provides more significant management services for INH.

3. Immediate Board and Management Priorities

Assuming that the INH board accepts the above-stated recommendations and agrees to engage Covenant first as a consultant and, subsequently, as an independently-owned member in the Covenant network, there will be multiple important tasks ahead leading to re-opening. These tasks are highlighted below for consideration and are in addition to those being recommended both by the Housing and Recruitment and Retention subcommittees.

Implement Interim Management Leadership Plan

INH does not currently have an administrator. There will be an immediate need for interim leadership until such time as a new full-time administrator is appointed, which may not be until 120 days prior to re-opening. At a minimum, there will be building management needs that will need attention. These interim management responsibilities might be carried out by the current administrator-in-training with back-up support provided by Covenant, among other options.

Complete Board Recruitment

It is the understanding of the Subcommittee that there are currently, and will be after the first of the year, several vacant INH Board positions. As emphasized here and obviously known by current members of the Board, INH Board membership is more than an honorary or casual volunteer position. In order to ensure the continued viability of INH, the Board needs to be constituted as a committed group of members with specific, targeted skills and talents. Among the talents and qualifications that are needed for current and future Board members are:

1. Respected Island and Peninsula Community Voices
2. Fundraising Skills and Experience
3. Healthcare Management and Financial Skills
4. Awareness of Senior Service Needs
5. Clinical Background to Monitor Quality of Care
6. General Management Skills for Housing and Physical Facility Management

It is the impression of the subcommittee that vacant Board positions are being filled simply by accepting those volunteers who come forward. If this is the case, we suggest that the current Board consider altering this approach and review/modify the above talent requirements, in order to actively seek individuals that can fulfill any unmet needs. The challenges ahead are very significant and the INH Board will need to maintain strong and effective leadership by continuing to maintain a talented and skilled membership.

Finalize Re-Opening Plan, its Budget, Timing, and Mix of Beds

Assuming Covenant is engaged and it confirms INH viability, it will be presenting recommendations for the timing, extent and phasing of re-opening. This is a foundational piece for much of INH's future work. It will drive budgeting, fundraising efforts, staff hiring, the license suspension extension request, and a whole host of other activities. It will be important to get this plan right. Too many beds opened too soon could overwhelm fundraising and borrowing abilities. Too few beds opened too late might require less working capital but may be too few to achieve operational economies. Although more resource intensive and perhaps more difficult to initially open, skilled beds and rehabilitation services when available can provide much needed community services and also financial benefits to INH.

Initiate Interim Rental Housing Plan

The Housing Subcommittee Report outlines both an immediate interim rental housing plan as well as a longer-term plan. INH's reopening is dependent upon successfully finding upwards of 20 rental units for occupancy as early as the fall of 2022. Progress has already been made toward this goal, but more work is needed. The INH Task Force published in the local paper on 12/2/21 a community appeal for interim rental housing. This effort needs to be followed up by a vigorous and planned appeal to the community by the INH Board.

Obtain License Suspension Extension

Although October 2022 might seem quite distant to some, many obstacles are likely to arise in the process of re-opening INH. Although it would be ideal to not need an extension to the INH license suspension period, such an extension may well be required. An immediate task should be to research this process and begin as soon as possible to initiate a first 6-month extension request. Starting quickly would also allow sufficient time for any required political efforts related to the request.

Initiate Fundraising Plans

The INH has been fortunate to have received generous community support over the years. This is another time for the community to help sustain INH's mission. Board leadership will be required to immediately plan and mount a campaign for re-opening INH. The cause has broad community support, but the needs for pre-opening costs and housing must be very specifically identified and articulated to the community. We also recommend that making on-going annual campaigns become a standard part of INH Board activity.

As mentioned above, although traditional fund raising does not normally include seeking state and federal funding, these avenues should also be considered since the Covid crisis may have made available new sources of state and federal funds for both LTC services and affordable housing.

Continue Community Engagement Activities

The subcommittee observed at its last community Zoom meeting a general improvement in the tone and nature of comments regarding INH. This was encouraging. The Board should consider prioritizing this overall engagement effort. Responding to the need for interim staff rental housing is a possible avenue to further engage the community in helping to support INH. Although not listed in the Board recruitment section, many community healthcare organizations have local political leaders as ex-officio members on their boards. This may not be the right time but should be considered.

Another common practice for community healthcare organizations is to have a formalized community volunteer program. Often a staff member organizes and runs this effort and it can be a very positive method to engage the community. The recent Adopt-a-Resident program is an excellent example of the benefits of a community volunteer program.

Identify Key Employees and Initiate Future Labor Contracts

Although Key Employees may not come aboard full time until 90-120 days prior to re-opening, there may be many months required to identify and successfully recruit these individuals. These recruitment efforts need to begin as soon as is possible and should focus on at least the permanent Administrator, the Director of Nursing, and the HR director.
During the Covenant consulting engagement, the re-opening plan and budget will certainly include a discussion of overseas staffing. Once the size and mix of overseas staffing is determined, there may well be a requirement to commit contractually in order to begin the recruitment of such staff. These contracts usually have phased payment plans with an initial payment required upon signing. Given the required multiple months lead time from contract signing until on site availability of staff, these early financial commitments need to be anticipated.

Consider Alternative Options for INH

The subcommittee certainly hopes that Covenant will confirm the subcommittee's initial findings that INH can be viable long term if solutions to the staffing crisis can be developed. However, if upon further and more detailed review viability is not confirmed, the subcommittee did consider alternative strategies for INH which were consistent with its mission. This review was by no means exhaustive, but a cursory analysis was done for the sake of completeness and due diligence.

Given the State's restriction on new LTC beds, there have been examples of existing LTC facilities transferring the ownership of their LTC beds to other organizations. The State has an application and review process for such bed transfers. If INH were not to continue as a LTC facility, a transfer/sale of its beds in conjunction with its existing resources might well allow INH to transform itself into a facility which provided housing, outpatient rehabilitation, and/or other senior-related services. The subcommittee hopes such an outcome does not occur, but it might be a way in which INH could continue to address the needs of the local senior population.

ATTACHMENT B

Island Nursing Home Task Force
Staffing Recruitment and Retention Subcommittee
Final Report and Recommendations
December 14, 2021

The charge to the Staffing Recruitment and Retention Subcommittee was to recommend a long-term sustainable plan for recruiting and retaining skilled staff, as well to identify and recommend services and support the staff may need to continue working at INH. We interviewed former staff members, collected available data, and researched options relevant to this charge. Our recommendations are as follows:

1. **Determine the number and possible configurations of staff needed to re-open with full coverage in full capacity (as before INH closed).**

The numbers of staff needed are entirely dependent on the mix of Skilled Nursing, Long Term Care, Residential, and Rehabilitation Services that the Board and their selected Management Team determine to be the most viable for the reopening of INH. Clearly, numbers would be smaller in the beginning, as INH re-opens with limited beds, and would grow as more beds were opened and the residential count increased. Suggestions have also been made to increase the number of private rooms to make the facility more attractive to private pay residents. A memory care locked unit may be a higher revenue use than residential care; this would need dedicated staff with specialized training. Changes in the use of the facility would, of course, result in changes to the staffing numbers previously required.

The structure of services offered before the recent closure required the following staff numbers and positions:

A. Administration		
i.	Administrator	1
ii.	Director of Business Operations	1
iii.	Administrative Assistant	1
iv.	Financial controller	1
v.	HR Director	1
vi.	Payroll/Training Coordinator	1
B. Activities		
i.	Activities Director	1
ii.	Activities Aide	1
C. Dietary		
i.	Food Service Director (CDM)	1
ii.	Cook	4.5

iii.	Cook Aide	4.5
iv.	Contract Dietician	1

D. Environmental

i.	Environmental Services Director	1
ii.	Maintenance	1
iii.	Housekeeping	6
iv.	Laundry	1

E. Nursing

i.	Director of Nursing	1
ii.	Registered Nurse	2
iii.	LPN	2
iv.	CNA-M	3
v.	CNA	20
vi.	Ward Clerk	1
vii.	Contract Beautician	1
viii.	Driver	1
ix.	MDS Coordinator (RN)	1

F. ResCare

i.	ResCare Director	1
ii.	CRMA/PSS (1 CRMA per shift)	10
iii.	Consultant Nurse	1
iv.	Unit Assistant	1

G. Social Services

i.	Social Services Director	1
ii.	Social Services Assistant	1

H. Therapy - (could be contracted services)

i.	Therapy Director	1
ii.	OT	2
iii.	PT	2
iv.	OTA	1
v.	PTA	1
vi.	SLP	1

At the time of closure, there were 37.5 FTE positions unfilled. It is vital that INH maintains full staffing to ensure quality care and prevent staff turnover and burn out. Issues caused by under-staffing such as staff members having to work double-shifts without prior notice are important factors that cause staff to leave. Adequate staffing in all departments is necessary for a smoothly functioning facility.

2. Estimate how many staff in each department might be recruited locally and how many will need to be contracted.

Based on interviews and other feedback, we estimate that nearly all the administrative, office staff and employees other than direct care staffing could be recruited locally. Nursing and direct care staff (CNAs, CNA-Ms, PSS/CRMAs) would require both locally recruited staffing and contracted staffing. Over the past three years, an average of 26 contracted staff were utilized for these positions. This is the equivalent of roughly ⅓ local and ⅔ contracted staff for the 38 positions. It would be the prudent estimate that this mixture is what would be needed to reopen INH to full capacity with the same service structure as before. It is our hope that with a collaborative, holistic approach to recruitment and retention, INH could change this ratio over time to source many more direct care staff members locally. We were intrigued by the staffing model of a higher nurse: patient ratio for staffing, as mentioned by Phil Hickey of Covenant Health, as that would mean a higher ratio of staff who were more able to afford to live locally on their wages. This is used in their skilled nursing unit. However, even with nurses providing more direct care, there would still need to be teams of CNAs and PSSs working with them. The average age range of nurses in Maine is 48-51, and a lot of direct care work is physically demanding and easier for employees in the 20-40 age range.

We recommend that management maintain their current thoughtful practice of staying in contact with former employees. Lori Morey reports that they had an employee dinner in November and had about 22 attended; they are planning another for January to keep the connections strong. Lori is contacting all staff by emails and personally contacting as many as possible and documenting these contacts. There will be a monthly newsletter that will go out letting them know the progress being made to re-open. The Board will give her that information. She is also contacting staff with clinical licenses to remind them of their upcoming renewals so that no one goes in-active, as well as helping them to do that. Lori says, “Many staff are hoping to return and have found that there isn’t any place like INH. Many have said, ‘I want to come home’.” Building and maintaining this sense of community and family among staff as well as with residents is a vital ingredient to the success of INH, and we will address this further in other sections of our report. It is recommended that these loyal former staff members be the first approached to fill positions during the initial phases of re-opening next fall.

Deer Isle Adult & Community Education has funding from local donors to run 1-2 CNA classes free of charge to INH and the participants before the anticipated reopening of INH. They are awaiting approval documents from DHHS and a finalized legal agreement to hold labs and clinicals at Northern Light Blue Hill Hospital before the classes can begin. Recruiting for the classes may be a bit easier with the current awareness of the staffing needs, however, it will also be important to vet applicants to be sure that they are committed to performing the jobs once they are trained, and that they have the social skills to work well in teams. It is possible that components of the WorkReady curriculum could be embedded in the classes to teach some explicit soft workforce skills as well as the clinical content. It is possible that ongoing CNA classes could produce from 5-10 new CNAs per year, helping to ameliorate the turnover rate for staffing at INH, which has averaged 46.4 % over the last five years. The partnership with Adult Ed could be

expanded to offer PSS, CNA-M, and CMA classes nearby or onsite in the future, something made even more likely if there is access to reliable, experienced nurse educators through an affiliation with an organization such as Covenant Health. Adding a Clinical Care Coordinator position to work with the Director of Nursing would provide important staff support and mentoring for new employees as well as team-building and continuing education for all direct care employees.

We also recommend that the Board continue to investigate the possibility of obtaining long-term 3-year contracts with foreign nurses, such as those discussed with Infinity Care Partners, currently being used by Covenant Health. Focusing on long-term contracts will help build sustainability and the team camaraderie that has been such an important part of staff retention in the past. Foreign workers who make a commitment for three years and who are welcomed and cared for in our community may readily be converted to permanent, long-term employees, building out more local staff for the future. When considering foreign workers, it will be important to be sure they are properly vetted in terms of background, clinical certifications and standards of care, and commitment to the contract. Phil Hickey from Covenant reports that their nurses from the Philippines have raised the consumer survey ratings for their post-acute care facility. The Philippine nurses they employ have excellent English skills and are very kind and caring to their patients. Their medical training is also excellent; the Philippine training is on a par with US nursing standards, and all have baccalaureate degrees if not Masters. Covenant's retention rate with contracted staff is 72%; many buy homes and become permanent employees.

Contracting for long-term workers will need to be initiated as soon as January, as ICP quoted 6 months as the timeframe for nurses, and 8 months for non-nurses. These timeframes may also be impacted by whatever changes in immigration practices may result from the new variants of COVID-19. Non-nurses are harder to bring into the country, but Covenant mentioned that there may be contracted nurses with spouses who would accompany them and be trained as CNAs. ICP also mentioned the possibility of RNs from other countries such as Kenya who could be doing CNA work while upskilling and awaiting their certifications. These options should be considered, as long-term contracted CNAs would provide a better foundation for team building than short-term CNAs contracted from the US who are only here for 8-12 weeks.

Afghan refugees have been mentioned as another source of foreign workers. More information needs to be discovered as to whether the types of vetting of refugees is like those of the foreign workers noted above. This committee has tried to contact Catholic Charities to find out how the refugee process works, but we have not received a call back yet about our inquiries. Because refugees are not necessarily apt to be healthcare professionals, this may be an effort better made in a collaborative fashion with other local employers and our municipalities. Housing would need to be immediately available once we made the commitment to them, which might prove difficult at this time.

3. Estimate childcare/eldercare, transportation, and housing needs for full staffing.

We recommend that INH develop a structure/staff person to work with all onboarding and ongoing staff members to help them access the support and resources they need to be successful and reliable team members. Each of the categories below, as well as in the next section, would depend upon having a resource advocate to work with staff on these issues. This could be an added 1 FTE position in Social Services/HR that would also provide other services recommended in Section 4.

Childcare/Eldercare:

During the pandemic, staff members have not been able to rely on school age children being able to attend regularly due to remote weeks and quarantines. This is a pattern we hope ends soon but given the new variants of COVID-19 still occurring, it is hard to predict when that might happen. This impacts INH staff in two ways; unpredictability of care and additional care needed for school age children who cannot be left home by themselves to attend school remotely. Childcare is limited on the Island and immediate towns. There is no coverage for workers on the weekend shifts or outside the 6:30 a.m. to 5 p.m. operating schedule of most childcare facilities. Two day care providers (one in Deer Isle and one in Sedgwick) have noted interest in expanding. It is recommended that INH collaborate with local childcare providers to:

1) Expand operations, possibly in conjunction with the construction of an affordable housing project located close to the INH facility. This would be the ideal location, both for staff living in the housing and for those living elsewhere. School buses could pick up and drop off school age children as needed for before and after school hours. Some after school care can be provided by the Deer Isle-Stonington CSD's Afterschool program which operates Monday through Thursday from 2:45 - 4:45 p.m. during the school year and provides transportation home for the students. This is free to any family that fills out the application.

2) Guarantee payment for a certain number of slots from our local providers, so these are available for INH staff families. This could be negotiated to change on an annual basis, based upon need.

It is, of course, impossible to accurately estimate the need for childcare for future employees. If we were to assume that the minority of the contracted direct care staff are arriving with their families (26 x 20% = 5.2 children), and that the majority of the local staff do have families (39 x 80%), at least half with preschool-age children (due to the average age of CNAs and PSSs = 15.6 children), that could easily average 20 childcare slots each year. Whether it is more financially sustainable to pay directly for these slots, or to pay only for slots not used by offering high enough wages to staff members so that their childcare is affordable would need to be worked out in the future. The Early Childhood Interest Group, facilitated by Healthy Peninsula, is a good resource for information and advice.

Eldercare would be needed for a much smaller segment of the staff population, but if providing Adult Daycare were a financially sound option for INH, that would remove an additional challenge for staff members.

Transportation:

Transportation is often an issue with local staff who are working in the lower-paid positions. The costs of owning and maintaining a personal vehicle can be difficult to manage if one is also paying childcare, and housing is scarce and expensive as well. Even though INH has been paying the highest wages for direct-care positions north of Boston, the living costs for local staff (especially single parents) can easily exceed those wages. We recommend that INH develop a system to encourage car-pooling among staff on similar schedules (this can also increase reliability as people are depending on staff members to drive or be ready for pickup); provide information and application support for local funds that help low-income families repair, buy, and maintain vehicles; consider van transportation to and from areas that might provide more housing options for staff, such as Bucksport and Ellsworth. Jackson Lab has done this for years in order to fill their employment needs for their mouse factory. INH could investigate doing it on a much smaller scale with existing vans if the need for housing will drive staff members to locate in larger regional communities with more available housing.

Housing:

Housing is both the most difficult and most important resource to address. If INH can re-open with primarily local staff who already have housing, it provides the opportunity for a bit more time to develop housing resources for contracted staff. It also, however, could put the arrival of contracted staff into a timeframe that almost immediately includes summer housing. Timing aside, in order to contract for long-term staff INH will need to be able to guarantee year-round housing for a significant length of time. For 26 long-term contracted staff, it would be prudent to estimate at least 20 housing units; fifteen private units and five 2–3-bedroom units that could be shared. Housing is a widespread issue for all employers on the island, and the best long-term solution would no doubt involve working with other employers, organizations, and the municipalities. Making the need explicitly known with a direct ask to community members who own housing units that sit idle for much of the year is a place to start for the short-term. Creating a pool of available housing wherein INH vets the tenants and has contracted their employment might be possible, as it would diminish the issues and challenges such as non-payment of rent and damage to property that can come with individual long-term rentals. It is possible that some homeowners with vacant housing might be able to donate their properties for 1-2 years for the tax write-off, as historically has happened with the housing of Island Institute Fellows. For the long-term, the island and INH need to develop affordable rentals and permanent housing.

4. **Recommendations for equitable staff compensation, schedules, and supports that will lead to continuous and successful staff recruitment, retention, and professional growth.**

Equitable Staff Compensation:

To retain local staff, it is important that the compensation they receive is clearly perceived as equitable with the long-term contract agency staff. Local staff may need housing support at times during their careers with INH. All staff, both long-term contract and regular permanent staffing, should be compensated in a manner that allows them to live locally and see the benefits of working at INH as a long-term career. Providing referrals and access to external resources is also important in maintaining a sustainable workforce. As well as compensation, the implementation of fair policies and practices for personnel need to be the same for all employees, regular or contracted. Building a sense of equity is vital to team-building and neutralizing feelings of resentment and conflict. We realize that this and the following recommendations will no doubt result in a significant budget increase. We agree with Operations and Management that fund-raising, donor appeals, and community awareness of INH need to be front and center of a reopening and need to become an ongoing primary practice with a full-time development officer/committee at the administrative or board level.

Scheduling:

Schedules will need to be as flexible as possible for all staff; no subgroup of staff should be expected to work every weekend, overtime, or unexpected double shifts, and all attempts should be made to meet the scheduling needs of local permanent staff who have childcare/eldercare or transportation needs. At the same time, there need to be clear scheduling staff changes during shifts with practices put in place that guarantee proper communication between incoming and outgoing teams of workers. This lack of communication was noted by recent employees and a return to team reports and "rounds" between shifts was recommended, both for proper communication about residents and also team-building.

Given some recent interest from community members to fill a shift or two a week, it could be wise to build a pool of these per diem staff who have the necessary training and certifications to fill sudden absences, and who will commit to being on call for specific days/shifts each week or month, so that regular staff do not have to constantly work overtime or unexpected double shifts. Regular training sessions for per diem staff/volunteers could be held for departments other than direct care workers to aid this process, and community members who would commit to being in this pool could be included in local CNA and PSS classes. Regular employees could be cross-trained and work in more than one department, which could expand the opportunities for filling absences and a change of scene and duties could provide some measure of relief from staff burnout. It would also be wise to consider job shares, given the high wage opportunities of seasonal employment in this area. For example, a school employee with summers off or someone who goes south for the winter might share a position with a permanent resident who wants to fish or do house cleaning in the summer.

Additional feedback from former staff included the need to carefully match new residents brought in to fill vacant beds with the capacity of the staffing on hand. If it is necessary to find residents outside our local area, it is preferable to meet with the resident before accepting them. While there is a clear financial need not to let beds go empty, there needs to be thoughtful consideration of the specific needs of new residents and whether or not those needs can be met by the staffing levels available. Adding new residents with conditions such as severe obesity and/or severe disabilities can tax staffing beyond their physical limits and their abilities to provide quality care, resulting in additional stress and exhaustion.

Ongoing Education and Upskilling of Employees:

Ongoing educational opportunities need to be provided for all employees, and especially for any lower wage worker who is interested in upskilling and following a career pathway to a higher wage position. Collaborations with the schools, Adult Ed, post-secondary institutions (Beal University, UMA at Ellsworth, etc.) and other regional organizations would allow for supported employee upward mobility and better provide staff with the financial resources to continue to live in our area and build strong economic foundations for themselves and their families. INH could work with the schools, through their commitment to place-based education, to offer regular student experiences at the facility, including overviews of all the departments, job shadowing opportunities, internships, community service experiences, and classes/training sessions for entry-level positions (such as CNA and Dietary). Adult Ed could provide free career/college advising for employees both in-house and nearby through their state-funded Maine College and Careers Access programming. Beal University provides two-year RN programming that starts new cohorts 3 times a year, is accessible online for many courses and just two days a week for clinical and lab courses, making it possible to schedule around workdays. This results in an associate degree; they also have transfer options from this degree to a Bachelor's and Master's degree. The University of Maine at Augusta once again has a Bachelor's level RN cohort running out of their Ellsworth Center with classes and clinicals available in Ellsworth. Many other degree programs are available online both from UMA-Ellsworth and other campuses of the UMS system. There are a number of scholarships available beyond regular financial aid for adult students continuing their education in Maine, especially for those seeking high-wage, in demand jobs. Anything INH could offer on top of external financial support for their employees enrolling in higher education would be money well-spent, and a fully supported career pathway program would be a significant benefit in recruiting entry-level workers. Most entry-level jobs are physically demanding and lower wage; creating an upward spiral for these workers keeps the flow moving in a positive direction for both recruitment and retention. The vision is that no one is expected to stay in entry-level positions; upward movement is encouraged, and these opportunities are a major recruitment advantage over other forms of employment.

Housing:

We have addressed housing needs earlier in this report; now we address additional housing supports. Ideas to be considered could include rental referrals/guarantees,

financial support - either by higher wages, direct subsidies for housing costs, and/or matching savings accounts for housing down payments - and access to resources such as home-buyers workshops, bank-led workshops on building savings and credit, etc. Perhaps in collaboration with other employers and municipalities an institution could be created through which local homeowners commit to selling or willing their properties to a program that provides access to homeownership for local employees, or a program like Habitat for Humanity could be formed to develop new housing. There are many builders and community members with construction skills here on the island. These latter two ideas are clearly beyond the scope of the INH Board but could be brought forward to the larger community. These supports would make it possible for young people from the island offered employment at INH to have hopes of renting/owning their own home on the island and make it easier to recruit employees from other areas that are also experiencing housing issues.

Social Emotional Wellness

Rebuilding a team/family culture at INH will need to start from the top levels and be a primary facet of the INH rebirth, both for residents and for employees. The current acting administrator, Heidi Gillen, has received much positive feedback from former staff and may well be the best candidate to lead this process. Another very important position that will need to be filled is that of Director of Nursing. The turnover in DONs in recent years has been even greater than that of the Executive Directors, which has made it difficult to maintain any sense of a cohesive team. Employing a Clinical Care Coordinator in conjunction with a DON may help to retain an effective, committed DON. Well-qualified administrative personnel need to be out and about in the facility as much as possible and truly demonstrate an open-door policy. Regular staff meetings and events, workshops, and fun and joyful celebrations of employees and residents need to be part of everyday practices. The feeling of family is a huge part of employee retention and a draw for employees and residents alike. Every individual needs to be treated as a valued person. Once past the pandemic, rebuilding regular community connections including volunteers will also be important. Staff needs to feel supported both internally and externally to keep doing what are both vitally important and demanding jobs.

Employees also need access to inhouse counseling and social emotional wellness workshops/supports. Serving in an end-of-life facility brings constant feelings of trauma, loss, and grief. Learning how to process these feelings in as healthy a way as possible needs to be a significant piece of what employees are able to do at INH. Ignoring these needs contributes to burnout, stress, and emotional distress, which all lead to absenteeism and resignations.

Wrap-around quality-of-life support of employees is the recommendation of this committee, in order to build a loyal, committed, healthy local workforce for the long-term sustainability of INH. A full-time position, perhaps with social worker qualifications, could be added to HR in order to coordinate the suggested new programming and provide counseling sessions and workshops. This position might also be able to do a considerable amount of community outreach and communications. There are also many local

organizations that would partner to provide additional support and resources, including the Family Resource Advocate from Deer Isle Adult & Community Education.

5. Recommendations for staff representation and voice in governance and oversight.

Given a true open-door policy on the part of the administration, staff representation and voice in governance and oversight is not a big issue. However, as many former employees have expressed, if talking to a supervisor or other administrative staff member does no good, or these discussions are not encouraged or welcome, it very much is a large issue. Our recommendation is that the board consider a foolproof method for providing staff voice to the Board, without fear of reprisal or retribution. This could perhaps be a staff member to the board, elected by staff to serve limited terms.

Staff voice is also an important part of making administrative decisions as well; non-administrative staff are often those with the longest historical knowledge of the facility, the residents, the community, and how practices and policies have worked or not worked over time. If INH truly rebuilds a team/family culture in the face of distrust and dis-association between prior administration and staff, structures need to be put in place institutionally to provide avenues for important feedback from staff as well as some inclusion in decision making. A team is strongest when all its members' voices and perspectives are fully heard and taken into consideration.

ATTACHMENT C

Island Nursing Home Task Force
Affordable Housing Subcommittee Report
Final Report and Recommendations
December 14, 2021

It is generally now understood that the lack of available year-round housing affordable to INH Staff was one of the single most important contributing factors to its closure. Therefore, the identification and/or creation of long-term housing resources needed to attract and retain staff is critical to its re-opening. The Affordable Housing subcommittee was formed and charged with exploring this topic and making recommendations to the INH Board. Subcommittee members include Ronda Dodge, Genevieve McDonald, Peter Roth, and Anne Schroth, and were supported by Board member Judy Williams and INH HR Director Lori Morey.

What is "affordable housing"?

According to United States federal and state policy, housing is affordable if it requires no more than 30% of a household's gross income to be spent on its "housing burden." For a rental dwelling, housing burden includes both rent and utilities, and in the case of homeownership, it includes the sum of principal, interest, taxes and insurance ("PITI.")

For the INH staff, one can readily translate this policy into rents they could afford based on average wages and utility allowances (the latter conveniently provided by the US Department of Housing and Development ("HUD") for nearly all parts of the country on an annual basis.)

Staff Category	Average Wage Per Hour/Annual	30% Max Housing Burden/Month	less Utility Allowance*	Maximum Monthly Rent
Envir/Dietary	$14/hr-$29,100/yr	$728	($153)	$575
CNA/PSS	$18/hr-$37,400/yr	$936	($153)	$783
LPN	$30/hr-$62,400/yr	$1,560	($153)	$1,407

* HUD utility allowance for 1 BR apt in Hancock County

There are almost no apartments available to rent on a year-round basis anywhere on the Peninsula at under $800/month. Due in part to the fact that the area housing stock is mostly 2- and 3-BR units, market rents start at $1,000 a month, not including utilities, for a small unit in poor condition. Rents for two-bedroom units, if they can be found, are typically in the $1,200-$1,500 range, not including utilities.

If INH staff are willing to share an apartment or house, it would extend their capacity to support more of a market rent. For example, two single maintenance or dietary workers sharing a two-bedroom apartment could afford to pay $1,150 per month in rent, while two single CNA's could share a two-bedroom apartment and together afford to pay just over $1,500 per month in rent.

How much housing is needed for INH Staff?

To answer this question, the Affordable Housing subcommittee relied on input from the Recruitment & Retention subcommittee and information provided by INH HR Director Lori Morey. They interviewed former staff to assess how many of them might return if INH was able to re-open, and which of those returning staff members were already housed. They then compared that returning staff roster to the total number of staff in each category to determine how many units of housing would be required to accommodate new recruits.

Staff Category	Number Housed Staff Returning	Estimated New Recruits Needed	Notes on housing preferences	Indicated # of Dwelling Units Needed
Environmental/ Dietary	20	2	could share	1
CNA-M/CNA CRMA/PSS	13	20	25% +/- could share	17
LPN/RN	3	2	few want to share	2

While the assumptions made to determine these numbers could vary based on who actually returns, evolving staffing models, etc., it is estimated that new INH staff required for a successful re-opening would require approximately twenty (20) year-round dwelling units.

What is the current supply of housing available to accommodate new INH staff?

Unfortunately, there is very little housing available to rent on a year-round basis in the Deer Isle-Stonington community, and very little such housing available in nearby Peninsula communities. To better respond to this question, however, Task Force volunteers put out requests to the local papers, called property owners, and interviewed realtors. The Affordable Housing subcommittee created a housing inventory to organize the data collected, and sorted properties into two categories of possible interest: Off-season (Winter) rentals, and year-round rentals. Given the Task Force's current understanding of the license suspension agreement with Maine HHS, a re-opening must occur no later than October 2022. If this holds, Off-Season Rentals might be helpful as a temporary transition, but only until the end of April 2023.

A number of year-round rentals have been identified as potentially available in response to outreach by INH Board and subcommittee members, which has only just started. One significant opportunity is the Fall 2022 scheduled completion of new workforce housing rental apartments on the Sunset Cross Road in Deer Isle, under development by Island Workforce Housing ("IWH.") Preliminary discussions with the IWH Executive Committee indicate a willingness to set aside approximately 30% of these two-bedroom workforce housing units for a long-term contract with INH, which could yield three (3) 2-bedroom rental units for INH's year-round, long-term, lease use. Two additional 2-bedroom properties have been identified on the island that are being assessed.

INH currently rents two furnished units in Blue Hill, including one 1-bedroom and one 2-bedroom, which have historically been popular with travelling nurses. The current contract, at $2,500 a month for both units, expires in June 2022, and might be available for renewal. In addition, Ben Gifford, the owner of a 4-bedroom, 5-bath property in Blue Hill has reached out and offered to lease his property to the INH on a year-round basis for $2,400 a month, not including utilities.

In summary, outreach to date has yielded the potential for eight (8) year-round rentals, incorporating a total of seventeen bedrooms, that could help bridge the gap between a potential INH re-opening in October 2022 and the availability of permanent new housing sometime in 2024. This outreach needs to really ramp up, with a goal of getting commitments for at least 15 rental properties in Peninsula communities that can be leased by INH for a minimum of two years, beginning in October 2022.

How can INH develop needed long-term housing resources?

Given the dearth of available year-round rentals in the area to accommodate INH staff over the long haul, it is clear that INH will have to acquire and/or develop housing for its long-term staff needs, either itself, or in partnership with a local or regional housing organization. Obvious strategies include acquisition of existing properties, and development of new housing.

Acquisition/Rehab of existing properties

Existing properties available for purchase under $300,000 that might be appropriate for INH staff rental do come on the market from time to time, although their condition, energy-efficiency, and location vary widely. Such properties in good condition with reasonable layouts typically sell very quickly, while properties with awkward layouts in poor condition tend to remain on the market longer.

An example is a 2-bedroom, 1-bath house located on Deer Isle Road on LDI, currently on the market for $275,000. This property is awkwardly laid out, with headroom-constrained bedrooms located on the upper floor but the only bathroom on the lower floor. Built in 1930, it has a lot of condition issues, is poorly insulated, has an older heating system, and may need a septic system rebuild. It would likely require an investment of $25-50,000 to bring it up to maintainable rental property standards, however addressing energy-efficiency and the awkward layout to make the home more desirable would require a substantially greater investment.
https://theislandagency.com/maine-homes-for-sale/87-Little-Deer-Isle-Road-Deer-Isle-ME-04627-1511664/

This example is helpful in illustrating the likely capital cost to the INH of local acquisition/rehab opportunities. The cost per dwelling unit, brought up to maintainable, rental property standards, is likely to be in the range of $275,000 to $350,000 per dwelling unit, depending on size and other factors. The other factor to be seriously considered is the operating cost associated with maintaining a portfolio of "scattered-site" houses. Many of these properties are older and could, therefore, have lead paint, and could not be rented to households with young children. In addition, most are poorly insulated, have windows of questionable quality, and will be expensive

to heat. This would add to the housing burden of INH staff, and would reduce the amount of rent they could pay if maintaining a 30% of gross income total burden.

In sum, while the total capital costs would likely be similar per unit, operating and heating costs for a scattered site rental portfolio of existing buildings could cost 2 to 3 times more than those costs for new or recently-constructed, energy efficient rental units developed in a duplex or multi-family format.

Development of New Rental Units

A second alternative to address the housing shortage is to develop new rental housing for use by INH staff. This could be done directly by the staff and board of INH, through a partnership with a local housing organization like IWH, or by hiring an experienced private developer. While new development that yields attractive and energy-efficient rental units is likely to be the best long-term investment for INH to attract and retain new staff, it will take considerably more time to implement than purchase/rehab of existing properties. Based on the recent experience of IWH, it would likely take at least two years to acquire land, and then plan, permit, and construct new housing. The cost would likely range between $225,000 and $275,000 per dwelling unit, depending on the size and format of the units and buildings, the cost of land, and the delivery method (stick-built vs. modular vs. factory-built).

Land costs have risen substantially in the past few years, and is greatly affected by the density at which one can build. Subdivision Regulations in the Town of Deer Isle require a substantial amount of land per dwelling unit, effectively ranging from 2.3 acres per unit for detached single family home development to approximately 0.6 acres per unit for multi-family housing.

To illustrate the capacity of land under the Deer Isle Subdivision Regulations, the Affordable Housing Subcommittee completed a capacity analysis of a nineteen (19) acre parcel, located near the INH, for different housing typologies ranging from duplex buildings (2 units per building) to single- and multi-story multifamily buildings. A parcel such as this would be ideal because of its size, and its proximity to the nursing home, potentially allowing staff to walk to work.

The maximum number of units by type are shown in the following table.

Housing Type	Maximum # Dwelling Units
Single Family Detached	7
Duplex (2 units/bldg.)	12
Small Scale Multi-family	21
Large Scale Multi-family	27

The subcommittee also looked at the theoretical capacity of this parcel to accommodate mobile homes, which is approximately 32. The subcommittee does not recommend mobile homes as a long-term strategy for a number of reasons, including their inferior durability, longevity, and energy-efficiency, and their reduced capacity for community acceptance. However, given the need to secure staff housing within less than a year, the subcommittee recognizes that mobile homes might be an appropriate short-term solution, should an insufficient number of year-round

rentals be secured to bridge the gap between INH re-opening in Fall 2022 and the availability of new INH staff housing sometime in 2024.

It should be noted that each parcel of land will have a different actual capacity based on topography, extent of wetlands or other unsuitable features, availability of existing soil types required for wastewater/septage disposal, extent of ledge, etc. In general, smaller parcels tend to yield lower net unit densities than larger parcels. In addition, each land parcel would require its own distinct subdivision permit application and public hearing process, so developing multiple smaller parcels will require significantly more planning, engineering, and entitlement work than developing a single larger parcel.

Should INH develop staff housing itself, or partner with others?

If the INH Board decides to develop its own housing, it will need to decide whether to do so alone, or in partnership with another organization. Such an undertaking involves a broad range of skills, including knowledge regarding legal, regulatory, financial, design, engineering, construction and real estate operations and management. To successfully develop housing itself, INH would need to make a major commit to develop its Board and staff to include individuals knowledgeable and experienced in managing the development of housing. Given the complexities of housing development, as well as the need for INH staff to focus primarily on running the nursing home, INH might be better served to establish a partnership with an experienced developer or housing organization that has the skills and experience organizing projects of similar or greater scale and scope. There are a number of area non-profits with housing expertise and experience, including Island Housing Trust on MDI, and Island Workforce Housing on Deer Isle. There are also a number of builder-developers in the region that might have an interest in supporting INH, on a partnership or contract basis.

Another consideration for the INH Board is the potential impact of unrelated business income tax (UBIT") on INH's non-profit status. Unless the creation and provision of housing to accommodate its staff was part of the charitable purpose for which INH received non-profit 501c3 status, any net revenue from housing operations could be taxable as if it were a for-profit corporation. This suggests that INH would need to either set up a separate special purpose non-profit organization with its own 501(c)3 status, to develop and operate housing for its staff, or partner with an existing not for profit that would not be subject to UBIT. The Board should seek legal and accounting expertise on this issue.

What should INH be prepared to invest in housing for its staff?

Assuming that INH needs to provide housing for approximately 25-26 staff members, with the further assumption that 25% of such staff would be willing to share a multi-bedroom dwelling unit, then INH needs to acquire, master-lease, and/or develop a total of twenty (20) dwelling units. This total should be broken down into roughly 65% two-bedroom units for sharing singles, couples, and small families; 25% one-bedroom units for singles and couples; and, 10% three-bedroom units for staff coming with a spouse/partner and two or more children or other family members, or for 3 single staff sharing a larger apartment. If INH is able to secure a long-

term lease agreement with IWH or other landlords, then it could consider reducing the targeted number of units to develop.

The subcommittee advises INH that the cost of acquiring/rehabbing existing units and/or developing new units will likely come at a similar average total development cost between $225,000 and $275,000 per dwelling unit, for a total investment of $4.5 to $5.5 million. It is likely that a bank will finance up to 65-70% of this cost in long-term amortizing debt, secured by the property, an assignment of rents, and a pledge of other INH assets. The balance of the capital required, being 30-35% of the total, or approximately $1.35 to $1.925 million, will have to be raised in the community through a capital campaign targeting the reopening, including gifts from charitable foundations, and grants from the State of Maine. It should be noted, however, that there is good chance that much of this "equity" investment in housing could be repaid over 30 years from net cash flow from the INH properties, depending on the level of rents collected from staff.

How long would it take to develop needed staff housing?

Based on the recent experience of IWH, the Subcommittee recommends INH plan on two years from acquisition through completion, assuming modular construction.
The following lays out a possible schedule for development of staff housing:

	Q1/22	Q2/22	Q3/22	Q4/22	Q1/23	Q2/23	Q3/23	Q4/23
Acquisition/Planning	------>|							
Subdivision Approval	|-	---------	------>|					
Site & Roadwork Const.	price		|	---------	-->			
Build Modular Homes	price		|	---------	---------	---------	-->	
Foundations				-----	----->			
Set/Button-Up Homes					-------	---------	------->	
Landscaping/Occupancy						----	---------	---->

How could INH manage rental properties it acquires or develops for its staff?

Should INH acquire or develop housing to rent to its staff, it can either develop the staff capacity to operate and maintain such housing, or partner with another organization with property management capacity. If INH eventually owns twenty (20) rental units, it will likely require a dedicated half- to full-time maintenance person to manage day-to-day interior, exterior, and site-related tasks and unit turnovers, depending on the number, location and type of buildings involved. In addition, it will need part-time administrative staff to collect rents, pay vendors, maintain lease paperwork and other contracts, respond to tenant inquiries and maintenance requests, etc.

Alternatively, INH could hire a property management company or partner with a local housing organization such as IWH to manage the INH's rental properties. The costs are likely to be similar, though unlike development activity which would be short term, property management would be on-going for as long as INH operates the nursing home, and thus may justify the

development of Board and staff expertise and manpower to handle property management and maintenance.

Proposed Next Steps for the INH Board/Staff

1. Identify and assess specific sites that could be acquired for development concurrent with Covenant's analysis of operational feasibility, with the goal of getting a parcel under agreement immediately if receiving a positive recommendation from Covenant at the end of January 2022.

Identification of possible land parcels should be undertaken by a committee of the INH Board, working with an experienced realtor to represent INH as "buyer's broker" and to search for potential parcels. A single parcel of 17-20 acres, if the quality and topography were generally suitable, would accommodate the total long-term need for 20 dwelling units. Such land could be located in a Peninsula community within a 20-minute drive of the INH facility, but ideally would be much closer. Based on current land values, which have increased considerably through the course of the pandemic, the Subcommittee recommends that INH be prepared to spend up to $250,000 for such a parcel.

INH will also need to engage a surveyor and civil engineer to assist in evaluating the capacity of such parcels. Local surveyor Due North is the likely candidate for survey assessment. McCullough Engineering is a well-known small civil engineering firm in the area and worked with IWH on its Sunset Cross Road project, while Haley Ward (formerly CES) is a much larger multi-state firm based in Bangor, and is well known for its land development services.

2. Decide whether to: recruit the skills to develop housing internally within the INH Board and staff; partner with an experienced housing organization such as Island Workforce Housing, Island Housing Trust of MDI, or a private developer; or, engage a consultant to undertake this effort, under the direction of a committee of the Board.

All of these alternatives will require resources, and INH should be prepared to provide the necessary funds beginning in February of 2022. Costs could range from $125,000 for a part-time contract staff person working closely with a highly committed Board committee over a two-year development period, to a high of $250-$300,000 representing a standard development fee in the range of 5% of total development costs. INH should also determine if Covenant might have any resources to support housing development, or an existing consulting relationship that might be tapped.

3. Conduct further due diligence into modular housing and affiliated builders and site developers, select unit and building plans based on the bedroom breakdown recommended above, and confirm pricing. Ronda Dodge has already begun this process, having reached out to Broughman Builders and Coastal Homes, two area builders that work with a number of modular home manufacturers. The subcommittee recommends selecting a so-called "all-in" builder who can handle everything from roads and site infrastructure to foundations, placement of modular homes, and all button-up and finish work. Local contractors are stretched beyond their limits, and probably do not have space in their schedules for a big project.

4. Ramp-up outreach for commitments from Peninsula property owners for year-round rentals, with a minimum commitment of two years beginning in the Fall of 2022. INH needs at least 15 two- to four-bedroom winterized homes or apartments to accommodate 20-26 new staff likely to need housing (assuming the staff can tolerate a somewhat greater degree of sharing during the first two years of operation.) The number of staff likely to need housing should be confirmed by Covenant as part of its consulting scope.

5. Consider purchasing and temporarily placing mobile homes on the chosen development site to supplement year-round rentals, if necessary, given the results of year-round rental outreach in the area. Mobile homes could be purchased and connected to site infrastructure, with a plan to replace them with permanent, higher-quality and more energy-efficient modular homes. Two-bedroom, 2-bath single-wide mobile homes can be purchased for $65-80,000 each, and could be re-sold within a few years at 60-75% of their original value, assuming they are "lightly used" during that time. The net investment after re-sale, amortized over a two-year period, would not be dissimilar to the cost of renting year-round homes over the same period.