

By Rep. Kelley Potenza on September 25, 2026

Special Committee to Look at Long Term Care in Strafford County

**Riverside Rest Home
Comprehensive Future Planning, Utilization,
Fiscal and Phase-Down Report**

*Updated Through Source Documents 2025: RRH Census & Admissions Data
Through 2025, Spreadsheet Updated September 2026*

Purpose. This consolidated report combines the three supplied RRH reports, reconciles overlapping figures, updates census/admissions information with the September 2026 spreadsheet, and identifies figures from census data from the County Administrator.

Executive Summary

The updated RRH spreadsheet materially changes several figures used in earlier drafts. The 2025 total Average Daily Census (ADC) is 172.35, not 172.71. Medicaid ADC is 159.94, Medicare ADC 0.85, private/self-pay ADC 7.93, and insurance/other ADC 3.63. The behavioral unit ADC increased to 35.70 and the memory-care unit ADC to 61.70. Total admissions and re-admissions were 312 in 2025, compared with 304 in 2024 and 346 in 2018.

The long-run utilization picture remains substantially below RRH's earlier peak. Total ADC was 212.35 in 2016, 198.22 in 2019, 136.55 in 2021, approximately 143.34 in 2023, 170.21 in 2024, and 172.35 in 2025. Thus 2025 remained 18.8% below the 2016 peak and 13.0% below 2019, despite the recovery from the 2021 low.

Budgeted RRH expenditures rose from \$27.59 million in 2021 to \$37.46 million in 2025 and \$42.23 million in the updated 2026 budget figure. Using the updated 2025 ADC of 172.35, the 2025 budgeted annual cost per average resident is approximately \$217,322, or \$595.40 per resident-day. For a direct 2026 budget comparison, if RRH operates at the same 172.35 average daily census, the \$42,232,579 2026 budget equals approximately \$245,040 per average resident per year, or \$671.34 per resident-day. This is a budget-based 2026 calculation using the 2025 ADC as the stated census assumption; it should not be described as an actual measured 2026 ADC.

Medicaid cost reports in the supplied financial reports show cumulative reported operating losses of \$74,484,620 from 2015 through 2025, an average of approximately \$6.77 million per year. These reported losses and the rising budget are distinct measures and should be presented separately.

For policy discussion, this report retains the two phase-down pathways contained in the source materials: a 32-month orderly closure model and a five-year phase-down model. They are presented as alternatives for evaluation, not as a directive. Both depend on individualized resident assessments, regulatory coordination, and verified receiving-facility capacity.

Two additional findings sharpen the capped-facility alternative. First, RRH's 2025 resident-day budget cost of approximately \$595.40 is materially above 2026 private-pay benchmarks reported by the American Council on Aging, including New Hampshire's estimated \$440 shared-room and \$463 private-room daily averages. Second, RRH's 2025 new-admission origin data show 142 of 312 admissions (45.5%) originated outside Strafford County. These are different measures—cost benchmarking and admission origin—but together they support closer scrutiny of the mission, scale, and admission priorities of any continuing county-operated facility.

Proofing Corrections and Reconciliations

Item	Earlier Figure	Proofed/Updated Figure	Basis
2025 total ADC	172.71 in fiscal report	172.35	Updated 9/22/2026 RRH spreadsheet
2023 total ADC	144.10 in portions of draft	≈143.34 annual ADC	Weighted from Jan–Jun 142.56 and Jul–Dec 144.10
2025 Medicaid ADC	not included	159.94	Updated spreadsheet
2025 Medicare ADC	not included	0.85	Updated spreadsheet
2025 private/self-pay ADC	not included	7.93	Updated spreadsheet
2025 insurance/other ADC	not included	3.63	Updated spreadsheet
2025 behavioral-unit ADC	not included	35.70	Updated spreadsheet
2025 memory-care ADC	not included	61.70	Updated spreadsheet; note spreadsheet caveat
2025 admissions/re-admissions	not included	312	Updated spreadsheet

2025 cost per resident	\$216,869	≈\$217,322	\$37,455,410 ÷ 172.35
2025 cost per resident-day	not included	≈\$595.40	\$37,455,410 ÷ 172.35 ÷ 365
2026 cost at 172.35 ADC assumption	Earlier draft: 171.00 / \$230,074	≈\$245,040/year; ≈\$671.34/day	\$42,232,579 ÷ 172.35; 2025 ADC held constant as stated 2026 assumption

The updated 2026 county budget total is \$99,560,611. Using the payroll figure of \$57,683,528 carried in the fiscal materials, payroll represents approximately 57.94% of the 2026 county budget. The payroll figure should still be confirmed against the underlying payroll schedule before final public release if that schedule is available.

1. RRH Utilization and Census: 2005–2025

The updated series shows a high-utilization period through the mid-2010s, followed by a material decline after 2019 and a partial recovery in 2024–2025. The recovery does not return RRH to its 2016 peak or 2019 level.

Year	Total ADC	Change vs. 2016
2005	208.97	-1.6%
2010	211.36	-0.5%
2015	207.10	-2.5%
2016	212.35	Peak reference
2017	204.74	-3.6%
2018	199.35	-6.1%
2019	198.22	-6.7%
2020	185.54	-12.6%
2021	136.55	-35.7%
2022	144.61	-31.9%
2023	143.34	-32.5%
2024	170.21	-19.8%
2025	172.35	-18.8%

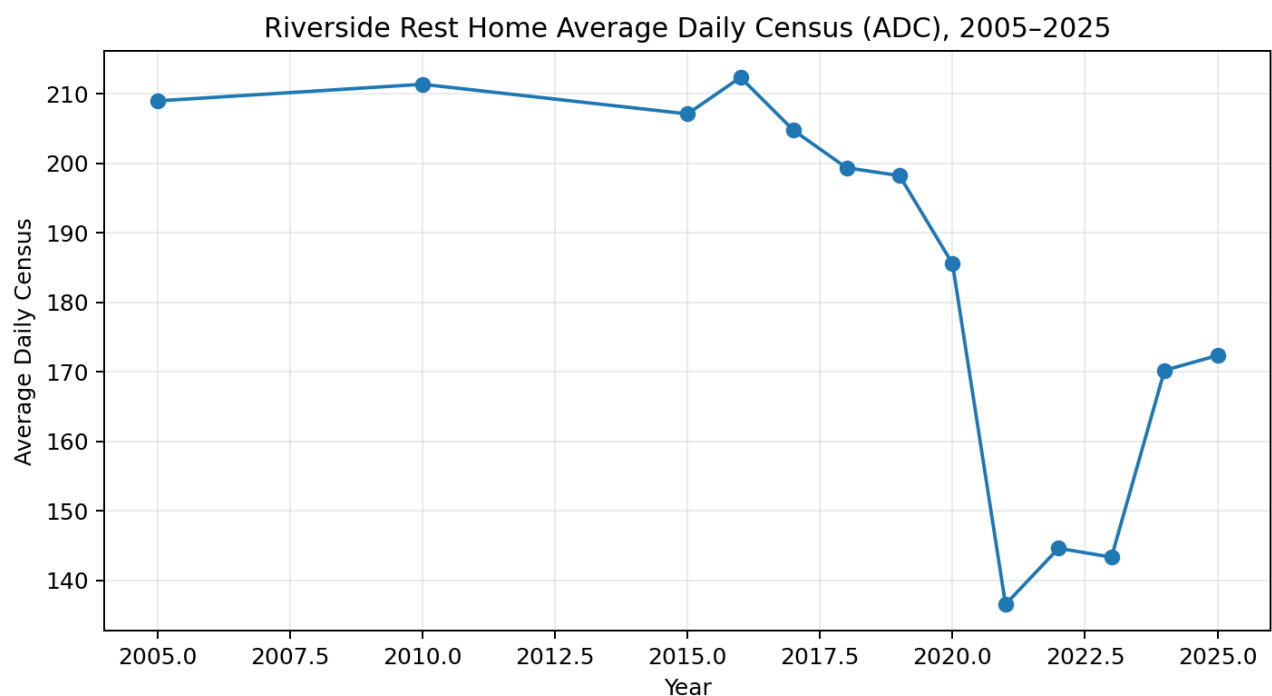


Figure 1. RRH Average Daily Census, updated through 2025.

Source: RRH Census Admissions Data.xlsx, Total ADC row.

Key Utilization Comparisons

- 2016 peak to 2025: -18.8% (212.35 to 172.35).
- 2019 to 2025: -13.1% (198.22 to 172.35).
- 2019 to 2021: -31.1%.
- 2021 to 2025 recovery: 26.2%, but still below 2019.

The correct inference is narrower than saying population aging is irrelevant: the RRH series shows that an aging population has not, by itself, produced a return to RRH's earlier utilization levels. Demographic projections should therefore be evaluated alongside actual utilization, length of stay, home- and community-based services, availability of alternative long term care settings (ALF, CCRC, supported senior housing, etc.) workforce constraints, payer policy, and private/nonprofit capacity.

2. Payer Mix: Medicaid Dominance Continues

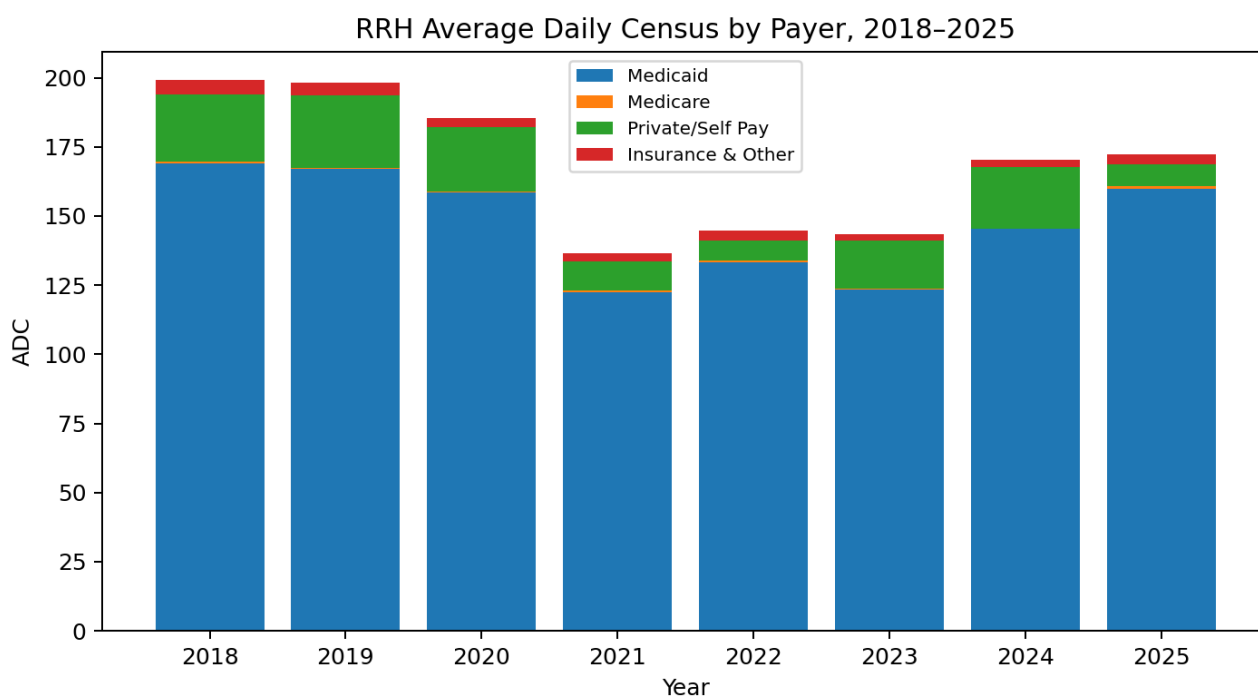


Figure 2. RRH ADC by payer, updated through 2025.

Year	Medicaid	Medicare	Private/Self Pay	Insurance & Other	Total ADC
2024	145.38	0.18	22.19	2.46	170.21
2025	159.94	0.85	7.93	3.63	172.35

In 2025, Medicaid represented approximately 92.8% of total ADC. Medicare remained very small at roughly 0.5% of ADC. The 2025 increase in total census was therefore overwhelmingly Medicaid-driven, while private/self-pay ADC fell sharply from 22.19 in 2024 to 7.93 in 2025.

Source: Updated RRH spreadsheet, payer ADC rows.

3. Admissions and Re-Admissions

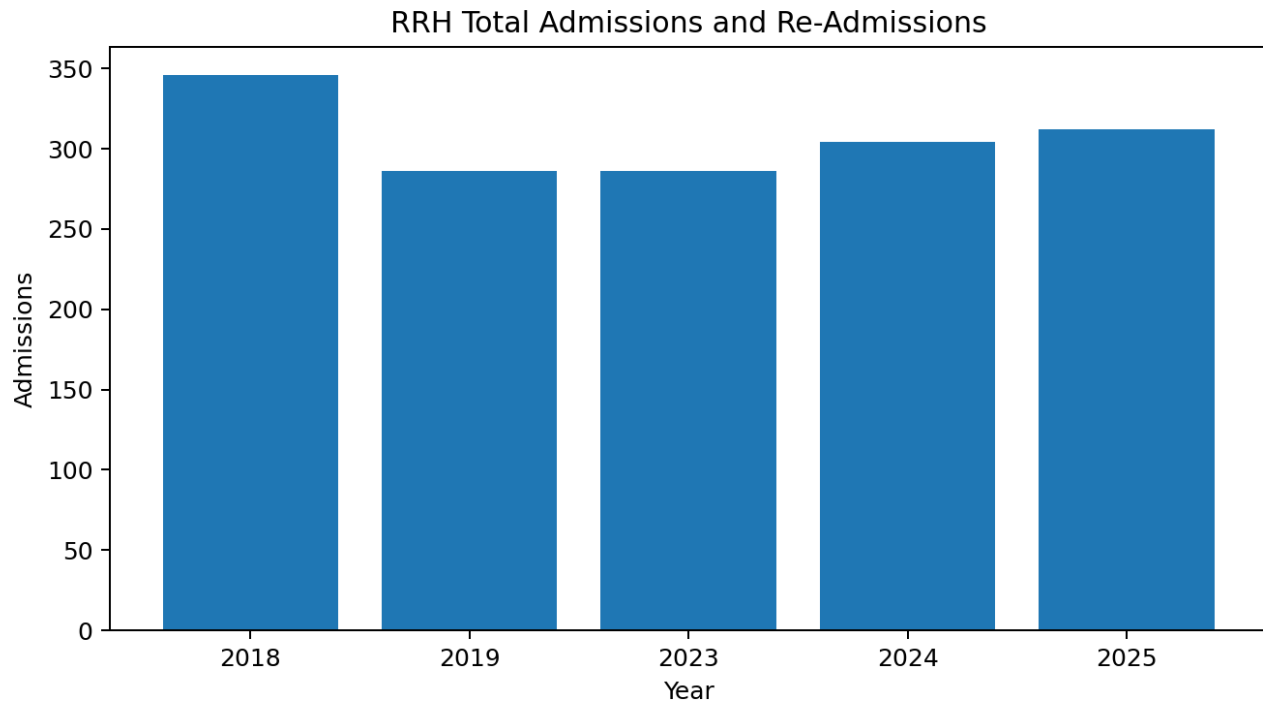


Figure 3. Total admissions and re-admissions for years supplied in the RRH spreadsheet.

Year	Total Admissions & Re-Admissions
2018	346
2019	286
2023	286
2024	304
2025	312

The updated 2025 total is 312. This is higher than 2019 (286), 2023 (286), and 2024 (304), but remains below 2018 (346). Admissions volume therefore does not show the same simple downward pattern as ADC; the report should distinguish admission flow from average daily occupancy. The continued high admission numbers with reduced overall census may also simply reflect a shorter overall average length of stay that has been a trend in nursing homes.

2025 Admission Sources

Source	2025 Count
From Home	185
Homeless	0
From Assisted Living	5
From Another Nursing Home - New Admit	13
Re-admission From Another Nursing Home	53
From Hospital - New Admit	51
Re-admission From Hospital	5
From Inpatient Rehab Facility	0
Psych Hospital	0
Other Source	0

The 2025 source data is particularly relevant to transition planning: 185 admissions originated from home, while 53 were re-admissions from another nursing home and 51 were new admissions from hospitals. These categories should

be analyzed operationally before changing admission policy because they represent different clinical and placement pathways.

4. Behavioral and Memory-Care Census

Year	Behavioral Unit ADC	Memory Care Unit ADC
2018	14.73	60.20
2019	16.16	60.10
2023	17.59	≈59.65
2024	31.08	61.20
2025	35.70	61.70

The behavioral-unit ADC more than doubled from 16.16 in 2019 to 35.70 in 2025. This is an important countervailing trend within the overall facility census and supports a separate placement analysis for residents with behavioral or psychiatric needs. The memory-care figure is comparatively stable. The spreadsheet itself cautions that its memory-care line does not represent all memory-care residents who are RRH residents.

5. Strafford County Skilled Nursing Facility Landscape

The draft report identifies five other skilled nursing facilities in Strafford County for background and transition planning: Birch Healthcare Center (Rochester), Langdon Place of Dover (Dover), Dover Center for Health & Rehabilitation (Dover), Rochester Manor (Rochester), and Saint Ann Rehabilitation and Nursing Center (Dover). Facility status, certified beds, current occupancy, specialty capability, and admission availability should be refreshed from CMS Care Compare / Provider Data and direct facility contacts before any resident-specific transition plan is implemented.

Facility	Municipality	Ownership Stated in Draft
Birch Healthcare Center	Rochester	For-profit
Langdon Place of Dover	Dover	For-profit
Dover Center for Health & Rehabilitation	Dover	For-profit
Rochester Manor	Rochester	For-profit
Saint Ann Rehabilitation and Nursing Center	Dover	Nonprofit

The existence of multiple facilities is evidence of a regional provider network, but it is not by itself proof that an appropriate bed is available for every RRH resident at a given time. Real-time placement capacity must be verified by clinical need, payer, specialty services, resident preference, and actual admission availability.

6. New Hampshire and National Long-Term Care Context

Utilization vs. Occupancy

The draft report's national-market section emphasizes an important distinction: occupancy can rise when the number of operating beds falls, even if underlying utilization does not materially increase. The Plante Moran material summarized in the source report states that U.S. nursing homes lost roughly 55,000 beds between 2008 and 2023 and that utilization relative to the 65+ population declined before COVID-19 and stabilized at a lower level after 2021.

New Hampshire Ownership and Quality

The draft report summarizes a 2023 University of New Hampshire study of 73 New Hampshire skilled nursing facilities. It reports average CMS overall ratings of approximately 3.48 for for-profit facilities and 3.35 for nonprofit/government facilities, with overlapping 95% confidence intervals. The appropriate conclusion is that the study did not identify a statistically significant quality difference by ownership category; it does not establish that every private facility is equivalent to RRH for every resident.

HCBS and Consumer Preference

The source report also describes a state and national shift toward home- and community-based services (HCBS), along with consumer preference to remain at home or in community settings when feasible. This context should be used alongside, not in place of, RRH-specific census and resident-acuity data.

7. Length of Stay, Turnover, and Natural Census Change

The draft report cites published research indicating that median nursing-home stays among decedents are often measured in months and mean stays around one year, while RRH records are described as showing approximately 70 resident deaths per year. If the local death figure is confirmed from RRH records, natural turnover is a material planning variable. It should not, however, be treated as a guarantee that any particular resident will transition within a fixed period.

8. RRH Budget Trend and Updated Cost per Resident

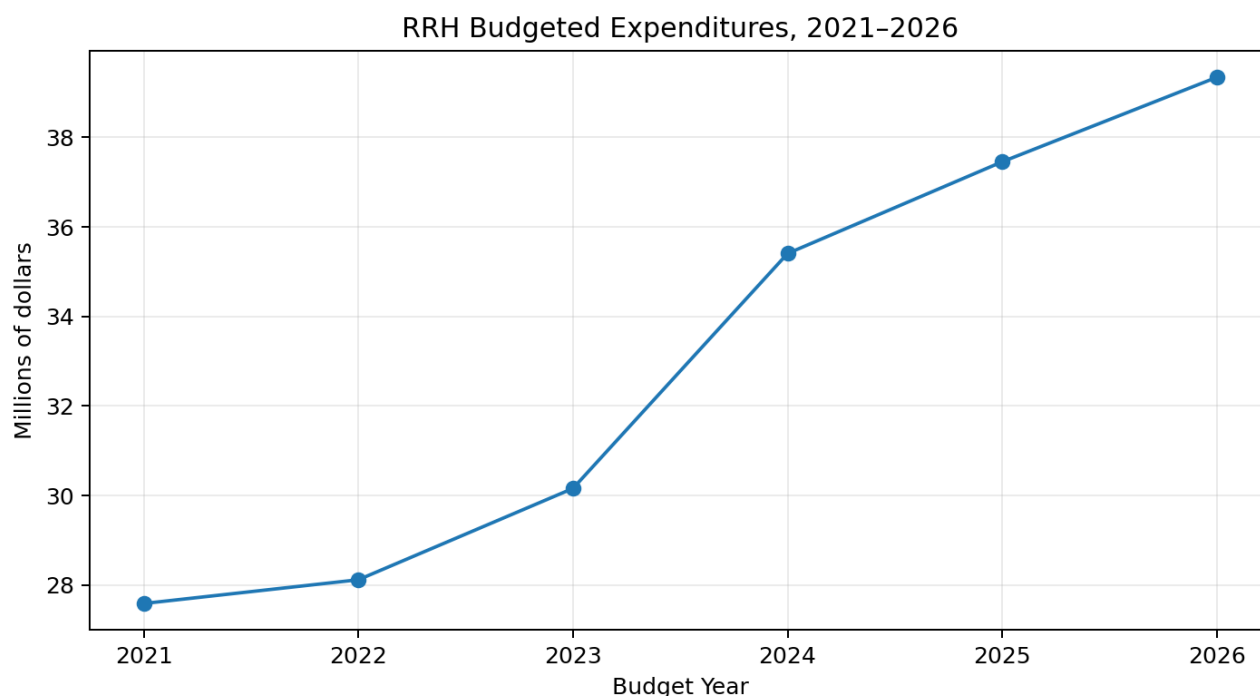


Figure 4. RRH budgeted expenditures, 2021–2026. NOTE: the chart image immediately above reflects the earlier 2026 figure; see Figure 4A below for the updated 2026 budget.

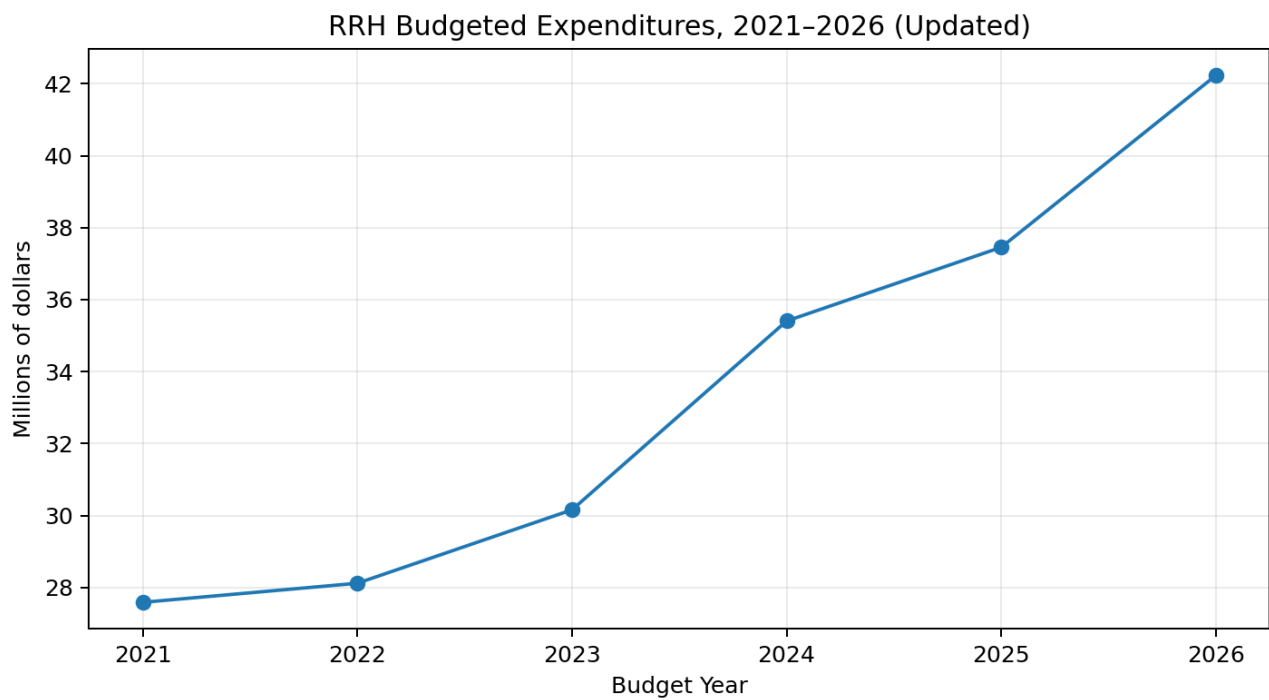


Figure 4A. Updated RRH budgeted expenditures using the revised 2026 figure of \$42,232,579.

Budget Year	RRH Budget	ADC	Budget / Avg Resident	Budget / Resident-Day
2021	\$27,587,470	136.55	\$202,032	\$553.51
2022	\$28,117,961	144.61	\$194,440	\$532.71
2023	\$30,158,231	143.34	\$210,396	\$576.43
2024	\$35,406,322	170.21	\$208,016	\$569.91
2025	\$37,455,410	172.35	\$217,322	\$595.40
2026	\$42,232,579	172.35 (2025 ADC held constant for comparison)	\$245,040	\$671.34

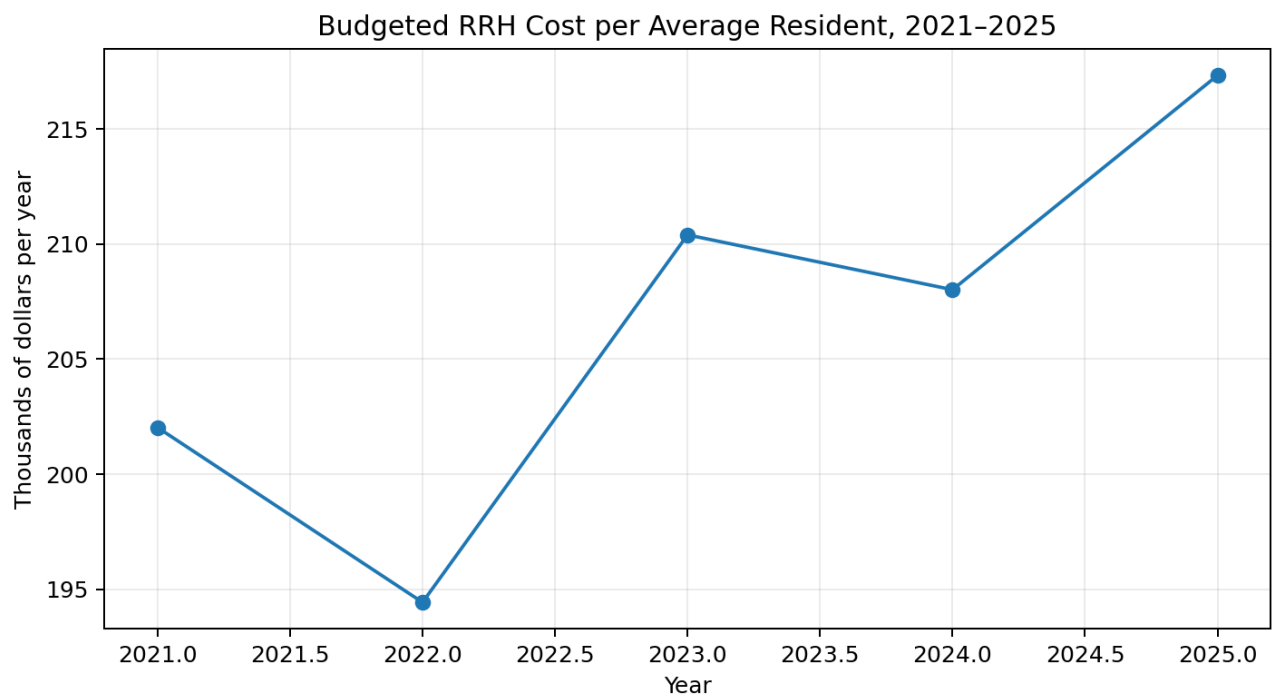


Figure 5. Budgeted annual cost per average resident, proofed through 2025.

8A. External Cost Benchmarks: RRH Compared with 2026 Private-Pay Nursing Home Costs

The RRH cost-per-resident calculation is an operating-budget measure, not a room charge. In 2025, the RRH budget of \$37,455,410 divided by the Average Daily Census of 172.35 equals approximately \$217,322 per average resident per year, or \$595.40 per resident-day. Using the same 172.35 ADC as the stated assumption for 2026, the \$42,232,579 RRH budget equals approximately \$245,040 per average resident per year, or \$671.34 per resident-day. For context, the American Council on Aging’s January 2026 nursing-home cost compilation estimates the nationwide private-pay average at \$327 per day (\$119,340 annually) for a shared room and \$375 per day (\$136,948 annually) for a private room. For New Hampshire, it estimates \$440 per day (\$160,425 annually) for a shared room and \$463 per day (\$169,033 annually) for a private room; the Manchester-area estimates are \$475 and \$525 per day, respectively.

Benchmark	Annual Cost	Daily Cost	RRH Difference
RRH 2025 budget / ADC	\$217,322	\$595.40	Baseline
RRH 2026 budget at 172.35 ADC assumption	\$245,040	\$671.34	2026 constant-census comparison
U.S. 2026 private-pay shared room	\$119,340	\$327	2025 RRH +82.1%; 2026 RRH +105.3%
U.S. 2026 private-pay private room	\$136,948	\$375	2025 RRH +58.8%; 2026 RRH +79.0%
NH 2026 private-pay shared room	\$160,425	\$440	2025 RRH +35.3%; 2026 RRH +52.6%
NH 2026 private-pay private room	\$169,033	\$463	2025 RRH +28.6%; 2026 RRH +45.0%
Manchester-area 2026 shared room	\$173,337	\$475	2025 RRH +25.3%; 2026 RRH +41.3%
Manchester-area 2026 private room	\$191,727	\$525	2025 RRH +13.4%; 2026 RRH +27.9%

Interpretation and limitation. Even against the higher New Hampshire private-room benchmark, RRH’s 2025 budgeted cost per average resident is about 28.6% higher; against the New Hampshire shared-room benchmark it is about 35.3% higher. Against the national shared-room benchmark, the gap is about 82.1%. These comparisons identify the scale of the cost difference, but they are not perfectly apples-to-apples: the RRH figure is a public facility’s

total budget divided by average census, while the American Council on Aging figures are estimated private-pay market prices. The comparison should therefore be used as a benchmarking signal requiring explanation—not as proof that every dollar of the gap is avoidable.

Source: American Council on Aging, “2026 Nursing Home Costs by State and Region,” updated January 7, 2026. The source states that its figures are estimated private-pay costs and reports national, New Hampshire statewide, and Manchester-area shared/private room benchmarks.

From 2021 to 2025, RRH budgeted expenditures increased by 35.8%. Using the updated 2025 ADC of 172.35, budgeted cost per average resident was approximately \$217,322 per year and \$595.40 per resident-day. The updated 2026 RRH budget is \$42,232,579. Holding the census constant at the same 172.35 ADC for comparison, the 2026 budget works out to approximately \$245,040 per average resident per year and \$671.34 per resident-day. This is the appropriate way to show what the 2026 budget costs at the same census level: it is a stated constant-census calculation, not a claim that 172.35 is the actual 2026 ADC.

9. Medicaid Cost-Report Losses, 2015–2025

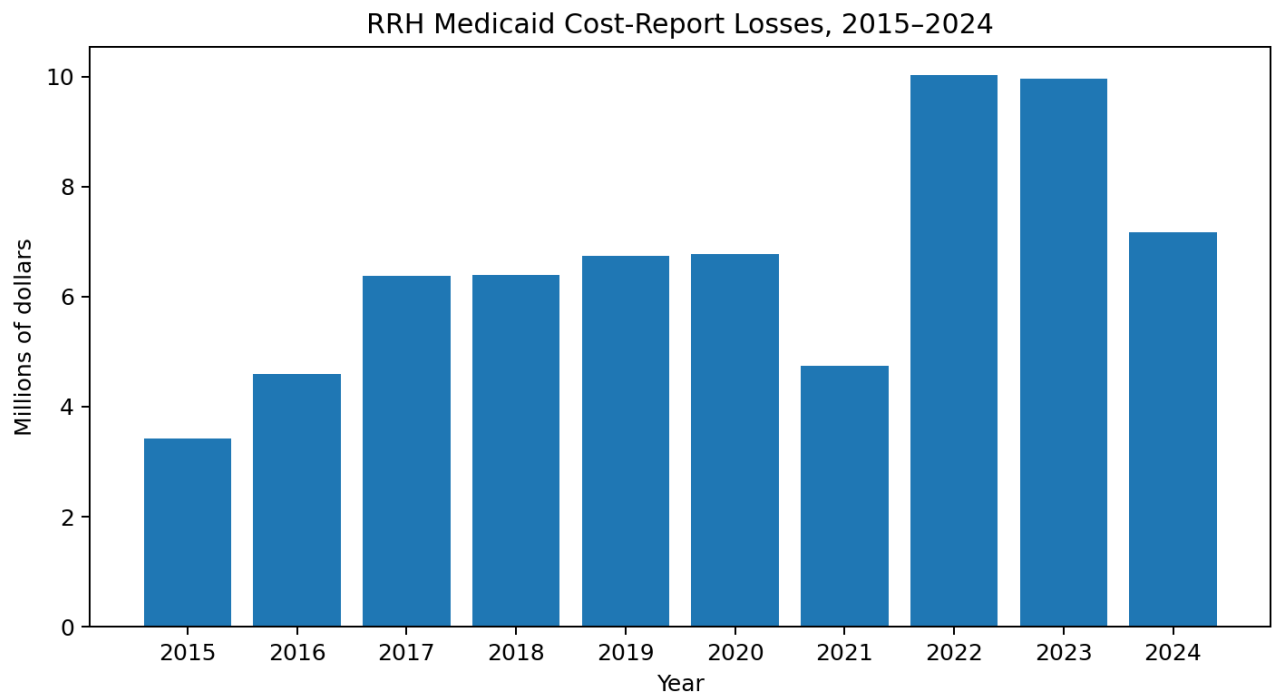


Figure 6. Reported Medicaid cost-report operating losses in the supplied financial reports.

Year	Reported Operating Loss
2015	\$3,414,920
2016	\$4,600,098
2017	\$6,374,389
2018	\$6,394,548
2019	\$6,733,385
2020	\$6,769,509
2021	\$4,748,329
2022	\$10,034,466
2023	\$9,955,644

2024	\$7,165,426
2025	\$8,293,906

The Medicaid cost-report series now includes the 2025 reported operating loss of \$8,293,906. **Cumulative reported operating losses from 2015 through 2025 total \$74,484,620**, averaging approximately \$6,771,329 per year over eleven years. These figures should be described as Medicaid cost-report operating results, not as the same thing as the annual county budget or tax levy. The source materials state that they exclude future capital replacement and major renovation costs.

Source and interpretation of the Medicaid cost reports. The Medicaid cost reports used in this analysis were provided by Raymond Bower, Strafford County Administrator. The “loss” identified in those reports is the closest standardized measure in the materials provided to a nursing-home net operating gain or loss comparable in concept to the bottom line of a typical business profit-and-loss statement. It should not be confused with the County budget, cash flow, tax levy, or a private-company audited income statement.

Why the cost-report series is useful. Medicaid-reimbursed nursing facilities report revenues and expenses using a standardized cost-report format. The reporting process allocates indirect and overhead costs to the licensed nursing-home operation so that costs associated with the licensed services are captured consistently. This makes the series particularly useful for evaluating operating performance over time and reduces the risk of comparing unlike accounting categories from one year to the next.

The long time series is also important because the COVID-19 years were atypical for nursing facilities nationwide. Rather than drawing a conclusion from 2020–2021 alone, the report examines the full 2015–2025 pattern. The losses remained substantial after the acute pandemic period: \$10.03 million in 2022, \$9.96 million in 2023, \$7.17 million in 2024, and \$8.29 million in 2025. The persistence of losses after operations moved toward a post-pandemic “new normal” is therefore more informative than any single COVID-era year.

The **2025 reported loss is \$8,293,906**. The supplied analysis interprets this as evidence of a recurring operating deficit because reimbursement and other revenues do not cover allocated nursing-home costs. For public presentation, that interpretation should be paired with the underlying cost report and its accounting definitions so readers can distinguish standardized cost-report loss from cash flow, budget appropriations, and county-wide taxation.

10. Wage and Benefit Commitments

Year	Contractual Increase	Effective Date
2021	2.10%	4/1/2021
2022	4.00%	1/1/2022
2023	+\$2.00/hour	1/1/2023
2024	2.00%; plus +\$4/hr for 30+ hrs and +\$3/hr for <30 hrs	1/1/2024; 4/1/2024
2025	4.50%	1/1/2025
2026	4.00%	1/1/2026

The supplied financial report argues that repeated wage increases compound payroll-related costs through overtime, payroll taxes, retirement contributions, workers' compensation, and benefits. That is a valid cost-mechanics point; however, wage policy should be evaluated together with labor-market conditions, staffing requirements, turnover, vacancy rates, and resident-care obligations rather than inferred solely from operating losses.

The source report also identifies a \$684,860 RRH union settlement / wage-adjustment line in the proposed 2026 budget and materially higher employee health-insurance costs. Those line items should remain tied to the underlying budget page in any final public packet.

11. County-Wide Budget and Payroll Context

Year	Total County Budget	Payroll (as stated in supplied report)	Payroll % of Total Budget
2016	\$60,058,257	\$34,827,531	57.99%
2017	\$67,515,715	\$37,381,925	55.37%
2018	\$71,304,002	\$40,001,398	56.10%
2019	\$73,787,020	\$41,967,443	56.88%
2020	\$76,714,024	\$44,642,645	58.19%
2021	\$75,067,535	\$32,246,293	42.96%
2022	\$73,897,523	\$27,411,147	37.09%
2023	\$78,002,950	\$33,576,984	43.05%
2024	\$87,405,856	\$35,373,324	40.47%
2025	\$90,109,776	\$38,517,402	42.74%
2026	\$99,560,611	\$57,683,528	57.94%

The updated county budget total increases from \$60.06 million in 2016 to \$99.56 million in 2026, a rise of approximately \$39.50 million or 65.8%. Using the stated 2026 payroll figure of \$57.68 million, payroll represents approximately 57.94% of the 2026 budget. This is no longer the highest payroll share in the series; several earlier years were near or above this level.

12. Resident-Centered Transition Framework

Transition-Now Clinical Screening During Any Transition

- Resident is clinically stable and does not have unresolved acute instability.
- Care needs can be met safely by the receiving facility.
- Behavioral, psychiatric, memory-care, bariatric, dialysis, wound-care, or other specialty needs are specifically assessed.
- Resident and family/guardian are engaged in choice and planning.
- A receiving facility has documented acceptance and the payer/coverage pathway is confirmed.
- Transfer records, medication orders, MDS/care plan, therapy notes, and follow-up arrangements are complete.

A small transition team (social work, nursing, case management/utilization, and billing/Medicaid expertise) could conduct weekly placement rounds. The objective would be to identify residents who already prefer and can safely use another setting, while preventing involuntary or clinically inappropriate movement.

Behavioral Unit Policy

Because the behavioral-unit ADC rose to 35.70 in 2025, this population deserves a dedicated workstream. Before any reduction in specialized capacity, the County should complete an individualized audit of psychiatric, behavioral, dementia, safety, and supervision needs and identify realistic receiving options. The source draft proposes freezing new behavioral-unit admissions during that assessment period; if considered, such a freeze should be reviewed for clinical, regulatory, access, and emergency-placement implications.

Regulatory Coordination

The source draft calls for early engagement with NH DHHS and the Long-Term Care Ombudsman, a written closure/relocation plan, individualized transfer decisions, resident-choice protections, and compliance with federal transfer/discharge and facility-closure requirements. It cites 42 C.F.R. §§ 483.15 and 483.70(l). Any final closure schedule should be built around the actual state approval and notice requirements in effect at the time.

Natural Turnover and Its Role in Phase-Down Planning

Published research shows that median nursing-home stays among residents who die in a facility are often measured in months, with mean stays around one year. **RRH records from Raymond Bower, Strafford County Administrator indicate an average of approximately 70 resident deaths per year**, representing a significant and predictable level of natural turnover. This natural attrition should be incorporated into any phase-down strategy because census can decline substantially without requiring the transfer of every existing resident. By limiting new long-term admissions, RRH could allow census to decline organically while maintaining continuity of care for remaining residents.

13. Policy Option A: 32-Month Phase-Down / Orderly Closure

This option, carried forward from the draft report, is the faster of the two pathways. It would require the most intensive transition management and the earliest reduction in new long-stay admissions.

Timing	Workstream	Illustrative Actions
0–2 months	Governance and protections	Adopt no-displacement-without-placement policy; designate transition lead; engage Ombudsman and resident/family representatives.
0–3 months	Admissions policy	Review or stop elective long-stay admissions where safe alternatives exist; do not increase specialized census without placement analysis.
0–6 months	Resident triage	Classify residents by immediate transition potential, stabilization needs, and complex/end-of-life needs.
3–18 months	Footprint consolidation	Close or consolidate units only as census and safe staffing allow; use attrition/redeployment where feasible.
6–24 months	QoL mini-renovations	Limit work to occupied areas: mattresses, lighting, paint, seating, accessibility, quiet space, wayfinding, comfort/HVAC.
18–32 months	Final sequence	Maintain safe care for remaining residents; complete records/licensure steps; determine property disposition separately.

The earlier draft mentioned negotiated placement 'blocks' or priority pathways. Because the same draft also warns against preferential arrangements or inducements, this combined version reconciles the two: the County may establish communication and capacity-planning relationships with facilities, but resident placement should proceed through lawful, clinically appropriate processes that preserve resident choice and avoid improper inducements.

14. Policy Option B: Five-Year Phase-Down

The five-year model provides more time for resident choice, workforce attrition, specialty placement, and property planning. It also prolongs exposure to operating deficits and fixed costs relative to a faster closure, although the actual difference cannot be quantified reliably without a detailed cost-behavior model.

Year	Illustrative Milestones
Year 1	Freeze net growth in long-stay census; create transition team; begin voluntary transitions; complete behavioral/specialty audit.
Year 2	Consolidate to fewer wings where safe; expand HCBS/private-facility coordination; use attrition and redeployment.
Year 3	Reduce licensed/operating footprint where legally and operationally feasible; focus remaining capacity on residents already in-house with higher placement barriers.
Year 4	Operate a smaller bridge footprint while completing difficult placements; finalize disposition planning.
Year 5	Complete final resident transitions and closure, subject to regulatory approval and safe placement.

15. Policy Option C: Draw Down and Cap RRH at Approximately 100 Residents

This option would not commit the County to immediate closure. Instead, RRH would be deliberately reduced from the 2025 ADC of 172.35 to an operating cap of approximately 100 residents—a reduction of about 42%—and then maintained as a substantially smaller county nursing-home operation while the County evaluates longer-term economic, reimbursement, capital, and demand conditions. The cap should be treated as an operating ceiling, not a requirement to fill beds.

Resident transitions would remain individualized. Residents who can safely and voluntarily transition to another appropriate nursing facility or community setting would be prioritized, while RRH would retain a smaller bridge population that may include residents with higher placement barriers, specialized needs, or a strong preference to remain, subject to clinical and regulatory requirements.

Renovation envelope. Under this alternative, the County could authorize a limited capital envelope of up to approximately \$2 million, focused only on improvements that directly affect resident safety, dignity, comfort, and building reliability. Illustrative work includes room and bathroom improvements, accessibility and shower upgrades, HVAC and heating repairs or targeted replacement, lighting, electrical reliability, plumbing, flooring, resident common areas, and other high-priority life-safety or comfort items. The purpose would be to improve the smaller active footprint—not to undertake a major expansion or replacement project.

Component	Illustrative Framework
Census	Draw down toward an operating cap of ~100 residents; no obligation to refill vacancies.
Admissions	Use a controlled admissions policy consistent with the cap and resident-care obligations.
Staffing	Reduce staffing in step with census, acuity, regulatory ratios, and the smaller occupied footprint; emphasize attrition, redeployment, and retention only where needed for safe care.
Building footprint	Consolidate residents into the smallest safe and efficient portion of the facility; close or mothball unused areas where feasible.

Capital	Up to ~\$2 million for targeted room, bathroom, HVAC/heating, accessibility, life-safety, and comfort improvements.
Review point	Require periodic fiscal, census, placement-capacity, reimbursement, and building-condition reviews before any decision to expand, continue, or move toward closure.

Fiscal effect and staffing. A 100-resident cap would create an opportunity to reduce direct-care and support staffing and consolidate the occupied footprint, but savings should not be estimated by simply multiplying the current per-resident cost by the census reduction. RRH carries substantial fixed and semi-fixed costs. Before adoption, the County should build a line-item cost model identifying positions, utilities, contracted services, insurance, maintenance, and overhead that can actually be eliminated or reduced at each census threshold.

Economic-risk rationale. This alternative can also function as a contingency strategy during a period of elevated economic uncertainty: it limits new long-term capital commitments while preserving a smaller public-care capacity. Current federal data support describing the environment as uncertain and inflationary, but not as an established “Great Depression.” The Federal Reserve’s September 2026 projections show continued positive GDP growth while also projecting elevated 2026 inflation, and the September FOMC statement describes economic activity as expanding at a solid pace. FDIC data list two bank failures in 2026 through its latest posted summary. CMS has also finalized positive aggregate Medicare SNF payment updates for FY2026 and FY2027. Accordingly, this report frames recession, financial-market stress, reimbursement volatility, energy costs, and construction-input costs as downside risks to stress-test—not as certainties or as facts that federal reimbursement has stopped.

Policy value of the 100-resident option. Compared with full-scale continuation, this approach could reduce operating exposure and defer large capital decisions. Compared with a fixed closure timetable, it preserves a smaller county safety-net capacity while decision-makers observe actual post-pandemic utilization, Medicaid reimbursement, labor costs, energy costs, private-facility capacity, and broader economic conditions. Its principal tradeoff is that the County would continue to own and operate RRH and would therefore retain significant fixed-cost, labor, capital, regulatory, and liability exposure.

County-Residency Priority Under the 100-Resident Cap

If Strafford County retains RRH as a smaller public safety-net facility, the County should explicitly examine whether scarce county-funded capacity is being reserved primarily for Strafford County residents with the greatest financial and placement need, subject to federal and state law, Medicaid requirements, resident rights, and nondiscrimination rules. The strongest available 2025 RRH data point is not a snapshot of current residents by county; it is the spreadsheet’s “Resident Origin” table for new admissions. That distinction is important and should be stated clearly.

In 2025, RRH recorded 312 new admissions. Of those, 170 originated from Strafford County municipalities and 142 originated outside Strafford County. Thus, approximately 54.5% of 2025 new admissions were from within Strafford County and approximately 45.5% were from outside the county. The largest out-of-county sources were Merrimack County (79 admissions) and Rockingham County (51), followed by Hillsborough County (5), Carroll County (3), Grafton County (2), and Sullivan County (2). The spreadsheet reports no 2025 admissions from Belknap County or out of state.

2025 New-Admission Origin	Admissions	Share of 312
Strafford County municipalities	170	54.5%
Merrimack County	79	25.3%
Rockingham County	51	16.3%
Hillsborough County	5	1.6%
Carroll County	3	1.0%
Grafton County	2	0.6%

Sullivan County	2	0.6%
Belknap County	0	0.0%
Out of State	0	0.0%
Total outside Strafford County	142	45.5%
TOTAL NEW ADMISSIONS	312	100.0%

Policy implication for a capped facility. A cap near 100 residents is materially more defensible as a county safety-net model if admission policy is aligned with the county purpose of the facility. The 2025 origin data show that nearly half of new admissions came from outside Strafford County. That does not establish that 45.5% of the current resident census is out-of-county, nor does it by itself establish legal authority to exclude otherwise eligible applicants. It does, however, support a formal review of admission priorities, residency criteria, inter-county financial responsibility, and whether Strafford County taxpayers are subsidizing capacity that is serving substantial demand originating elsewhere.

Recommended implementation under Option C. Before adopting a 100-resident cap, direct RRH and County administration to produce: (1) a current resident roster summarized by county of domicile immediately before admission; (2) payer source and county financial responsibility for each resident category; (3) a legal review of permissible county-residency preferences; and (4) a written admission policy that gives lawful priority to indigent Strafford County residents who cannot be safely served elsewhere, while preserving required resident protections and emergency exceptions. This would turn the cap from an arbitrary number into a defined county safety-net mission.

Source: RRH Census & Admissions Data spreadsheet updated September 22, 2026, “Resident Origin” section, 2025 column. The spreadsheet defines the measure as the number of new admissions by city/town/state of origin and, for hospital/external short-stay admissions, the resident’s home town immediately before that stay.

16. Limited Quality-of-Life Improvements During Any Phase-Down

- Bathroom safety upgrades: grab bars, non-slip surfaces, shower seating.
- Lighting improvements in occupied rooms and corridors.
- Noise reduction and quiet-space improvements.
- Refresh visitor/family areas and resident seating.
- Courtyard safety/accessibility improvements.
- Wi-Fi, telehealth, and resident connectivity improvements.
- Mattress replacement, wayfinding, paint, and modest comfort/HVAC work in active areas.

The governing principle is to maintain dignity, safety, and comfort without making major capital investments premised on decades of continued operation. Any proposed project should be evaluated for useful life, resident benefit, regulatory necessity, and whether it remains valuable under a reduced footprint.

17. Fiscal Risk: County-Owned vs. Private/Nonprofit Provider

Cost / Risk	County-Owned RRH	Private / Nonprofit Facility
Employee compensation / benefit commitments	Direct county obligation	Provider obligation; Medicaid/Medicare reimbursement still public where applicable
Major building repair / replacement	County capital exposure	Provider balance-sheet exposure
Census volatility	Directly affects county operation	Provider operational risk
Regulatory staffing/compliance	County bears operating cost	Provider bears operating cost
Liability/insurance	County exposure	Provider exposure

Resident Medicaid entitlement	Public payer obligation continues	Public payer obligation continues
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This comparison should not be read to mean that transitioning a Medicaid resident eliminates all public cost; Medicaid reimbursement remains a public expenditure. The distinction is that county taxpayers would no longer directly own the facility, employ its workforce, or carry its building, operating, and employer liabilities.

18. Property Disposition and Reuse

The draft report proposes competitive sale of the RRH property for adaptive reuse and cautions against replacing the nursing-home enterprise with a new county-operated housing or care enterprise. Property disposition is legally and financially distinct from resident-care planning and should be handled through the County's applicable authority, appraisal, procurement, delegation, and public-asset requirements. Any minimum price, deed restriction, buyer qualification, or proposed use should be separately documented and reviewed.

19. Conclusions for Subcommittee Review

The updated 2025 spreadsheet strengthens some portions of the prior analysis and complicates others. Total ADC increased modestly from 170.21 in 2024 to 172.35 in 2025, and admissions/re-admissions increased from 304 to 312. At the same time, 2025 ADC remained materially below the 2016 peak and 2019 level, the payer mix became even more Medicaid-dominant, and behavioral-unit census increased to 35.70.

Financially, the proofed 2025 budget-to-census calculation is approximately \$217,322 per average resident per year. The Medicaid cost-report series now documents \$74.48 million in cumulative reported operating losses from 2015–2025, including a 2025 reported loss of \$8,293,906. These facts support continued examination of RRH's long-term operating model, but they do not by themselves answer resident-specific placement questions or establish real-time bed availability.

The three pathways in this report provide a structured basis for that examination: a 32-month orderly closure, a five-year phase-down, and a draw-down/cap model of approximately 100 residents with limited targeted renovations. Before any pathway is adopted, the subcommittee would need current facility-capacity data, a resident-level acuity and placement audit, a detailed fixed/variable cost model, workforce impacts, regulatory requirements, and legal review of any eventual property disposition.

Economic Stress-Test Sources for Option C

Federal Reserve, September 16, 2026 Summary of Economic Projections and FOMC statement: median 2026 real GDP growth 2.3%, unemployment 4.1%, PCE inflation 3.7%; the FOMC described economic activity as expanding at a solid pace while inflation remained elevated.

Federal Deposit Insurance Corporation, 2026 Bank Failures in Brief: two bank failures listed in the 2026 summary as of the latest posted update.

Centers for Medicare & Medicaid Services, FY2026 and FY2027 Skilled Nursing Facility Prospective Payment System final rules: estimated aggregate Medicare SNF payment increases of 3.2% for FY2026 and 2.4% for FY2027. These Medicare updates do not resolve RRH's Medicaid-dominant payer-mix issues, but they do not support stating that federal SNF reimbursement has stopped.

Appendix A – 2025 Updated RRH Data Snapshot

Measure	2025
Total ADC	172.35
Medicaid ADC	159.94
Medicare ADC	0.85
Private/Self Pay ADC	7.93
Insurance & Other ADC	3.63
Behavioral Unit ADC	35.70
Memory Care Unit ADC	61.70*
Total Admissions & Re-Admissions	312

* Spreadsheet note: memory-care line does not represent all memory-care residents who are Riverside Rest Home residents.

Appendix B – Key Reference Sources

- Strafford County RRH budgets: approved budgets 2021–2026
- RRH Census & Admissions Data spreadsheet, updated September, 2026.
- Medicare Care Compare nursing-home facility pages.
- CMS Provider Data Catalog nursing-home datasets.
- NH DHHS Data Portal and nursing-facility / closure guidance.
- ProPublica Nursing Home Inspector / Tracker.
- NH GRANIT / New Hampshire Geodata Portal nursing-home dataset.
- University of New Hampshire study: Analyzing Quality of Care in New Hampshire Nursing Homes in Relation to Ownership Status.
- Plante Moran (2024), Future of Skilled Nursing Facilities.
- KFF nursing-facility facts and occupancy/resident analyses.
- MedPAC skilled nursing facility services chapters.
- Peer-reviewed research cited in the draft regarding SNF capacity and nursing-home length of stay.
- 42 C.F.R. §§ 483.15 and 483.70(l), plus other applicable resident-assessment and transfer/discharge requirements.

CENSUS ADMISSIONS DATA

Riverside Rest Home

	2000	2005	2010	2015	2016	2017	2018	2019	2020	2021	2022	2023	2023	2024	2025
	Leap Yr				Leap				Leap			OLD PCC	NEW PCC	Leap	
CENSUS: Average Daily Census (ADC)												Jan-Jun	Jul-Dec		
MEDICAID ADC		173.32	186.12	181.98	183.66	177.05	169.01	167.2	158.61	122.33	133.29	127.67	119.2	145.38	159.94
MEDICARE ADC		3.66	1.63	1.23	1.3	0.58	0.79	0.14	0.3	0.72	0.56	0.25	0.32	0.18	0.85
Private (Self) Pay ADC		30.94	18.85	22.23	22.77	21.68	24.24	26.19	23.17	10.58	7.39	12.63	22.19	22.19	7.93
Insurance & Other ADC		1.05	4.76	1.66	4.62	5.43	5.31	4.69	3.46	2.92	3.37	2.01	2.39	2.46	3.63
Total ADC		209	211.36	207.1	212.35	204.74	199.35	198.22	185.54	136.55	144.61	142.56	144.10	170.21	172.35

Behavioral Unit - Avg Daily Census							14.73	16.16				17.59	17.59	31.08	35.7
Memory Care Unit - Avg Daily Census							60.2	60.1				59.7	59.6	61.2	* 61.7

							2018	2019				2023	2023	2024	2025
ADMISSIONS SOURCES															
From Home							129	129				88	125	172	185
Homeless							0						2	1	0
From Assisted Living							11	12				2	13	17	5
From Another Nursing Home (New Admit)							12	5				1	28	27	13
Re-Admission From Another Nursing Home													17	19	53
From Hospital (New Admit)							150	96				42	56	60	51
Re-Admission From Hospital															5
From Inpatient Rehab Facility							6	16				3	2		0
Psych Hospital							10	7				3	7	8	0
Other Source							28	21				1	36		0
Total NEW Admissions Only															
Total ALL Admissions & Re-Admissions							346	286				140	286	304	312

* This does not represent all memory care residents who are Riverside Rest Home residents

CENSUS ADMISSIONS DATA SUBMITTED

Riverside Rest Home

Resident Origin		2018	2019		2023	2023	2024	2025
# of ADMISSIONS from each City/Town & State where NEW admissions originated from.								
For hospital and external short stay nursing home admissions what was the residents home town immediately prior to the hospital or short term nursing home stay?								
Barrington		7	5		7	5	9	10
Dover		49	29		21	54	74	52
Durham		9	8		5	16	21	13
Farmington		9	6		4	5	4	8
Lee		9	3		5	8	14	4
Madbury		2	3		0	4	2	0
Middleton		2	1		0	6	3	0
Milton		3	3		4	5	6	9
New Durham		0	3		2	1	1	9
Rochester		65	52		24	63	71	48
Rollingsford		3	2		5	5	1	1
Somersworth		25	18		5	9	7	15
Strafford		6	0		1	1	1	1
Belknap County, NH		2	4		1	1	2	0
Carroll County, NH		2	3		5	6	5	3
Grafton County, NH		0	0		0	8	1	2
Hillsborough County, NH		3	2		0	0	0	5
Merrimack County, NH		5	1		1	6	9	79
Rockingham County, NH		94	107		33	27	38	51
Sullivan County, NH		0	1					2
Out of State		49	31		15	32	35	0
Unkown / Unable to Determine		2	4		2	24		
TOTAL ALL NEW ADMISSIONS		346	286		140	286	304	312