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CODE # 9150
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INCORPORATED

STUDY OF THE MINNESOTA STATE VETERANS HOME

CONDUCTED FOR THE MINNESOTA STATE DEPARTMENT OF ADMINISTRATION

MANAGEMENT SCIENCES DEPARTMENT
WASHINGTON, D.C.

JULY 1968

STATE OF MINNESOTA
DEPARTMENT OF ADMINISTRATION
CONTRACT # E-2599
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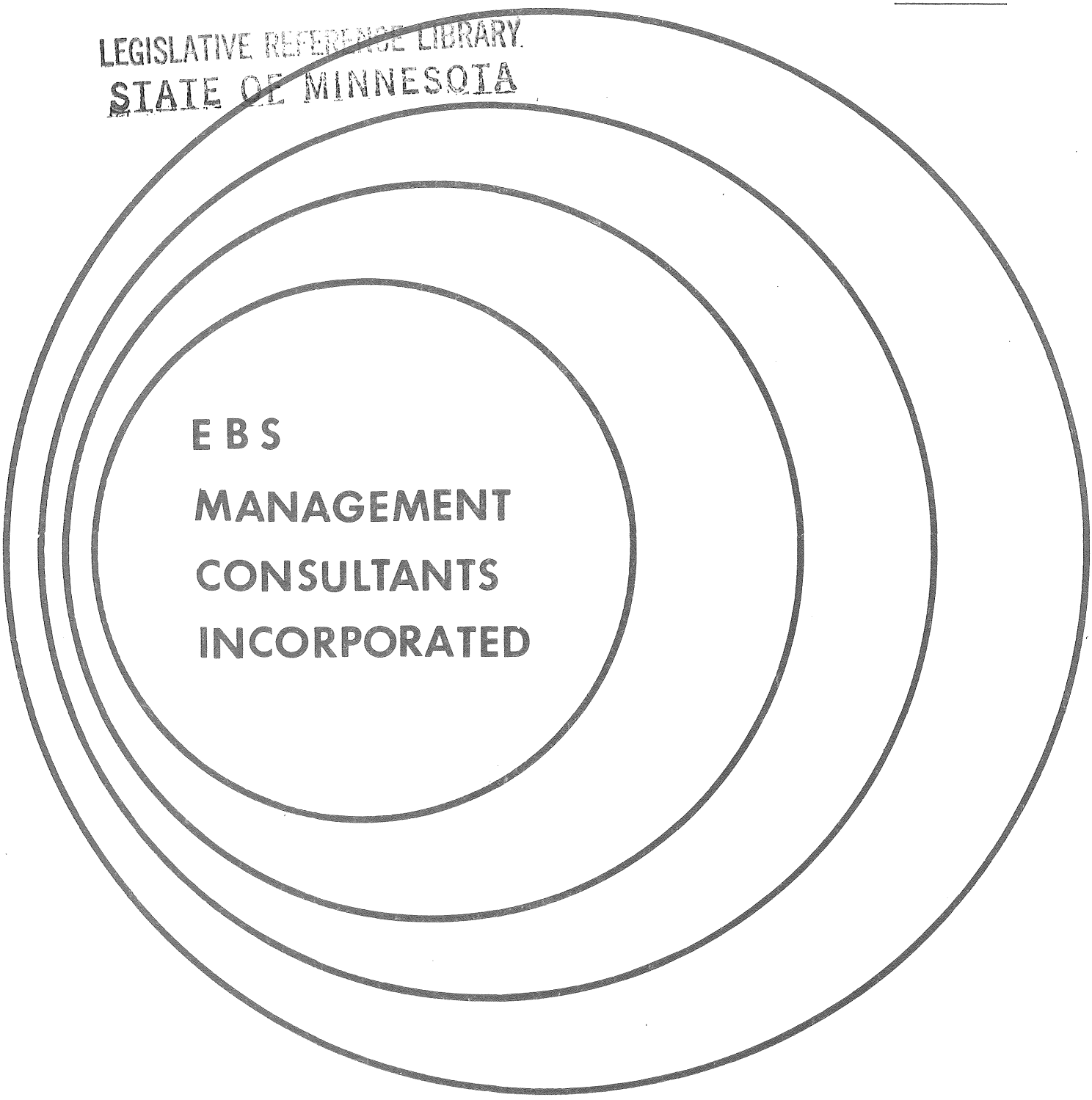

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JULY 1968

EBS MANAGEMENT CONSULTANTS
INCORPORATED

1225 CONNECTICUT AVE., N.W.
WASHINGTON, D.C. 20036

202-293-1950
CABLE ADDRESS "EBSMACI"

July 17, 1968

Rolland Hatfield, Commissioner
Department of Administration
State of Minnesota
State Administration Building
St. Paul, Minnesota 55701

Dear Mr. Hatfield:

There has been delivered to you, in accordance with the provisions of our contract with the State of Minnesota, one hundred copies of the final report on the "Study Of The Minnesota Veterans' Home" dated July 1968.

The oral presentation of the findings, in accordance with the request of the Legislative Building Commission, will be held in your offices on Monday, July 22, 1968. The entire study group will make the presentation and will be available for discussion.

I am very pleased to again note the good spirit of cooperation provided by the State of Minnesota and its officials to the study group and to EBS Management Consultants Incorporated.

If you have any further questions concerning this work, please do not hesitate to call upon me.

We enjoyed working with you and your staff and hope to again be of service to the State of Minnesota.

Sincerely,

Lester A. Barrer

Lester A. Barrer
Manager, Client Services

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STATE OF MINNESOTA
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CONDUCTED FOR THE MINNESOTA STATE DEPARTMENT OF ADMINISTRATION

JULY 1968

CONDUCTED BY

EBS MANAGEMENT CONSULTANTS INC.
MANAGEMENT SCIENCES DEPARTMENT
WASHINGTON, D.C.

LESTER A BARRER - PROJECT DIRECTOR

BILLY CHARLTON
JORDAN BRAVERMAN
DEAN PRICE
BARBARA DEROBA

ACKNOWLEDGEMENT

EBS Management Consultants Incorporated is pleased to be able to state that during the conduct of this study, we received as great an amount of cooperation as we could have hoped for. Without a doubt, the spirit of cooperation and assistance permeated through all interested individuals and organization within and without the State government, with all of the Veteran Service Organizations and their Women's Auxilliaries, with representatives of the Federal Government in the Veterans Administration and the U.S. Department of Health, Education and Welfare and with many others who assisted us in the study.

In addition, we wish to gratefully acknowledge the assistance of the Minnesota Veterans' Home Board, the Staff of the Minnesota Veterans' Home and of course, the individual members of the Home.

Of special interest to the reader will be the letter attached as an addendum to this portion of the paper. We thank the contributor for his valuable insight into the overall study area.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

OFFICE OF: CARL S. McCARTHY, CONSULTANT
4700 BRANDYWINE STREET, N.W.
WASHINGTON, D. C., JUNE 25, 1968

Mr. Lester A. Barrer,
Project Manager, Minnesota Veterans' Home Study,
EBS Management Consultants Incorporated,
1225 Connecticut Avenue, N.W.
Washington, D. C.

Dear Mr. Barrer:

In consideration of the future of the Minnesota State Veterans' Home at Minneapolis, Minnesota, it is my judgement that your decisions should be based wholly and entirely upon what is to be done for the veteran and what his individual needs are. This should outweigh any other consideration or any other factor entering into your study, including the views of veterans organizations, civic service groups, State or local governments, or any others who have no direct responsibility for the direct care of the individual.

The State of Minnesota has a long history of wanting to provide care for its citizen veterans, but I am sure that it wants this care to be the best type of care that can be given commensurate with the individual needs of the veteran. This principle should be adhered to above everything else.

Sincerely,

Carl S. McCarthy

CARL S. McCARTHY, Consultant,

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INTRODUCTION

It is apparent to those who have devoted themselves to an in-depth study of the program and administration of the Minnesota Veterans' Home that there are four specific periods of time to be considered in the determination of the goals and future of the Home by the State of Minnesota:

1 - period prior to the appointment of the current Commandant, 1887 - 1965

2 - period from the appointment of the current Commandant up to the time of the decision by the Legislative Building Commission to authorize a study of the Program, Operations, Facility, and Site of the Home (termed "special study" in the Commissions' Authorization Statement), and the start of the study 1965 - April 1968

3 - period of this special study April 1968 - July 1968

4 - period following the study - the future

A review of the history of the Minnesota Veterans' Home prior to the appointment of the current Commandant, provides very little in the way of guidance or useful information concerning the future of the Home. Survival of the indigent and sometimes disabled veteran had appeared to be the main goal of the Home. Without much effort, the Home existed. Some veterans were cared for and the State of Minnesota was able to comment on the existence of a facility capable of meeting the verbiage of the State Statutes. The desires of the State of Minnesota to remain in the

forefront of a new era of technological and medico-social progress was not attainable under this type of operation. The most that can be said is that the Home provided food, clothing, and shelter to some veterans, who from all evidence may have required more than food, clothing, and shelter. The prevalence of the concept of "status quo" was evident in all forms of the management and control of the Home.

When the current Commandant was selected and appointed by the Minnesota Veterans' Home Board, a new concept was advanced. The "desirable" concept of progress and advance entered the actions of the Commandant. There entered, also, a vigorous and aggressive approach to the care of a special interest group within the State - the Veteran. The approach was overtly one of "nothing is too good for our veteran." This was to be expected since the selection of the Commandant was dependent upon qualifications which would assure the interested parties that the advancement of such a concept would be the prime point of reference in any future activities.

Another concept developed during this period, was the concept that a Commandant was a "public relations man," one to develop and court the Veteran Service Organizations within the State of Minnesota. A new relationship between the Commandant of the Home and the Veterans' Home Board came about . There was no understanding as to who had what responsibility and authority or who was in control of the Home. In various areas each either aggressively searched for and found functions to their liking and aspired to control them, of there were attempts to ignore implied responsibility where each attempted to avoid conflict and thus ignored

the overall responsibility. Neither saw the need nor had the desire for a "meeting of the minds" to put forth an effective effort in response to the needs of the State and the veterans they were to serve in accordance with the intent of the State.

Meanwhile, the Veteran Service Organizations, relatively quiescent in the prior period became active, but active in a personal sense. One in which the organizations as a group attempted to obtain a measure of control over both the Veterans' Home Board and the Commandant as well as the mission of the Home.

Evidence of a rise in personal animosity, prejudice and self-interest began to appear. Efforts were directed more towards individual interests rather than the interests of the individual of true concern for the veteran member of the Home and the potential veteran member of the Home. Attention was paid to everything except the member of the Home and his day-to-day care, and, above all, his future in the Minnesota Veterans' Home, his community and in his State Organizations and individuals fought over principles, mechanical details (among the lowest orders of priority of need), and worst of all, for recognition. No one searched for, much less accepted, responsibility with concommitant authority. All searched for authority, no one desired responsibility. All desired control, none desired responsibility. All desired resources, but no one created or established a useful course or plan of action for the effective use of these resources from the State, Federal Government and the individual member. Although an intent may have been expressed, it was only in generic terms, neither specific nor realistic and it was not based on

demonstrated need with supporting documentation. Despite the absolutely similarity of expressed intent by the involved groups and individuals, none attempted to coalesce the efforts into a united desire and plan. The State government, both the Executive and Legislative branches, were placed in an untenable position.

During the development of a more active Commandant, Veterans' Home Board, Veterans Service Organization, and the State continued to pursue a related well developed program for public aid and assistance for all types of Minnesota citizens who needed the various levels of aid and assistance. At the same time there was an authorized creation of a Department of Veterans Affairs charged with "assisting Minnesota Veterans and their dependents in obtaining Federal and State benefits to which they are entitled." There was also developed a Minnesota State Plan for Implementing Title III of the Older American Act of 1965.

There arose a realization that the existing facility of the Minnesota Veterans Home had entered an aged, decrepit state, economically wasteful of the State's resources. There developed an open antagonism between all interested parties on one hand wanting things to be done, and on the other hand not really knowing what to do, thereby entering into an era of "do nothingness." All wanted something done, no one knowing what to do.

Once the "special study" began, all interested groups and individuals experienced a period of introspection, one in which some severe changes started to appear. The appearance of an experienced and unbiased

group who were authorized to inquire into the deepest realms of the actions and objectives of all concerned with the Minnesota Veterans' Home and with no relationships with any of the interested parties, led to a reconsideration of efforts and objectives. The "special study" in its interaction with all parties naturally led to numerous detailed discussions involving consideration of alternate points-of-view, approaches, and decisions. In other words, the study team provided a sounding board to those who wanted one. It was fully realized by all interested parties and individuals that a point of transition had been entered into from which there was no return. Changes were imminent. Some painful decisions were going to have to be made, and above all, there was need to establish a firm ground of understanding of the role of the State by the involved parties, i.e., the Minnesota Veterans' Home, the Minnesota Veterans' Home Board, the Commandant, the veteran members of the Home, and the interaction, if any, of all of these groups with the Minnesota Department of Public Welfare, the Minnesota Department of Veterans Affairs and the Minnesota Veteran Service Organizations.

In consideration of the future, which is that period of time when the State must not only make the key decisions in accordance with the best of its ability, but must authorize action and provide resources to carry out these decisions. It is that period of time when the State and its citizens must decide its own course and plan of action. The study team cannot make the State's determinations. It cannot decide for the State. It can provide nothing more than guidance in the form of recommendations.

It has done so. It is now up to the State and its citizens to select from among the potential alternatives in accordance with its desires, to provide public aid and assistance for a special interest group - the Minnesota Veteran.

It should be understood by all who read and use this report that the study group considered its charge from the points of view of all interested parties and individuals. It should also be understood that the team conducting the study felt an obligation to report to the users of this report a factual, documented review of findings with recommendations based on the study. An important factor in the study was the desire of the team to provide useful guidance to the State, recommendations, based on requirements, that were reasonable, feasible and economical in their implementation.

The "Recommendations" are presented on two levels. First, there are those in the nature "short-range" for immediate action requiring improvement in the program and operations of the Home, which we believe are necessary until such time as major changes occur, (if any), as the result of this study.

Secondly, there are those recommendations designed for the "long-range" plan of the State in its desire to provide proper and dignified care of the Minnesota Veteran, now and in the future.

PHILOSOPHY

It is relevant to ask about the philosophy of the study team in its approach to the study as well as in their conduct of the study. The results of the study can only become useful if the philosophy of the team is known about its planning, conducting, analyzing, and interpreting its work.

The basic charge given to the team was to:

"...CONDUCT AN IMPARTIAL STUDY AND MAKE RECOMMENDATIONS"

"...STUDY THE MINNESOTA VETERANS' HOME, ITS PROGRAM OPERATIONS, SITE AND FACILITY"

"...COMPLETE STUDY IN THREE MONTHS."

By "impartial we mean a study in which the factors considered, the data and information collected, the alternatives evaluated, the inter-relations made, and the recommendations proposed are based on incontrovertible evidence.

We must consider "evidence" to encompass the appropriate degree of documentation, as would, or could be, obtained in the same manner by other qualified study groups or individuals. An open-mind to all points-of-view was maintained throughout the study and in accordance with professional codes of ethics. All relevant data and information obtained was utilized to arrive at our recommendations. There was no deliberate omission of statements of fact or other evidence received.

...MAKE RECOMMENDATIONS...

This necessarily infers providing a "course of action" as determined by:

- the bases of the documented evidence
- the degree of relevance to the study
- the established requirements
- the degree of reasonableness and feasibility expectations of being implemented
- the bounds of ethics and legality.

It should be noted further that recommendations cannot be based realistically upon other than evidence considered by the team. Expressed or implied desires of partisan individuals and/or organizations cannot be substituted for evidence based upon requirements of need. Personal bias, desires, hopes, and aspirations of either the individuals or organizations being studied, or of the members of the team, could not and have not been considered.

...STUDY THE MINNESOTA VETERANS' HOME, ITS PROGRAM, OPERATIONS, FACILITY AND SITE...

The Minnesota Veterans' Home is a complex management and technical, and special interest oriented organization. It has official State organization status, yet is unknown to most State officials. It receives funds from the State, the Federal Government, and private sources, yet is an informal organization in the way it operates. Its function as a "Home" is the result of a complex interaction of a "Program" and administrative

operation with a number of physical facilities in a specific geographical location. A change in one (Program, Operation, Facility or Site) would and does result in side-effects involving all the others.

Thus, the study must and did encompass all aspects of this complex interaction. No one aspect could be relegated to a minor role (if such minor roles do exist) until its impact was studied. No part of the personnel, procedures, or plans could be ignored. Sufficient depth had to be plumbed until the basic interaction, purpose and result could be understood.

...COMPLETE STUDY IN THREE MONTHS...

The meaning here is implicit. The study is to be conducted in sufficient detail within the specified period of time with sufficient resources to enable the final product (the final report containing the reocmmendations) to be valuable to the users. Any study can be made to last for practically any period of time. A longer period may provide opportunity to gather more facts to consider more detail. It does not assure a more valid recommendation. The period of three months provided the study team with a goal. A goal in which the evidence to be collected and recommendations made were to be accomplished with a given time frame. This period of time, we considered to be adequate and sufficient for the study of the Minnesota Veterans' Home. By a proper utilization of a skilled team the evidence was collected and recommendations were made.

Above and beyond the specific charge made to us, the study team has adopted several points of view that have proved to be of paramount importance:

First - we consider the care and needs of the individual as an "entity" to be of prime concern, far above the concern we may have for organizations, formal or informal, official or nonofficial.

Second - we consider the intent of the State of Minnesota as expressed in its existing statutes, plans, programs and operations to be of major concern to all.

Third - we consider the primary needs of the individual as an "entity" far above his secondary needs as a member of a special interest, social, or fraternal organization, veteran or nonveteran.

Fourth - we consider that emotional appeal, excessive partisanship pressures, and unreasonable demands not based on realistic requirements as being totally unresponsive to the overall evaluations demanded by this study.

STATE-OF-THE-ART

Until recent times medical care programs in the United States have been concerned primarily with the treatment of the acutely ill of all ages including those in the younger working age groups who were disabled. This emphasis was based upon the premise that a decrease of disability among the young was an essential step in making them productive members of society. Until recently, very little attention was paid to the older individual who was handicapped or incapacitated as a result of disability or chronic disease. Neither was attention given to the possibility of decreasing the severity of these disabilities among those aging individuals lodged in nursing care institutions in the later years of their lives.

The nation has had and continues to have many nursing homes. Generally, these have been places with nothing more than practical nurses in care of older persons who were receiving a simplified residential-type care, custodial care, or a minimal degree of nursing care. Almost nothing in terms of real medical attention was furnished to the patient, and certainly little or nothing in terms of rehabilitation, physical medicine, or other therapies. It has been through this spectrum in recent years that care for the chronically ill has evolved, that is, from minimal custodial care of the individual to his actual rehabilitation or restoration.

Rehabilitation, in its broadest meaning, is concerned with past, present, and future individual behavior, and with assisting the individual to find a balance which will permit him to live with dignity.

Within the framework of the handicaps imposed by his particular disability, concern is directed toward his potential development in line with his individual abilities, aptitudes, interests, and personality.

Today, the emphasis is upon restoration for those who can profit from it. Restoration, as used here, means a return to the community, either as a self-supporting individual or with an independent living arrangement. It is recognized that in many instances, complete restoration of the individual may not be possible. Programs are being put forth (as in the VA Domiciliary Care Program), where emphasis is directed toward returning the individual to the community for varying lengths of time. Additional subsequent action may involve readmitting him to the domiciliary as needed.

We have seen an increase in the number of alcoholic prevention programs; in new programs where emphasis is placed on helping to improve the individual's capacities through prescribed therapy so as to restore him to the maximum obtainable level of physical and mental health; through a program of retraining or education the individual is able to improve his intellectual capabilities and functions.

Today, such institutions as the U. S. Veterans Administration not only plans for restoration of the veteran's health, but also in assisting him to find employment in the community and resettlement in the community.

Increasingly, medical care programs are becoming reoriented in terms of putting the patient, who needs some particular form of care, into the physical facility with the equipment and the staff to provide the

required level of care at the least cost. As of late there has been a great deal of discussion concerning varying kinds of care which might be rendered to the patient to alleviate his ill health as much as possible. These include an entire panorama of care which can be further identified by terms such as "progressive," "acute," "intensive," "intermediate," "long-term," and "self-care." It is necessary to be aware that more than just "ill health" is involved in this type of restoration. A basic premise is that the individual's degree of illness is influenced to a great extent by a whole variety of social, economic, cultural, and psychological difficulties and problems. The successful treatment of the patient calls for close cooperation and teamwork with psychological, social service, physical medicine and rehaiblitation, and restoration services.

The end result of having a spectrum of these services is witnessed by the transformation of the VA domiciliary at Los Angeles from the image of an Old Soldiers' Home institution to that of a facility for progressive medical care for the chronically handicapped veteran. The facility attracts a highly qualified and competent professional staff members, promotes the active interest of community organizations, volunteers and industry; and demonstrates that the restoration of the veteran is practical.* In the final analysis the restoration of an

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* Veterans Administration, Report of Multi-Disciplinary Conference on Domiciliary Care. VA Center, Dayton, Ohio. Nov. 20 - Dec. 2, 1965, p.12.

individual's health, as fully as possible, and in turn his dignity, self-respect, usefulness and productiveness to society is the goal of all health care practices whether it be for the civilian or the veteran. This is the true meaning of the "state-of-the-art" in philosophical terminology.

OBJECTIVES

The objectives of this study may be grouped as follows:

1. Characterize the current membership of the Minnesota Veterans' Home.
2. Characterize and predict future requirements, if any, for a program, the operations, facilities and site(s) for Minnesota Veterans' Home or nursing care facilities.
3. Estimate the future veteran population for Minnesota by counties and the State up to the year 1980.
4. Evaluate the existing Minnesota Veterans' Home in terms of:
   - Current and planned program.
   - Current and planned administrative operations and control.
   - Current facilities.
   - Current site.
5. Establish management decision selection criteria.
6. Establish and consider appropriate alternatives to the existing Minnesota Veterans' Home program, operations, facility and site.
7. Make recommendations to the State for a course of action for implementation for "the proper and dignified care for the Minnesota Veteran now and in the future."
8. Determine potential resources able to be utilized by the State.

9. Document all relevant data and information which will give the broadest possible bases for the policy decisions that will best provide dignified care for the Minnesota Veteran now and in the future.

METHODOLOGY

Determination of a viable plan of action by the team members regarding various interested individuals and organizations at the beginning of the study led to a detailed plan of implementation. The following steps were found to be essential:

1. Comprehensive compilation of listing of interested individuals and organizations
   - ° within and without the State Government;
   - ° within and without the Minnesota Veterans' Home; and
   - ° within and without the veteran population.
2. Review of objectives and methodology of the study with the individuals and organization referred to above.
3. Collection, compilation, and review and evaluation of existing documentation relevant to the study.
4. Collection of data, information, and documents relevant to the study through comprehensive interviews.
5. Observation of the interested individuals and organizations in action.
   a. Perform extensive observation and review of Minnesota Veterans' Home in action (including Minnesota Veterans' Home Board, Board Secretary, Commandant, Business Manager, Cashier, Secretary, Home Physician, Chief Nurse and staff, Director of Activities Chaplain, Chief Engineer, Chief Cook, Matron and others) to obtain an understanding of their role and actions.

b. Perform interviews with members of the Minnesota Veterans' Home.

6. Solicitation of written expressions of interest, concern, opinion, and verifiable data from individuals within the State from the following:
   a. general public (through a press release from the Governor's Office)
   b. veteran population (through a request to the Commanders of all of the Minnesota Veteran Service Organizations, by group and organizational newspapers.
   c. members of the Minnesota Veterans' Home (through a written request to each of the members living at the home at the present time.)
7. Conduction of a detailed survey of the individual administrative and medical records of every member of the Veterans' Home and of those rejected upon application.
8. Review of appropriate documents and interview of relevant officials in the Federal Government.
9. Conduction of a review of the existing facility and site.
10. Conduction of a review of selected alternate existing facilities and sites.
11. Establishment of a management decision selection criteria. Consideration of those factors, elements, and criteria, upon which valid management decisions may be based.

Consideration of these criteria provide a measure of value to be placed on the interaction of the factors as they relate to specified alternatives. Weighting of the criteria enable the decision-maker to place a value judgement of the importance of each factor in meeting the requirements of the objectives.

12. Development of relevant alternatives based on a consideration of potential plans-of-action, eliminating impossible, impracticable, unreasonable alternatives which have no hope of implementation.

13. Selection of realistic alternatives, those which appear to provide the State of Minnesota with reasonable, feasible and economical solutions to the problems posed. Following the selection of the primary plans-of-action, they were ranked in the order of value in accordance with our best judgement, knowledge, and experience.

E. DEFINITIONS

To facilitate proper understanding of terms, this section will be concerned with providing comprehensive meanings to the key elements referred to throughout the report.

Two areas are covered. The first section deals with definitions relating to Veterans Administration definitions of the terms relating to States Homes and types of care. The second section deals with the term "Veteran".

Section 1: State Homes* and Care.**

a. State Homes

"State Home" means a home established by a State (other than a possession) for veterans of any war disabled by age, disease, or otherwise who by reason of such disability are incapable of earning a living. Such a term also includes such a home which furnishes nursing home care for such veterans. (38 U.S.C. 101 [19], [20]; 601 [2]).

A State-operated facility which provides hospital, domiciliary or nursing home care to veterans of any war must be formally recognized by the Administrator as a State home before Federal aid payments can be made for the care of such veterans. To qualify for VA recognition as a State home it must be demonstrated that the majority of veterans residing in such facility are receiving

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*Source: Veterans Administration, Department of Medicine and Surgery, "Payments of Federal Aid [To States for Care of War Veterans In State Homes]", Washington, D.C., 1965.

**Veterans Administration, Department of Medicine and Surgery, Washington, D.C., August 30, 1967.

domiciliary and/or nursing home care or that the majority of veterans that will be residing in such facility will meet such requirements and that the personnel and plant of the facility to be recognized as a "State Home" are or will be devoted primarily to the care of war veterans.

"Nursing Home Care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care but who require skilled nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. The term includes intensive care where the nursing service is under the supervision of a registered professional nurse. (38 U.S.C. 101 [28]). The quarters of nursing home care patients must be in a clearly designated area of the home not intermingled with those of either hospital patients or domiciliary members. Ordinarily, a member capable of performing all of the following will not be regarded as requiring nursing home care:

1. Perform without assistance daily ablutions, such as brushing teeth; combing hair; body eliminations.
2. Dress with a minimum of assistance.
3. Proceed to and return from the dining hall without aid.
4. Feed himself.
5. Secure medical attention on an ambulatory basis or by use of an appropriate prosthesis.

6. Have voluntary control over body eliminations or control by use of an appropriate prosthesis.

7. Share, by his personal efforts in some measure, however slight, in the maintenance and operation of the station.

The term "Domiciliary Care" means the furnishing of a home to the veteran, embracing the furnishing of shelter, food, clothing and other comforst of home, including such incidental medical care as is necessary to maintain him.

(To obtain recognition as a State home, an application must be submitted to the Administrator of Veterans Affairs. Upon receipt of such application by the VA, the Chief Medical Director will arrange for an inspection of the facilities described in the application. The Chief Medical Director will make his recommendation to the Administrator who will notify the State official in writing of his decision. No claim for Federal aid payments will be honored for any period prior to the date of recognition by the Administrator.)

(Any annex, branch, enlargement or expansion of an approved State Home which is not on the immediate grounds of the parent facility and which has not been recognized before the effective date of this regulation must be recognized in the manner described above before Federal aid for veterans' care may be paid.)

b. Types of Care

Intermediate Care - The Intermediate Care Patient is one who has completed his acute phase of illness (usually 90 days or less)

but has not reached maximum hospital benefit and requires medical services by a physician on a more or less daily basis with attendant laboratory and x-ray use for a protracted period. The mission of an Intermediate Care Service is to develop a comprehensive and coordinated pattern of service to meet the many and varied needs of a long-term chronic patient who continues to require hospital care and treatment.

This definition applies to patient care areas established as a separate Intermediate Care Service where the Chief of the Service reports directly to the Chief of Staff. It does not apply when intermediate care is an integral part of the regular Medical, Physical Medicine and Rehabilitation, Surgical, Neurological or Psychiatric Services.

Nursing Home Care - The term "Nursing Home Care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care (MHB), but who require skilled nursing care and related medical services, if such nursing care and medical services are prescribed by, or performed under the general direction of persons duly licensed to provide such care.

The primary purpose of a Nursing Home Care Unit is to provide skilled nursing care and related medical services, supportive care, and individual adjustment services, including social, diversional, recreational and spiritual activities and opportunities.

Domiciliary Care - Domiciliary care is the provision of a Home with such ambulant medical care as is needed. To be entitled

to domiciliary care, the applicant must consistently have a disability, disease or injury which is essentially chronic in type and is producing disablement of such degree and probable persistency as will incapacitate him from earning a living for a prospective period.

The domiciliary provides the means of caring for that part of the veteran population which can perform activities of daily living but is disabled by virtue of age or disease. Such veterans are not in need of hospitalization and do not need the skilled nursing home environment. Domiciliary care will encompass aggressive preventive medical care in conjunction with the various therapeutic programs needed to treat domiciled veterans.

Restoration Care - Restoration care is the combination of medical and psychosocial ingredients which helps selected veterans prepare for a return to community life despite physical and mental disabilities. It consists of intensive restorative care over an extended period of time which incorporates the application of many therapeutic and rehabilitative techniques. The course of treatment, usually one year, is climaxed by a return of the veteran completely or partially self-supporting to the community.

It is desirable that medical rehabilitation occur in each element of care. Except for the Restoration Program, it is not a criterion for admission to the programs. The determinant of which element of care is chosen for patient's treatment is based on the amount of medical and nursing care required.

Section 2: Veteran Defined.

State of Minnesota definition for a Veteran's entrance to the Minnesota Veterans' Home. (Minnesota Statues, Section 198.01, as amended, 1967).

> . . . all honorably discharged persons who served in the Mexican War, the War of the Rebellion, the Spanish-American War, the Phillippine Insurrection, the Boxer Rebellion, the War of 1917 and 1918, commonly called the World War, or the War between the United States of America and its allies, and Germany, Japan, Italy, and their allies, persons who actually served in any campaign against the Indians in this state in the year 1862, whether as soldiers of the United States or not, for honorably discharged members of the Minnesota National Guard mustered into federal service in 1916 who served on the Mexican border, and for all honorably discharged persons who served between September 16, 1940, and December 7, 1941, and in World War II between December 7, 1941, and December 31, 1946, and in the campaign against the North Koreans between June 25, 1950 and January 31, 1955, and in the campaign against the Viet Cong between August 5, 1964 and the date such campaign may be declared ended by competent federal authority.

"Veteran" defined (Minnesota Statutes, Section 197.447, as amended, 1967).

The word "veteran" as used in sections 197.29, 197.59, 197.601, 282.031, 282.032, 306.03 means any person honorably discharged from the armed forces of the United States who served in the Civil War, Spanish-American War, Philippine Insurrection, China Relief Expedition, World War I between April 6, 1917 and November 11, 1918, both dates inclusive, on or after December 7, 1941 and until final cessation of all hostilities as determined by the proper state authorities in order to give recognition for service performed in the following hostile actions: World War II, Korean conflict, Lebanon crisis, Berlin crisis, Quemoy and Matsu, Taiwan Straits, Cuban crisis, the Congo, Laos, the Dominican Republic, and Vietnam, and to include service therein but not to exclude persons who did not have service in those areas. The word "veteran" does not include a person enlisted and accepted for active training only for a period of six months or less.

"Veteran" defined by the Federal Government.*

"Veteran" means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

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*Source: Committee On Veterans' Affairs, House of Representatives Hearings. 90th Congress, "VA Nursing Home Care Programs", Washington, D.C., June - August, 1967.

"War Veteran" means any veteran who served in the active military, naval, or air service during a period of war and includes any veteran of the Indian wars, or any veteran awarded the Medal of Honor, Public Law 88-481.

"Period of War" means each of the Indian wars, the Spanish-American War, World War I, World War II, the Korean Conflict, and the period beginning on the date of any future declaration of war by the Congress and ending on a date prescribed by Presidential proclamation or concurrent resolution of the Congress.

"Spanish-American War" (1) means the period beginning on April 21, 1898, and ending on July 4, 1902, (2) includes the Philippine Insurrection and the Boxer Rebellion, and (3), in the case of a veteran who served with the United States Military Forces engaged in hostilities in the Moro Province, means the period beginning on April 21, 1898, and ending on July 15, 1903.

"World War I" (1) means the period beginning on April 6, 1917, and ending on November 11, 1918, and (2), in the case of a veteran who served with the United States Military Forces in Russia, means the period beginning on April 6, 1917, and ending on April 1, 1920.

"World War II" (1) means the period beginning on December 7, 1941, and ending on December 31, 1946.

"Korean conflict" means the period beginning on June 27, 1950, and ending on January 31, 1955.

SUMMARY OF RECOMMENDATIONS

BASED ON THE FINDINGS OF THE "SPECIAL" STUDY GROUP, THE FOLLOWING RECOMMENDATIONS ARE MADE TO THE STATE OF MINNESOTA:

1 - CONTINUE TO PROVIDE PROPER AND DIGNIFIED CARE FOR THE MINNESOTA VETERAN AS A GROUP NOW AND IN THE FUTURE.

2 - EXPAND THE VETERAN CARE PROGRAM TO A NURSING CARE LEVEL.

3 - CONTINUE TO UTILIZE THE CURRENT SITE FOR THE CARE OF THE VETERAN.

4 - PLACE THE RESPONSIBILITY FOR THE PROPER AND DIGNIFIED CARE OF THE VETERAN WITH A RECONSTITUTED VETERANS HOME BOARD OF TRUSTEES, UNTIL SUCH TIME AS THE STATE IMPLEMENTS A RE-ORGANIZATION OF THE STATE DEPARTMENTS AND AGENCIES. AT THAT TIME IT IS PRESUMED THAT ALL STATE GOVERNMENT PUBLIC AID AND ASSISTANCE UNITS WILL BE PLACED WITHIN ONE DEPARTMENT. AT THAT TIME THE RESPONSIBILITY FOR THE VETERANS HOME SHOULD PASS TO THE DEPARTMENT OF PRIME CONCERN.

5 - IMMEDIATELY RECONSTITUTE THE MINNESOTA VETERANS HOME BOARD OF TRUSTEES TO INCLUDE ADDITIONAL TECHNICALLY-ORIENTED MEMBERS.

6 - THE STATE AND THE VETERANS HOME BOARD OF TRUSTEES SHOULD DEVELOP A MASTER PROGRAM AND PLAN FOR THE CARE OF THE VETERAN POPULATION.

7 - THE STATE SHOULD NOT CONSIDER THE CONSTRUCTION OF ANY ADDITIONAL FACILITIES ON THE CURRENT SITE UNTIL SUCH TIME AS A MASTER PLAN SHALL HAVE BEEN DEVELOPED AND AUTHORIZED BY THE STATE FOR THE IMPLEMENTATION OF AN OVERALL PROGRAM FOR THE CARE OF THE VETERAN POPULATION OF CONCERN.

8 - THE STATE SHOULD NOT CONSIDER THE MODERNIZATION OF THE EXISTING MINNESOTA VETERANS HOME FACILITY. THE CURRENT FACILITY SHOULD BE MAINTAINED ONLY AS REQUIRED TO MEET ESTABLISHED HEALTH AND SAFETY STANDARDS AND AS A TEMPORARY PLACE FOR THE CONDUCT OF THE MINNESOTA VETERANS HOME PROGRAM AS PRESENTLY OPERATED.

9 - THE STATE PROVIDE NEW CONSTRUCTION FOR A NURSING HOME CARE FACILITY ON THE EXISTING VETERANS HOME SITE.

10 - THE MINNESOTA PUBLIC EXAMINER CONDUCT A THOROUGH REVIEW OF THE BOOKS AND ACCOUNTING PROCEDURES UTILIZED IN THE CONTROL OF THE INCOME AND EXPENDITURE OF ALL FUNDS FROM ALL SOURCES UNDER CONTROL OF THE BOARD.

11 - THE MINNESOTA CIVIL SERVICE DEPARTMENT CONDUCT A POSITION AND PERSONNEL ANALYSIS AND EVALUATION FOR EACH POSITION AND PERSON EMPLOYED BY THE HOME. ALL CLASSIFIED AND UNCLASSIFIED PERSONNEL (WITHOUT EXCEPTION) WOULD BE REVIEWED.

12 - OBTAIN THE SERVICES OF A COMPETENT MEDICAL UTILIZATION TEAM FOR THE PURPOSE OF EVALUATING THE QUALITY OF MEDICAL CARE PROVIDED BY THE HOME.

13 - ENCOURAGE THE BOARD TO REORGANIZE THE ADMINISTRATIVE STRUCTURE OF THE HOME.

14 - THE MINNESOTA VETERANS HOME BOARD OF TRUSTEES ESTABLISH WRITTEN SHORT AND LONG-RANGE PROGRAMS AND PLANS INCORPORATING PROCEDURES FOR EFFECTIVE UP-DATING AND MONITORING.

15 - THE MINNESOTA VETERANS HOME BOARD OF TRUSTEES ESTABLISH A WRITTEN MANAGEMENT AND PROCEDURAL MANUAL FOR USE AT THE VETERANS HOME INCORPORATING PROCEDURES FOR EFFECTIVE UP-DATING AND MONITORING.

16 - THE BOARD TO ESTABLISH A PROGRAM PLANNING AND BUDGETING SYSTEM (UTILIZING MINNESOTA PROCEDURES) FOR THE HOME AS AN ENTITY AND FOR EACH OF THE MAJOR FUNCTIONAL ELEMENTS OF THE HOME.

17 - THE BOARD ESTABLISH AN EFFECTIVE MANAGEMENT AND MEDICAL RECORDS SYSTEM IN ACCORDANCE WITH STATE AND FEDERAL STANDARDS.

18 - THE BOARD DEVELOP A MORE "HUMANIZED" ENVIRONMENT AT THE HOME BETWEEN THE BOARD STAFF AND THE VETERAN MEMBERS.

19 - THE BOARD ESTABLISH A MEDIATION GROUP CONSISTING OF VETERAN MEMBERS OF THE HOME, THE SENIOR STAFF, AND THE BOARD OF TRUSTEES FOR THE PURPOSE OF IMPROVING COMMUNICATION AND THE CONSIDERATION OF REAL OR IMAGINED INEQUITIES.

20 - THE BOARD ESTABLISH A CLOSER WORKING RELATIONSHIP WITH THE SENIOR STAFF OF THE HOME AND OTHER STATE ORGANIZATIONS AND AGENCIES CONCERNED WITH RELATED RESPONSIBILITIES AND DUTIES.

21 - THE BOARD ESTABLISH A CLOSER WORKING RELATIONSHIP WITH STATE VETERAN AND OTHER CIVIC SERVICE-ORIENTED ORGANIZATIONS.

22 - THE STATE CARRY OUT THOSE RECOMMENDATIONS MADE IN THE BODY OF THE REPORT.

PART I THE ROLE OF THE STATE

Any attempt to define the question: "What is the proper role of the State?" is beyond the scope of this study. This question has been argued since the days of Aristotle. For the purpose at hand, suffice it to say that the complexities of our society are such that a series of paradoxes are readily observable. On the American scene we find "separation and unity, freedom and conformity, individualism and collectivism, free enterprise and public regulation, a status society and a mass society, conservatism and rapid change."* Even though these especial traits appear to be contradictory and mutually threatening in appearance, they are essential parts of an evolving workable and working whole, wherein each part is dependent upon the interrelationships and interactions of its various parts.

On Reluctance To Change

Government, whether State or National in scope, is not static. When reluctant elements of our socio-economic-politoco oriented society fail to recognize that the dynamics of society require alteration of established precedents and existing lines of authority, conflict results. Usually the conflict is limited to verbal intercourse, but infrequently, physical hostilities have occurred. Overcoming precedents and inflexible lines of authority have been one of man's greatest dilemnas in evolving forward movement in government.

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* Corrine Lothrop Gilb, Hidden Hierarchies: The Professions and Government (New York: Harper and Row, Publishers, 1966), p. 3

Samuel W. Foss is well-remembered for his contribution to "well-established precedent." He wrote:

> One day through the primeval wood
> A calf walked home, as good calves should
> But made a trail all bent askew
> A crooked trail, as all calves do...

The poem continues to relate how a dog and a herd of sheep, then finally a man followed the trail. A village street was subsequently established, and finally a city thoroughfare.

> ...A hundred thousand men were led
> By one calf, near three centuries dead.
> They still followed his crooked way
> And lost a hundred years a day.
> For thus such reverence is lent
> To well-established precedent.

Further illustration of man's reluctance to change can be found in the words of Maeterlinck who said that for each progressive person there are "...a thousand men appointed to guard the past."*

From this brief discussion, one is able to see that the State must continually alter, appease, and/or advance its actions in line with the existing requirements of its society. In today's world, the State, out of necessity, must act out a variety of roles according to the environment in which it operates.

The State As An Actor

The three 'organization' levels of government--legislative, executive, judicial--existant in the State of Minnesota allows for simultaneous playing of many different roles.

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* Quoted in Homer W. Smith, Man and His Gods (Boston: Brown and Co., 1952), p. vi.

The matter of caring for veterans and certain members of their families (as defined by Minnesota Statute) is a particular service-oriented role originally assumed as a responsibility of the National government. Independent State action evolved and was financially assisted by the Federal Government in the form of what is known today as "grant-in-aid". Acceptance of these funds was a voluntary action on the part of the State. With continued interjection of this financial assistance into its operation and budgeting activities, Minnesota has become almost completely reliable on the Federal Government for supplemental assistance leading to continuance of its Veterans' Home.

It should be noted that originally the State Home design had as its intent that of providing for the domiciliation of disabled soldiers and sailors who had fought on the side of the Union, especially those who were disabled from earning their own livelihood as a consequence of wounds received or of sickness contracted in the service of their country in time of war. The trends of the time were to make the disabled veteran the ward of the State and in so doing provide them care when they became, or were unable, to provide for themselves or families.*

General programs for the care of individuals, whether aged, disabled, or infirm, were not as proliferate then as now. In this sense, perhaps a strictly "domiciliary" operation is a program of the past. The

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* See "Historical Analysis of the Nature of the State Home Program for Veterans and Related State-Federal Responsibility for Such Care," VA Nursing Home Care Programs, Committee on Veterans Affairs, House of Representatives, 90th Congress, 1st Session (June-August 1967), pp. 1814-1856.

socio-economic environment was not as complex then as today. Agriculture and mining were the chief economic and occupational pursuits of the State's inhabitants. Housing was inadequate or non-existent at least to the degree we know today. Demands on the State were not as great. State and community interests concerned with the welfare of its aging citizens was just receiving its initial thrust.* Old Age Assistance, Social Security, Medicare, Veterans' Benefits (relating to hospitalization and care on a wide-spread national basis), were either nonexistant or left to the States and local governments for handling. In most instances, however, family or friends took "care of their own" without governmental assistance of any type.

It is of interest to consider further the previous point concerning the disabled veteran as a ward of and within the State's jurisdiction. This philosophy was in line with the sociological thinking of the times which perpetuated the theme of institutionalism. The late nineteenth century and early twentieth century theorists on welfare and care of indigent persons tended toward "harmonious" institutional housing of individuals according to the similarity of personal requirements.

Through the years, science has advanced and views have changed. In addition, complex social problems, resulting from the advancement of technology, population growth, physical obsolescence of State-local facilities, and inefficient land uses have created the need to reevaluate the future of the State and the role it must adopt in providing the most efficient and effective plans-of-action.

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* See Arnold M. Rose, editor, Aging in Minnesota, (Minneapolis; University of Minnesota Press, (1963).

The State As A Provider Of Services

The State has necessarily assumed the role of a provider of services. These services encompass a multitude of activities ranging from education to land conservation, corrections to welfare, traffic regulation, to health care. In effect, the State has entered into areas previously within the realm of the private or local sectors of society. This may have come about, in part, as a result of a specific need by certain citizens who lacked the necessary personal resources to fulfill the need; as a result of special interests who saw the State as a means to justify certain ends; as a result of certain stimulation from the Federal or other State governments; or as a result of any combination of these. Whatever the reason may have been, the State assumed the responsibility to provide a certain service to its citizens in line with the dictates of its environment.

The area of service with which we are currently concerned deals with only one aspect of the total health care-welfare problem. Generally, it deals with an aging population. Specifically, an aging population of men and women, who differ from their peers only in the sense they, or members of their families, were required to serve their country in time of national peril.

What Should The Role Of The State Be Concerning The Aging Veteran Population?

Minnesota, by statute, has determined its role in this area. Appropriations are allotted annually for the continued maintenance and operations of the Minnesota Veterans' Home in Minneapolis.

The question as it relates to institutional housing of veterans (and the Veterans' Home must in the truest sense be considered an institution) should be answered in light of current scientifically developed social thought and existing economic parameters.

Concern should be especially directed to the existing members of the Home, in line with those human qualities and functions which in fact strengthen the singular members "individual" dignity, self-esteem, identity, and medico-sociological well-being as a productive contributor to the community and State at large. In essence, a programmed plan of action must be developed to instill for each member "a hope for the future."

Perpetuation of an institution and its management based on a preoccupation with a "bricks and mortar" sense of pride tends to override any concerted member-oriented goal-direction of that establishment.* Such restrictive action should be considered nothing more than a preemption and corruption of the raison d'etre of that institution, completely out of tune with the goals, intent and existing philosophy of the State in providing service and care to its aging veteran population.

The continuation of the Minnesota Veterans' Home as an institution, in the broadest and most favorable sense, cannot be specifically answered in this report. The final determination is a matter of public policy which can only be decided by the State's Chief Executive and the State Legislature.

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* See David J. Vail, Dehumanization and the Institutional Career. (Springfield, Illinois; Charles C. Thomas, Publisher, 1966).

PART II THE ROLE OF THE FEDERAL GOVERNMENT

We shall deal in this part with the implied role of the Federal government through a discussion of the various activities which are of direct and indirect concern to the Veteran and the State.

THE VETERANS ADMINISTRATION

The rapid expansion in the number of the chronically ill and aging veteran patients has had a major impact on the Veterans Administration in the past decade. To cope with this situation President Kennedy, on August 23, 1963, directed that additional nursing home beds be created within the Veterans Administration. The following year the Congress enacted Public Law 88-450, which in essence authorized a three-pronged program of nursing home care for veterans. The first section of that law directed the Veterans Administration to establish 4,000 nursing home care beds. The second section of the law directed the Veteran Administration's Administrator to authorize the transfer of appropriate veterans, who received maximum hospital benefits, to community nursing homes with rates of payments determined by law and standards of operation prescribed by the Administrator. The third and fourth section of the Public Law authorized individual states to operate nursing home care units and permitted the VA Administrator to assist the states in the construction of nursing homes through a Grants-in-Aid Program.

Extended Care Service

In 1967, the Administrator of the Veterans Administration approved the formation of an Extended Care Service. Its purpose is to formulate and recommend policies, plans and professional standards pertaining to

comprehensive chronic care programs in hospitals, domiciliaries, restoration centers, nursing home care units, and state homes, and to develop methods for their implementation. The Extended Care Service works in close cooperation with other services as a multi-disciplinary force toward fulfilling the veterans' extended care needs.

Private Nursing Home Care

Veterans hospitalized in VA hospitals who have attained maximum hospitalization benefits and require a protracted period of nursing home care may be furnished such care either in Veterans Administration facilities or in private nursing homes at VA expense. Normally, these veterans will be placed in private or community homes at VA expense, the VA paying the average payment rate charged to the general public, when it is reasonably certain that the aggregate requirement for care will not exceed six months. When it appears that more than six months' care will be required, veterans will be transferred to nursing home beds in VA facilities.

Admissions to VA Nursing Home Care units are effected only from inpatient or member status in a VA hospital or domiciliary. The movement from a hospital or domiciliary bed to a Nursing Home Care bed on the same station will be accomplished by discharge from a hospital or domiciliary. Veterans are not admitted to VA hospitals or domiciliaries for the sole purpose of subsequent admission to a Nursing Home Care unit.

Only veterans who have been hospitalized according to VA regulations and have attained maximum hospital benefit or have been domiciled under specific VA regulations and require a period of Nursing Home Care will be eligible. In addition, a patient must meet all of the following conditions:

1. Require skilled nursing services, supportive health services and intermittent services of physicians.
2. No longer needs hospitalization.
3. Has no current possibility for community care placement.
4. Cannot meet self-care criteria for admission to or continued care in a VA domiciliary as specified in VA regulations.
5. Is not terminally ill (life expectancy of less than 3 months) or does not otherwise require intensive medical care.

Under the VA nursing bed system, professional nurses supervise the VA nursing care bed units and provide the skilled nursing care services which are needed to maintain optimum physical and mental health for the patient and to meet his medical treatment needs. They assist the medical staff in assessing the veteran's ability to care for himself; apply nursing measures that prevent further crippling, and teach and supervise veterans in their practice of speech, walking, bathing, grooming, eating, and other activities of daily living. Social workers are also an integral part of the nursing bed care unit experience. The focus is on helping residents to live as fully as possible within the environment and to move back into the community as circumstances permit.

Reimbursement to the States

The Veterans Administration is authorized to reimburse the states at a rate up to but not to exceed $3.50 per day for each eligible veteran furnished nursing home care in state veteran nursing homes. Section IV of

of Public Law 88-450 provides construction grants to states on a "matching basis" to construct state home facilities for furnishing nursing care facility to a state veterans'home and these loans may not exceed 50 percent of construction costs, provided the veteran home is recognized as meeting the criteria established by the Veterans Administration. In the case of the Minnesota State Veterans' Home, such recognition has been granted.

Potential Future Benefits: Congressional Action

The status of the veteran continues to be of ever increasing concern to Congress, as evidenced by recent legislation passed by the House of Representatives. A brief mention of the important bills follows.

H.R. 16907 Is designed to promote the care and treatment of eligible veterans in State veterans' homes by increasing the maximum per diem rates of the Federal payments for hospital or domiciliary care from $2.50 to $3.50 and for nursing home care from $3.50 to $5. In addition, this legislation extends the authorization for appropriations at the present level of $5 million annually through the fiscal year ending June 30, 1974 to assist States in the construction of State home facilities for furnishing nursing home care to war veterans. The maximum Federal participation would remain at 50 percent of the estimated cost of construction.

H.R. 14954 Seeks to improve vocational rehabilitation training for service-connected disabled veterans by extending the authorization of subsistence allowances to include part-time training, now limited to those disabled veterans who are pursuing training only on a full-time basis. Allowances are provided for on a sliding scale for three-quarters-time and half-time institutional training, such amounts also taking into consideration the number of the veteran's dependents. There would be no change in allowances paid veterans pursuing full-time training under existing law.

H.R. 7481 Proposes to increase the amount which the Veterans' Administration is authorized to pay to private or public nursing home care facilities for care of eligible veteran patients from one-third the cost of care in VA general hospitals, as at present, to 40 percent of such costs. The period of such care for which the VA may pay in connection with any one transfer remains unchanged at

generally 6 months. The increase in the statutory limit will considerably broaden the scope and number of nursing homes with which the VA could contract as the demand for adequate and quality care in such facilities continues to increase.

Summary

In any discussion of those extended care services which are available to the Veteran, one must distinguish among four kinds of facilities. First, as previously mentioned, are the 4,000 Veterans Administration nursing home beds authorized by the President. Second, nursing home beds are established at Veteran Homes which are under the jurisdiction of a state and approved for Federal reimbursement according to criteria determined by the Veterans Administration. Thirdly, nursing care beds are available to qualified applicants, veteran or not, in those nursing care institutions which are operated by a state. Finally, nursing care beds are available to the Veteran in community facilities with which the Veterans Administration contracts for up to 6 months of care.

ROLE OF MEDICARE AND OTHER ASSISTANCE PROGRAMS

There are a variety of financial resources available to assist the veteran in meeting the costs of his health care. The principal ones include such Federal programs as Medicare, Medicaid and Social Security retirement benefits, each of which will be discussed in turn. The discussion of these payment aids do not preclude, of course, the utilization by the veteran of other sources of financial assistance which may be available in helping him defray his health care costs, including such assistance as Veteran compensation and pensions, private savings, financial assistance from relatives, casualty, health and accident insurance, workmen's compensation, and assistance from voluntary community organizations. Another major source of veterans' assistance is the health care system of the United States Veterans Administration, the costs of which are borne by the Federal Government as has already been discussed.

MEDICARE

As already noted in a preceding section of the report, the United States Veterans Administration will place veterans in private or community nursing homes at Veterans Administration expense when it is reasonably certain that the aggregate requirement for care will not exceed six months. For a veteran to receive Medicare payment benefits in such a facility, the nursing home must be approved by the Federal Government's Department of Health, Education and Welfare as qualifying for such payments according to the criteria established by the Federal Government.

It might be of interest at this point to briefly explain the eligibility requirements of and benefits available under Medicare for long-term care. The Medicare law contains two separate and distinct health insurance programs for those over sixty-five years of age. One is a "basic plan" covering hospital and nursing home care and is financed through a payroll tax on employees, employers, and self-employed people. The other program is a "voluntary plan", a supplementary medical insurance plan covering doctors and certain other medical and health services. It is financed with monthly premiums paid by people 65 and over who have signed up for this insurance and by government payments which match them dollar for dollar. Beginning in April 1968 the premium rate was increased from an original $3.00 to $4.00 a month and will remain at this rate at least through June 1969. Unlike the basic hospital plan which requires previous coverage under Social Security for determination of eligibility, the voluntary medical insurance program does not require such eligibility.

Eligibility - Everyone, 65 or older, who is entitled to monthly cash Social Security or Railroad Retirement benefits, receives hospital insurance automatically, including that portion related to nursing home care. Even if a person is still working for substantial earnings and does not plan to retire, the individual still has hospital insurance protection.

Hospital Insurance Protection - If a person reaches 65 before 1968, in almost all cases the individual can be covered for hospital insurance even if the individual is not entitled to monthly cash Social Security or Railroad Retirement benefits. A special provision of the law provided for the payment of hospital insurance protection for such people from general revenues.

However, there are some Federal employees and some retired Federal employees who are not eligible for Social Security benefits or Railroad Retirement benefits and therefore, cannot receive hospital insurance protection but they can sign up for medical insurance. In such questionable cases, the local Social Security office is the best source for resolving these questions.

If a person becomes 65 in 1968 or later and is not eligible for cash benefits under Social Security or Railroad Retirement, the individual will need some credit for work under Social Security to qualify for hospital insurance.

The following chart shows how many quarters of credit are needed for hospital insurance by people who reach 65 after 1967:

Year of Attaining Age 65	Quarters of Coverage Needed*	
	Men	Women
1968	3	3
1969	6	6
1970	9	9
1971	12	12
1972	15	15
1973	18	18
1974	21	21
1975	24	24

*The amount of work required is measured in 3-month periods - January, February and March; April, May, and June; July, August and September; October, November and December. In general, credit is granted for each 3-month "calendar quarter" in which wages of $50 or more are paid. Four quarters of coverage are counted for any year in which a person has $400 or more in self-employment income or cash wages from farm work.

Source: Department of Health, Education and Welfare, Social Security Administration, Health Insurance for People 65 or Older. February 1968, p. 3.

Hospital Insurance Benefits - Under the basic hospital insurance program, up to 100 days of care are covered in a participating extended care facility (a skilled nursing home or special part of a hospital) which meets the requirements of the Medicare Law. The hospital insurance will pay for all covered services for the first 20 days of care and all but $5.00 daily for next 80 days. A person is covered for extended care services only if he has been in the hospital for three days or longer and enters the facility within 14 days after he leaves the hospital. Extended care is covered only if further skilled nursing care is medically necessary in connection with an illness for which the individual was treated in a hospital. Custodial care (for example, room, meals, and bedside assistance with medication) is not covered if an individual's condition is such that he does not require continuing attention or medically trained personnel.

Covered services in a Medicare approved extended care facility include the cost of room and meals (including special diets) in semi-private accomodations (2-4 beds), regular nursing services and use of operating rooms. They also include the cost of drugs, supplies, appliances and equipment which are furnished for use in the facility and which are ordinarily furnished to inpatients of the extended care facility in which treatment is received.

Medical Insurance - The medical insurance portion of Medicare Law will help an individual pay for his private physician services -- no matter where the physician provides treatment. If an individual receives treatment in a nursing home from his own physician rather than the facility's resident physician, then the medical insurance would pay for the private physician services but not that of the resident physician. In addition, the medical

insurance covers certain services furnished by an extended care facility for which the hospital insurance cannot pay. Examples are X-ray and laboratory services furnished after hospital insurance benefits in a spell of illness are exhausted. Beginning July 1, 1968, outpatient physical therapy services furnished under the supervision of an extended care facility will also be covered under the medical insurance plan.

Benefit Coverage - Each year, as soon as individuals covered medical expenses goes over $50, the medical insurance will pay 80 percent of the reasonable charge for all covered services which an individual has incurred for the rest of the year regardless of the number of bills which are submitted. If, for example, the reasonable charges for the covered doctor and medical bills amounted to $500 in a year, the medical insurance would pay a total of $360 or 80 percent of the reasonable charges above the first $50 of expenses that year. In the first year in which the coverage starts, no covered medical expenses incurred before the month the coverage begins can count toward the $50 deductible. The "reasonable charges" are determined by the Medicare carrier. They are based upon the private physician's usual charges for the kind of services the individual received and on the rate charged for similar services by other doctors in the area.

Finally, there are some services which medical insurance does not cover. These include:

1. Routine physical checkups.
2. Prescription drugs and patent medicines.
3. Eyeglasses, examinations performed for the purpose of fitting eyeglasses, and eye refraction procedures

(measurements of a type usually performed in examinations for eyeglasses) regardless of why they are performed.

4. Hearing Aids.
5. Immunization.
6. Dentures and routine dental care.
7. Orthopedic shoes.
8. Services provided outside the United States.
9. The first three pints of blood an individual received, other than as a hospital inpatient in each calendar year (the hospital insurance can also provide blood, after a separate 3-pint deductible in a spell of illness, when an individual is a bed patient in a hospital).

MEDICAID

The year which saw Title 18 of the Social Security Law (Medicare) enacted also witnessed the addition of Title 19, commonly known as Medicaid. This program, the costs of which are shared by the Federal, State and local governments, is designed to meet the health care needs of persons who are either indigent or who have only marginal income and resources. The purpose of the program is to provide medical rehabilitative services that will help people, within their respective abilities, to a self-sustaining basis. Medical Assistance payments may be made only for medical services and may not be made for maintenance needs, such as food, shelter and clothing.

Eligibility - Persons are eligible for Medical Assistance, hereafter referred to as MA, in Minnesota if they are receiving,or if they qualify

for, aid under one of the other public assistance programs: Old Age Assistance (OAA), Aid to Families With Dependent Children (AFDC), Aid to the Blind (AB), or Aid to the Disabled (AD), or if they are medically needy children under 21 years of age.

The basic eligibility requirements in Minnesota are as follows:

1. Age - Persons of various ages who may qualify for MA - include those whose resources are within the limitations of the MA program and who are 65 years of age or older, or who are blind, or disabled, or dependent children and their caretakers, as in the AFDC program, or children under 21 years of age.
2. State Residence - To be eligible for MA from Minnesota, an applicant or recipient must make his home or have established an "abode" in the State. If absent from the State, it must be determined whether he has an established residence in Minnesota in accordance with the regulations of the Minnesota Department of Public Welfare. No specific length of residence in this State is required.
3. County Settlement - The Minnesota county of MA residence, i.e., the county responsible for paying the Medical Assistance, as a general rule, is the one in which the applicant last resided for one year or for the longest period of time in other than a hospital or other "care" facility. This county is determined at the time application is made for Medical Assistance.

4. Real Property - An applicant for MA, or any applicant and spouse, may not have an equity in excess of $15,000 in real property.

5. Personal Property - An individual may have $750 in liquid assets, or, if married, he and his spouse together may have $1,000 in liquid assets plus $150 for each additional legal dependent. Liquid assets include cash on hand, bank or postal savings, stocks or bonds, or other property that can be readily converted into cash. The applicant and his spouse may also have household goods, furniture, wearing apparel, $1,000 each in cash surrender value of life insurance, a burial lot, and each a prepaid funeral contract, not in excess of $600.

   Any person who transfers property, either to qualify for MA or to continue eligibility for this assistance or who disposes of a property asset without receiving a reasonable return for it, becomes ineligible.

6. Income - If an applicant is single, he may have income up to $1,620 annually. Two family members (man and wife, parent and child under 21, or two siblings under 21) together may have income not exceeding $2,220 annually plus $408 for each additional legal dependent. This includes income from all sources. Applicants who have income in excess of these amounts may be eligible if their medical expenses incurred during the month of application

and the three preceding months equals more than half of their annual "excess" income.

Persons whose continuing monthly medical expenses equal more than their average month "excess" income may also qualify.

7. Insurance Benefits - An applicant is required to use all the proceeds available from medical, surgical and hospital insurance before MA can be paid for medical care. If this insurance is not adequate to cover the medical expenditures, the difference can be paid through MA.

Services of Minnesota Assistance Program - The Minnesota MA Program includes the full scope of recognized health-care services, such as hospital care, nursing home care, physicians services, out-patient and clinic care, home health care, private-duty nursing service, physical therapy, dental care, laboratory and X-ray services, drugs, eyeglasses, dentures, prosthetic devices, and diagnostic screening and preventive services. All of the above services must be furnished by a licensed practitioner or a recognized vendor of health care services.

Although relatives other than the spouse, or parents of an applicant who is under 21 years of age, are not required to contribute toward the medical costs of MA recipients, income from other than MA must be available to the applicant or recipient for his continuing "maintenance" needs. For a single person in a nursing home, the applicant or recipient will be required to apply his or her income on the monthly cost of such care. If a nursing home patient receiving MA has justifiable expenses, such as health care

insurance, or support of minor or dependent children or spouse, the county welfare department will allow the application of the income to such costs.

In evolving payment schedules to nursing homes for Medicaid patients, the Minnesota State Department of Public Welfare has established four categories of care. These include minimum, moderate, maximum, and exceptional care. The payment classifications are based upon a point system in which each parent is categorized according to the degree of his health care needs, as well as physical status in such areas as nursing care, locomotion, continence, mental status, personal care, eating and other special requirements. After the patient's status is identified within each of these categories, the total number of points represented by the components of these classifications is totaled and the kind of care needed by the patient is then determined.

The point distribution for the varying kinds of nursing care are incorporated in the following chart.

The payment rates to nursing homes for varying kinds of care are established by each county in direct negotiation with the nursing homes, and thus, the rates within the same classification of health care vary among the counties as listed below:

Kind of Care	Range of Points For Care Classification	Payment Rate Range Per Month*	
		Low	High
Minimum Care	4-7	140	386
Moderate Care	8-12	150	386
Maximum Care	13-17	175	386
Exceptional Care	18 & over	200	440

*Estimated from State Welfare Department's payment schedule. Estimates made due to fact some rates expressed on a per diem basis while others on a monthly basis in various health care categories. Welfare payments for boarding or domiciliary care, 0-3 points, averaged $150.00 per month in the Spring of 1968.

In regard to the kinds of nursing home care which are available to the veteran, one possible sequence in the receipts of institutional care, for example, could be as follows:

If it is determined at the United States Veterans Administration that a veteran can be discharged from a nursing home within six months of care, as already noted, the veteran can be placed in private nursing homes with the United States Veterans Administration paying for the costs of the care at the same nursing home rates which is, on an average, charged to the public by the nursing care facility. If it is decided at the end of six months that the veteran still needs additional care he may be:

1. eligible under Medicare plan for an additional 100 days at a cost of $400 to himself;
2. placed currently in a nursing care facility of a State Veteran Home at a rate of up to $3.50 per day, from the Veterans Administration, for the rest of his life;
3. as a Medicaid welfare patient he may be placed in a private facility at whatever level of care and costs of care his condition warrants, as determined by county in which he is institutionalized; or,
4. readmitted to a Veterans Administration hospital and may, after several days, be admitted to a Veterans Administration nursing home bed, for as long as the condition warrants and at the expense of the Federal Government, depending upon their availability.

SOCIAL SECURITY

Finally, another major source of income to pay for nursing home care and Social Security retirement benefits. As already noted earlier in the discussion, those individuals who have worked a specified amount of time for which Social Security deductions were made are eligible to receive nursing home and other health care benefits under the Medicare Act as well as whatever Social Security retirement benefits and others for which they might qualify.

Gratuitous Social Security Wage Credits - In genera, veterans with 90 days active service between September 16, 1940 and December 31, 1956, and whose discharge was other than dishonorable, may receive gratuitous Social Security wage credit of $160 for each month of this duty. Veterans with less than 90 days service may receive credits if they were discharged because of disabilities or injury incurred or aggravated in service in line of duty. These credits are not actually listed on your Social Security earnings record until you or your survivors apply for benefits. At that time, proof of your military service will be required.

In some cases, veterans receiving military retired pay also may receive gratuitous Social Security wage credits, as may citizens of the United States who served in the Armed Forces of our allies during World War II.

Earned Social Security Credits - Beginning in 1957, military personnel began to pay Social Security taxes on their base pay, their contributions being matched by their employer, the United States Government. In addition, as a result of amendments to the Social Security Act in 1967, members of the Armed Forces and their families will have greater Social Security

protection starting in 1968. Under the old law, as already noted, only military base pay was counted toward Social Security benefits for the Armed Service and his family. The general affect of the new law is that starting with January 1968, an additional $100 will be counted for each month in which you receive active duty pay. No additional Social Security tax contributions will be deducted from the pay for these credits.

As far as the veteran population within the Homes is concerned, all individuals, including veterans, who reach 65 before 1968, are eligible for Medicare benefits whether they have worked a single day under Social Security or not. Beginning in 1968, the appropriate number of quarters of work for Social Security deductions in order to become eligible for Medicare benefits must be attained by an individual.

HEALTH CONSTRUCTION ASSISTANCE

In terms of the availability of Federal assistance to finance the construction of a nursing home, there exists a number of Federal Governmental programs. Most of these programs, however, are inapplicable to financing of nursing home construction at the State Veterans' Home. The various programs, whether applicable or not, will be mentioned so as not only to provide as complete an inventory as possible of these Federal resources, but also to show why they can or cannot be used in regard to the particular situation of the State Veterans' Home.

Small Business Administration. The Small Business Administration (SBA) provides financial assistance to privately owned convalescent nursing homes for expansion, improvements, and general operations. The SBA definition of these institutions are those facilities for the accommodation of convalescent or other persons who require nursing care and related medical services. However, to be eligible for SBA financial assistance the convalescent or nursing home must be operated as a business and for profit, with the profits benefiting its owners, stock holders, or members. In addition to being privately owned and operated for profit, a nursing or convalescent home must be a "small business" to qualify for a loan. Such a facility is considered small business according to SBA criteria if its annual dollar volume or receipts is not more than $1,000,000. Consequently, a nonprofit nursing care facility attached to the State Veterans' Home would not qualify for SBA financial assistance.

Economic Development Administration. This agency encompasses the activities of the former Area Redevelopment Administration and has received its authority from Public Law 89-136 (Public Works and Economic Development Act of 1965). The purpose of the legislation is to provide economic development in "redevelopment areas." Loans are authorized for commercial facilities in order that they may provide permanent jobs for the unemployed and better incomes in those areas economically lagging behind the rest of the nation. Under this Act, private nursing homes are provided loans if they are structurally adequate for the safety and proper care of occupants, and economically sound as business enterprises.

Other stipulations include:

1) Certification from the State that the Home is needed; minimum standards are in effect for licensing and operations, and that standards will be enforced.
2) Funds not available from the Small Business Administration or Federal Housing Administration (FHA)
3) FHA minimum property standards for nursing homes will be met in construction.
4) Participating and direct loans, up to 65 percent of aggregate project cost, with 5 percent minimum from governmental or community group, and 10 percent minimum equity
5) Rate: 4 3/4 percent for maximum of twenty-five years.

The Economic Development Administration may provide nursing home loans to local communities and public groups as nonprofit associations, but will not so readily provide loans to a State since it is difficult for the Agency to determine whether a State has sufficient finances for nursing home operations due to a State's access to such funds. Also, the Economic Development Administration discourages nursing home loans generally, because nursing homes do not have much of an economic impact on a redevelopment area.

Federal Housing Administration. Another Federal program concerned with nursing home construction relates to the Federal Housing Administration. The Housing Act of 1959 (Public Law 86-372) authorized the Commissioner of the Federal Housing Administration to insure mortgages for the construction or rehabilitation of qualified nursing homes. Projects must be skilled nursing homes of not less than 20 beds. Not only are proprietary facilities eligible under this program, but as of 1964 private nonprofit nursing home sponsors became eligible for FHA mortgage insurance for nursing home construction on the same terms as proprietary sponsors. Also, it is now possible for the sponsor of a nonprofit nursing home to qualify for combination FHA insured mortgage and Federal grant or loan made by the Department of Health, Education, and Welfare under the Hill-Burton Program.

The proprietary mortgagor may be a private corporation or association organized for purposes other than the making of profit for itself, or for persons identified with it, and found by FHA to be in no manner controlled by or under the direction of persons or firms seeking

direction of persons or firms seeking to derive profit from it. The project may be leased by the mortgagor to a nursing home operator under terms and conditions approved by the FHA.

Before insuring any mortgage, FHA must have certification from the appropriate agency of the State in which the nursing home is to be located that there is a need for the home; that there are in force in the State (or its political subdivision) reasonable minimum standards for licensing and operating nursing homes; and that these standards will be applied and enforced with respect to any FHA-insured nursing home in the State. FHA relies on the various States for enforcement of their requirements for continuing licensure.

The mortgage may cover either proposed construction of a new facility,or rehabilitation of an existing structure consisting of not less than 20 beds, and may include insured advances during construction. The maximum mortgage amount is limited by statute to $12.5 million per project. The loan-to-value ratio on nursing home mortgages was increased by the Housing Act of 1961, from 75 percent to 90 percent of the FHA estimated value of the project when the proposed improvements are completed. On a rehabilitation project the mortgage is limited to not over five times the cost of new improvements.

The FHA does not insure the construction of a facility for a State nursing home. For a State to obtain such mortgage insurance, it would have to establish a private nonprofit corporation through which it would construct a nursing home. The corporation would be the mortgagor and would get a private lender, and the private corporation would be responsible to FHA.

Veterans Administration. A State desiring to receive assistance for construction of facilities for furnishing nursing home care, must submit an application in writing for such assistance to the Administrator. The applicant must submit as part of the application:

1) The amount of the grant requested with respect to such project, which may not exceed 50 percent of the estimated cost of construction of such a project.
2) A description of the site for such a project.
3) Other plans and specifications as required by the Veterans Administration.

The applicant must furnish reasonable assurance in writing:

1) Upon completion of such project the facilities will be used principally to furnish nursing home care to war veterans, and that not more than 10 percent of the bed occupancy at any one time consists of patients who are not receiving nursing home care as war veterans.
2) Title to such site is, or will be,vested solely in the applicant, a State home, or another agency or instrumentality of the State.
3) Adequate financial support will be available for the construction of project, and for its maintenance and operation when complete.

4) The State will make such reports in such form and containing such information as the Administrator may from time to time reasonably require, and give the Administrator upon demand, access to the records upon which such information is based.

Hill-Burton Program. The Hill-Burton Program makes Federal grants or loans available to assist in constructing and equipping public and other types of nonprofit hospitals and health faciliteis for which a need is established. Among the faiclities eligible for the program are those rendering long-term care, such as nursing homes and chronic disease hospitals.

The kinds of projects for which the Hill-Burton program provides grants include:

1) The construction of new buildings or expansion of existing ones.
2) The alteration, major repair, remodeling, replacement, and renovation of existing buildings.
3) Initial equipment for new expanded, or modernized structures.

The Federal share varies from state to state, ranging from one-third to two-thirds of the cost of construction and equipment. Eligible applicants may accept a loan in lieu of a grand under the same requirements. Loans may be made for a maximum period of 40 years at a low interest rate determined at the time the project is approved.

Projects are selected by the State administering authority in accordance with the provisions of a State plan for hospital and other health facilities. This plan, developed by the State authority and approved by the Public Health Service, contains an inventory of existing hospital and other health facilities and shows the community's remaining need. Priority for Federal aid is determined on the basis of the relative need of the various areas of the State for additional facilities and services. The State agency is responsible for selecting projects for approval and for forwarding applications to the PHS for final approval.

Payments of the Federal share of project costs are made on the basis of work completed as determined by inspections of the project by the State administering authority. The initial payment usually is made after 25 percent of the construction is completed. Additional payments are made as the project progresses.

If the Veterans Administration contributes to the construction costs of the Minnesota Veterans' Home, the Hill-Burton Program will not make any contribution to the financing of construction. The Federal participating matching grant formula to the State of Minnesota under Hill-Burton is up to 45 percent, as opposed to up to 50 percent under the VA formula; thus, it would be to the advantage of Minnesota to seek VA rather than Hill-Burton financial assistance. Finally, the Hill-Burton Fund would not be available to Minnesota should the Veterans' Home nursing care unit be restricted primarily to the care of veterans. Hill-Burton requires that the nursing home facility be open to the general public - if construction funds are to be granted to the State.

III. FINDINGS

Introduction

This section presents a summary, by parts, of findings of the study of the Minnesota Veterans' Home. Each part relates to a specific functional unit of the Home and contains, where appropriate, a brief description of its current status insofar as we fine it carrying out its apparent function. We present recommendations for consideration and implementation which we believe will lead to a more effective Home IN ITS CURRENT FORMAT AT THE PRESENT TIME AND IN THE NEAR FUTURE [(up to the time of change (if any)) resulting from this study]. This section does not intend to provide a detailed review of existing organization and management policy and procedure leading to a complete systems analysis and design. It does intend to reflect the findings and present recommendations leading to a more effective Home.

Since it is top management which provides guidance and control of the organization and its functions, we limited ourselves to consider key decision-makers and their role in the Home.

A. MINNESOTA VETERANS HOME BOARD

"THE MINNESOTA VETERANS HOME SHALL BE MAINTAINED AT MINNEAPOLIS, UNDER THE MANAGEMENT OF NINE TRUSTEES, ONE OF WHOM SHALL BE A WOMAN, TO BE KNOWN AS THE VETERANS HOME BOARD, AS A HOME FOR ALL HONORABLY DISCHARGED PERSONS..."
(Minnesota Statute, Section 198.01, as amended)

It is apparent from the review of the statement of the Minnesota Statute cited, that the MANAGEMENT of the Home rests with the Minnesota Veterans Home Board of Trustees. It is clear, explicit and specific. It does not lead to interpretation other than placing upon the Board the total responsibility and authority for the establishment of policy and the management and control of the Home; its interaction with other State organizations, the citizens of Minnesota and others within and without the State; and for the actions and activities relating to the program, operations, facility and site of the Minnesota Veterans Home. It is definite in its charge to the Home Board in the scope of its effort to provide a "Home" for a special class of Minnesota citizen, the veteran, who meets the definition of veteran in this statute. It may not consider as to whether or not it will provide a Home -- it will provide a Home. It is the intent of the Legislature that a Home shall be provided for the veteran. It thus becomes the intent of the State and its citizens to provide a Home for the "proper and dignified care" of the Minnesota veteran now and in the future.

As the organization responsible for the development and management of the Home, it is encumbent upon the Board to provide direct guidance and instructions to the Commandant of the Home, informing him of the manner in

which they wish to have the Home managed. Upon the Board rests the establishment of policy decisions and actions affecting the Home. Upon the Board rests the determination of whether the Home is being managed in accordance with its desires. Upon the Board rests the responsibility and authority to determine its actions if its desires are not carried out. It is up to the Board to follow-up on its established policy and decisions.

Up until the time that this study began, the Board did not so function. It expressed some desires. It expressed some policy. It did not establish a firm guide line for the Commandant upon which it followed up and enforced. Its intent was in line with established State intent. It did not, however, act in accordance with well-known management principles of organizational and operational control. On some issues the Board told the Commandant what to do, and on others the Commandant told the Board what to do. A mutually respectful team did not exist.

With the onset of the study, the Board updated its attitude. A sudden realization of the need for introspection occurred. A new Board Committee was formed for the purpose of looking towards the definition and establishment of a long-range program. This action occurred since it was sharply brought to the attention of the Board by the study group that such a written program did not exist. Furthermore, the Board also realized that the Home had no written established procedures able to be reviewed by the study group. The Board immediately requested the Commandant to start the preparation of such a document for its review and approval prior to implementation.

A preliminary draft of a Veterans Home Board long-range program has been prepared and may be found at the end of this section. A rough draft of a "procedure manual" was submitted to the Board for review. Since this draft is in the early stages of preparation, and has not yet achieved the role of a completed Board reviewed or approved draft, it is not included in this report.

The recently completed draft of the Program of the Home Board was reviewed by the study group. It appears to be a useful program, certainly within the scope of the existing intent of the State. It appears to be a program worthy of consideration and development. An enormous amount of work is required by the Board to achieve its realization, however. The implementation of such a program would indeed provide proper and dignified care for the Minnesota veteran now and in the future. As a recognized preliminary statement, it shall require multi-disciplinary expertise to fully develop a well-defined program. Not only will it require expertise to develop the program, it will require that this expertise continually monitor its implementation and utilization. It will need to become continually aware of changes in the program reflecting changes in need and requirements of the State and its citizenship.

It is realized by the Board that such a program is neither developed overnight nor is it presently capable of being implemented in the existing facility with the existing staff of the Home. It is realized by theBoard that such a program results from an evolutionary development of a more complex program from a more simple program. That until a well-developed and operating

program in line with a basic principle of domiciliary care is proven useful and effective, one should not enter into the more complex environment of nursing home care and the rehabilitation and restorative areas, which is also realized by the Board.

RECOMMENDATIONS

1. IN ORDER TO PROVIDE AN EFFECTIVE BOARD, A TRULY EFFECTIVE MINNESOTA VETERANS HOME BOARD, WE RECOMMEND THAT THE BOARD BE RECONSTITUTED AS FOLLOWS:

a. 8 MEMBERS - ONE FROM EACH LEGISLATIVE DISTRICT.

These members represent the citizenship of the State, and one of these should be a woman and all should adhere to current requirements for appointment by the Governor.

b. 1 MEMBER - APPOINTED BY THE COMMISSIONER OF VETERANS AFFAIRS.

This individual would be a fulltime, Department of Veterans Affairs employee knowledgeable in the area of veterans claims and benefits.

c. 1 MEMBER - APPOINTED BY THE COMMISSIONER OF PUBLIC WELFARE.

This individual would be a fulltime employee of the Department of Public Welfare, preferably from the Public Assistance Division, and fully knowledgeable in the administration of State institutions.

d. 1 MEMBER - APPOINTED BY THE COMMISSIONER OF PUBLIC WELFARE.

This individual would be a fulltime employee of the Department's Rehabilitative Services Division of the Department of Public Welfare.

e. 1 MEMBER - APPOINTED BY THE COMMISSIONER OF HEALTH.

This individual would be a fulltime employee of the Department of Health and fully knowledgeable in the area of the evaluation of the quality of medical care.

f. 1 MEMBER - APPOINTED BY THE COMMISSIONER OF ADMINISTRATION.

This individual would be a fulltime employee of the Department of Administration and fully knowledgeable in good management practices.

By having these additional official VOTING members of the Board, the State would be more assured of a technically qualified group able to make the appropriate decisions. It might be expected that these additional members would each need to devote approximately 10 to 15 percent of their working time to activities of the Home. This would include attendance at Board Meetings and participation at Board Committee Meetings.

2. THERE BE ESTABLISHED AT LEAST THE FOLLOWING FOUR COMMITTEES BY THE HOME BOARD.

a. 1. Executive and Long-Range Planning Committee

b. 2. Medical and Rehabilitation Services Comm.

c. 3. Home Management and Fiscal Committee.

d. 4. Membership activities and Services Comm.

The functions of these committees are evident from their titles.

The following recommendations relate to the comments made previously and are not intended to be all inclusive. They reflect some immediate needs.

3. THE BOARD SHOULD IMMEDIATELY ESTABLISH ITSELF AS THE MANAGEMENT IN CHARGE OF THE HOME, ITS POLICY AND LONG-RANGE PLAN.

4. INSTITUTE A WELL-DEVELOPED PLAN FOR THE ESTABLISHMENT OF A WRITTEN PROGRAM, BOTH FOR SHORT-RANGE AND LONG-RANGE PLAN FOR THE HOME.

5. REQUIRE THE IMMEDIATE DEVELOPMENT OF A WRITTEN PROCEDURE MANUAL BY THE COMMANDANT OF THE HOME FOR PRESENTATION TO THE BOARD FOR ITS REVIEW, COMMENT AND APPROVAL PRIOR TO IMPLEMENTATION.

6. REQUIRE THE ESTABLISHMENT OF A BUDGETING PROCESS FOR ALL MAJOR UNITS OF THE HOME INCLUDING THE FOLLOWING:

a. ADMINISTRATION

b. ACTIVITIES AND SOCIAL SERVICES

c. PLANT OPERATION, MAINTENANCE AND HOUSEKEEPING

d. MEDICAL, NURSING AND HOSPITAL SERVICES

e. DIETARY

7. ESTABLISH A REORGANIZATION OF THE HOME ADMINISTRATION IN ACCORDANCE WITH THE PROPOSED ORGANIZATION CHART (FIGURE 1.)

8. REQUEST THE MINNESOTA PUBLIC EXAMINER TO CONDUCT A COMPLETE REVIEW OF ALL INCOME AND ALL EXPENSES OF THE HOME, INCLUDING ALL FUNDS FROM ALL ACCOUNTS UNDER CONTROL OF THE BOARD OR COMMANDANT.

9. REQUEST THE MINNESOTA DIRECTOR OF CIVIL SERVICE TO CONDUCT A 'DESK AUDIT' OF ALL EMPLOYED PERSONNEL, WITHOUT EXCEPTION, IN CLASSIFIED AND UNCLASSIFIED POSITIONS, FOR THE PURPOSE OF ESTABLISHING TWO FACTORS FOR EACH INDIVIDUAL AND POSITION.

a. WHETHER THERE IS AN APPROPRIATE CLASSIFICATION JOB DESCRIPTION, AND NEED FOR THAT INDIVIDUAL'S FUNCTIONS AS CURRENTLY PERFORMED.

b. WHETHER THE INDIVIDUAL SO EMPLOYED IN A PARTICULAR POSITION IS QUALIFIED IN TERMS OF STATE STANDARDS, AS USED IN OTHER COMPARABLE DEPARTMENTS AND AGENCIES AND INSTITUTIONS OF THE STATE.

10. REQUIRE THE COMMANDANT TO REVIEW WITH THE BOARD THE SELECTION AND EMPLOYMENT OF THE HEADS OF EACH OF THE UNITS DESCRIBED IN THE RECOMMENDED TABLE OR ORGANIZATION.

11. REQUIRE THE ESTABLISHMENT BY THE COMMANDANT OF A WELL DEFINED PROGRAM AND PLAN OF SENIOR STAFF DEVELOPMENT AND EDUCATION, THE INITIAL IMPLEMENTATION PROGRAM AND PLAN TO BE REVIEWED AND APPROVED BY THE BOARD PRIOR TO INSTALLATION.

12. REQUIRE THE COMMANDANT OF THE HOME TO DEVOTE ALMOST ALL OF HIS EFFORTS TO THE MANAGEMENT OF THE HOME AND A MINOR PART TO OTHER ACTIVITIES. ACTIVITIES IN THE REALM OF "PUBLIC RELATIONS" SHALL BE SUBJECT TO THE REVIEW AND PRIOR APPROVAL BY THE BOARD. ACTIVITIES IN THE REALM OF "PUBLIC RELATIONS" SHALL BE SECONDARY TO THE REQUIREMENTS OF THE HOME AND THE BOARD AND AS DETERMINED BY THE BOARD.

13. ESTABLISH THROUGHOUT THE STATE, AND FOR THE INFORMATION OF ALL INTERESTED ORGANIZATIONS AND INDIVIDUALS, A CONSISTENT ADMISSION AND DISCHARGE POLICY. DISCOURAGE THE REJECTION OF POTENTIAL APPLICANTS TO THE HOME BY ANY INDIVIDUAL OR ORGANIZATION OTHER THAN BY THE OFFICIALLY CONSTITUTED GROUP AT THE HOME, AS AUTHORIZED BY THE BOARD.

14. ENCOURAGE A POLICY OF FREQUENT INTERACTION WITH THE SENIOR STAFF OF THE HOME WITH THE HOME BOARD.

15. REQUIRE THAT THE STATUS OF THE COMMANDANT OF THE HOME BE CHANGED FROM ITS PRESENT UNCLASSIFIED MINNESOTA CIVIL SERVICE POSITION TO A POSITION COMPARABLE IN TITLE, CLASSIFICATION, SALARY, AND OTHER CHARACTERISTICS OF KNOWLEDGE, EXPERIENCE AND EDUCATION TO BECOME EQUIVALENT OF OTHER ADMINISTRATORS OF MINNESOTA STATE INSTITUTIONS DEVOTED TO THE CARE OF PERSONS IN STATE FACILITIES.

16. THAT THE BOARD REQUIRE THE ESTABLISHMENT OF A SET OF RULES AND REGULATIONS FOR THE CONDUCT OF MEMBERS DURING THEIR RESIDENCE IN THE HOME. THESE RULES SHOULD BE DISTRIBUTED TO ALL CURRENT MEMBERS OF THE HOME AND ALL NEW ADMITTEES.

17. THAT THE BOARD REQUIRE THE ESTABLISHMENT OF A "NEW MEMBER COMMITTEE" (OR OTHER APPROPRIATE NAME) FOR THE PURPOSE OF CONSIDERING EACH NEWLY ADMITTED MEMBER FROM THE POINT OF VIEW OF DETERMINING HIS OR HER REQUIREMENTS AND NEEDS IN TERMS OF FOOD, CLOTHING AND SHELTER; MEDICAL AND NURSING CARE; FISCAL COUNSELLING; AND ACTIVITIES IN TERMS OF SOCIAL/REHABILITATIVE NEEDS AND REQUIREMENTS. MEMBERS OF THE COMMITTEE SHOULD INCLUDE THE HOME PHYSICIAN, DIRECTOR OF ACTIVITIES, CHAPLAIN, AND THE BUSINESS MANAGER.

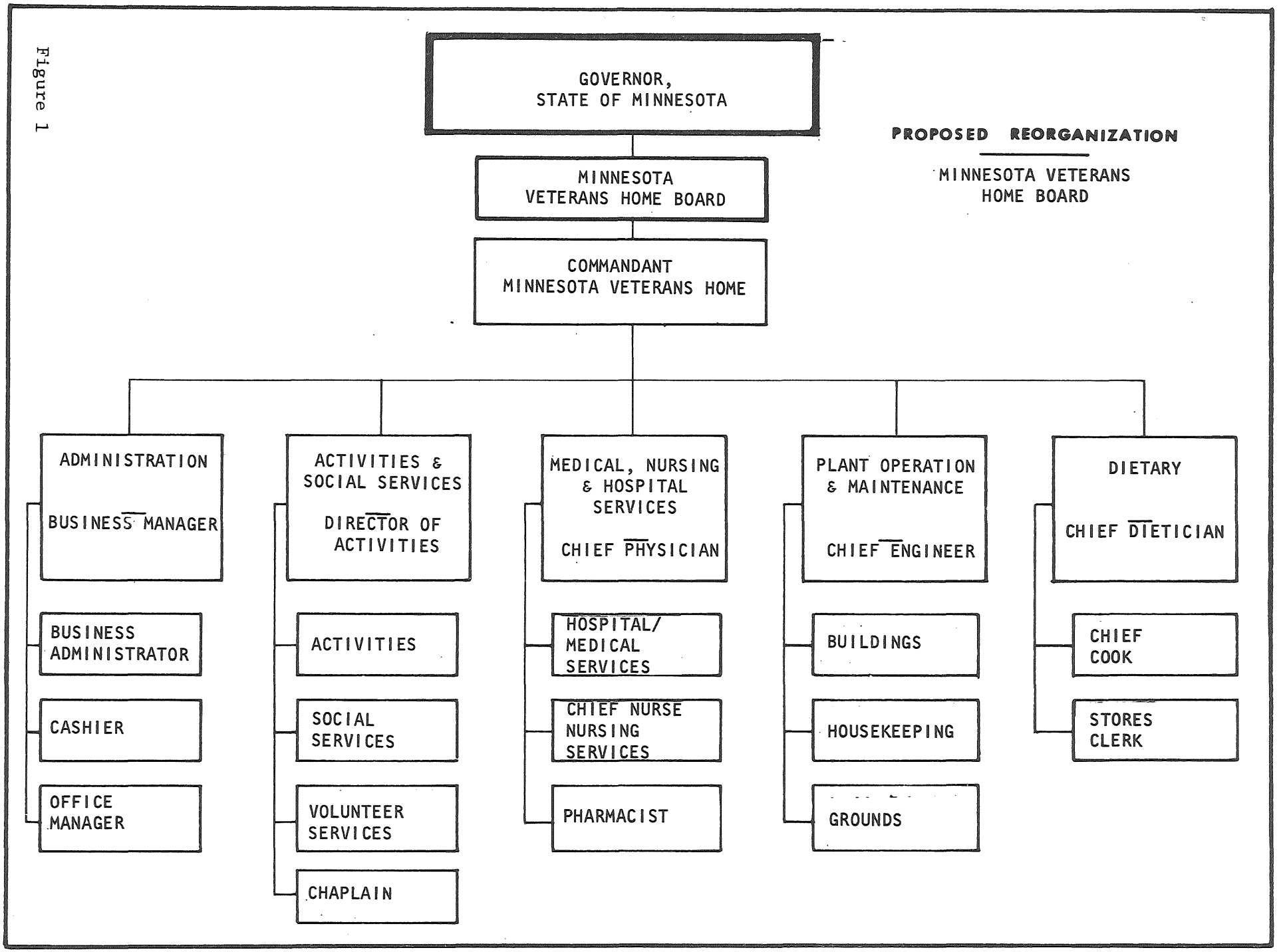
18. IT IS FURTHER RECOMMENDED THAT THERE BE INSTITUTED:

a. MORE FREQUENT INTERACTION BETWEEN THE BOARD MEMBERS AND THE VETERAN MEMBERS OF THE HOME.

b. MORE FREQUENT INTERACTION BETWEEN THE MEMBERS OF THE BOARD AND OTHER STATE OFFICIALS WHO HAVE SIMILAR FUNCTIONS, INCLUDING BUT NOT LIMITED TO THE DEPARTMENTS OF ADMINISTRATION, PUBLIC WELFARE, VETERANS AFFAIRS, HEALTH, AND THE UNIVERSITY OF MINNESOTA.

c. MORE FREQUENT PROGRAM OF INTERACTION WITH THE VETERAN AND OTHER CIVIC SERVICE ORGANIZATIONS.

Figure 1


GOVERNOR,
STATE OF MINNESOTA
PROPOSED REORGANIZATION
MINNESOTA VETERANS
HOME BOARD
MINNESOTA
VETERANS HOME BOARD
COMMANDANT
MINNESOTA VETERANS HOME
ADMINISTRATION
BUSINESS MANAGER
BUSINESS
ADMINISTRATOR
CASHIER
OFFICE
MANAGER
ACTIVITIES &
SOCIAL SERVICES
DIRECTOR OF
ACTIVITIES
ACTIVITIES
SOCIAL
SERVICES
VOLUNTEER
SERVICES
CHAPLAIN
MEDICAL, NURSING
& HOSPITAL
SERVICES
CHIEF PHYSICIAN
HOSPITAL/
MEDICAL
SERVICES
CHIEF NURSE
NURSING
SERVICES
PHARMACIST
PLANT OPERATION
& MAINTENANCE
CHIEF ENGINEER
BUILDINGS
HOUSEKEEPING
GROUNDS
DIETARY
CHIEF DIETICIAN
CHIEF
COOK
STORES
CLERK

COMMANDANT

Other than the Minnesota Veterans' Home Board, the Commandant (the administrative head of the Home) is the key to the successful operation of the Home. Its goal to provide proper dignified care for the Minnesota Veteran can be achieved only with his aid and assistance. It is through the Commandant that the senior staff would find guidance and control. Through him, the staff would develop a plan and budget for those functions which the Commandant is responsible, on a day-to-day basis. It is through the Commandant that information about the activities in the Home, as received by the staff, would be transmitted to the Board. Actions prior to the appointment of the present Commandant are of little value to describe and discuss in terms of the present objectives of this study. We find it necessary, however, to state that subsequent to the appointment of the present Commandant, the conditions of the Home and the care of the individual members of the Home have improved immeasurably. With the new Commandant came a realization of the need to provide care for the veteran. With an agressive enthusiasm, he embarked upon a series of actions leading to many improvements. This began three years ago.

This study and its recommendations are not related to degrees of progress attained during the periods of the two Commandants. Rather, we are concerned with the existing (April 1968 - July 1968) situation only. It is noted that we acknowledge the current Commandant's prior accomplishments, but we must now restrict our concern to the present and the future.

Responsibility

Without a doubt, the Commandant is responsible to the Board for all his favorable or unfavorable actions and decisions. He is responsible only to the Board and to no one individual or to any other formal or informal organization, within or without State Government. He holds his position at the pleasure of the Board.

Prior to the onset of this study, the Commandant labored under a difficult charge from the Board. The difficulty lies in the fact that there was no formal, written or specific charges. He was expected to conduct the activities of the Home, but without guidelines. He was expected to perform well, but was not given criteria for good performance. Practically anything he chose to do, he did. Practically anything he chose not to do, he did not do. In other words, he assumed complete control of the Home despite the presence and authority of the Board. Unfortunately, no one questioned him and his actions with sufficient enforced authority (not implied, but actual) to have him account for his actions and decisions. Few authoritative constraints affected his level of decision-making.

A predominant part of his time was devoted to "public relations", a considerable part of his time was spent off-site and out-of-state on matters indirectly related to his immediate responsibility of the Home's day-to-day operations.

He became devoted to the care of "veterans" per se as a special interest group rather than to the care of needy individuals who also just happened to be veterans. In addition, he became involved with microscopic operations of the Home rather than those of macroscopic proportions.

The Home, as a physical facility, superceded the requirements and needs of the members of the Home.

Due to his lack of managerial know-how, he tolerated a degree of "sustained mediocrity" in the performance of his senior and junior staff; permitted the records and books to be maintained in a less-than-effective and efficient manner. He has allowed special privileges and favoritism to arise in his relations between himself and his staff. The end effect has been a breakdown in morale of by-passed staff members as well as those Home members sensible enough to evaluate the overall conditions.

He has permitted conditions in the Home to reach such a state that a considerable number of the veteran members of the Home have stated verbally and in writing, to the study group, that they are not able to find anyone to talk to or to be able to discuss their own personal needs and wants.

The following recommendations are suggested for the purpose of improving the existing operations of the Home until such time as changes, resulting from this report, may be implemented.

RECOMMENDATIONS

1. THE THE COMMANDANT BE REQUIRED TO PREPARE, WITH FIRST PRIORITY, A PROCEDURE MANUAL. THE MANUAL TO CONSIST OF SECTIONS RELATING TO EACH OF THE PRINCIPAL FUNCTIONAL AREAS, AS DESCRIBED IN THE PROPOSED TABLE OF ORGANIZATION (SEE FIGURE 1).

   THAT THE MANUAL BE PREPARED BY THE SENIOR STAFF MEMBER IN CHARGE OF THAT UNIT WITH THE ASSISTANCE AND GUIDANCE OF THE COMMANDANT AND OTHERS WITHIN AND WITHOUT THE STATE ORGANIZATION. THE FINAL DRAFT OF THE MANUAL, AFTER REVIEW AND APPROVAL BY THE COMMANDANT SHOULD BE SUBMITTED TO THE BOARD FOR APPROVAL AND SUBSEQUENT IMPLEMENTATION. CHANGES IN THE PROCEDURE MANUAL, SUBSEQUENT TO THE INITIAL PUBLICATION, WOULD BE REVIEWED BY THE COMMANDANT AND THE BOARDS' HOME MANAGEMENT COMMITTEE

2. THAT THE COMMANDANT ESTABLISH, IMMEDIATELY, A SENIOR STAFF CONFERENCE ROOM WHERE THE STAFF MAY BE ABLE TO HOLD PRIVATE AND CONFIDENTIAL DISCUSSIONS WITH INDIVIDUAL MEMBERS OF THE HOME. THE ROOM SHOULD BE CONSONANT WITH A COUNSELLING ENVIRONMENT AND BE LOCATED FOR THE CONVENIENCE OF THE AGED AND POSSIBLY INFIRM MEMBER.

3. THAT THE COMMANDANT IMMEDIATELY UNDERTAKE A PROPERLY DETERMINED, COMPREHENSIVE REVIEW OF EXISTING RELATIONSHIPS BETWEEN THE STAFF AND THE MEMBERS OF THE HOME FOR THE PURPOSE OF INSTILLING IN THE MINDS OF THE MEMBERS AND THE STAFF THE NEED FOR A CLOSER UNDERSTANDING BY THE STAFF OF THE NEEDS AND REQUIREMENTS OF THE MEMBERS AS INDIVIDUAL PERSONS.

4. THAT THE COMMANDANT UNDERTAKE THE PRACTICE OF GOOD MANAGEMENT TECHNIQUES IN ACCORDANCE WITH THE STANDARDS AND GUIDELINES PROVIDED BY THE STATE AND OTHER RECOGNIZED SOURCES OF MANAGERIAL KNOWLEDGE AND EXPERIENCE.

5. THAT THE COMMANDANT DEVOTE A MAXIMUM PART OF HIS TIME TO MANAGEMENT OF THE HOME ON-SITE, AND A MINIMUM OF HIS TIME OFF-SITE.

6. THAT THE COMMANDANT PLACE THE EMPHASIS OF THE MANAGEMENT OF THE HOME THROUGH THE EFFORTS OF HIS SENIOR STAFF.

MEDICAL AND NURSING SERVICES

The Home is licensed by the Minnesota State Board of Health for the year 1968 for the maintenance of 56 nursing care beds and 375 boarding care beds. The personnel report of the Institution in the application states that the Chief Medical Officer of the Minnesota State Veterans' Home spends 20 hours per week in his duties at the Home. The contract between the Board and the Chief Medical Officer states the same requirements. In reality, the Chief Medical Officer spends approximately 8 to 10 hours per week on site, conducting his medical activities. The contract also stipulates an additional period of time after the 20 hours for availability for emergency call. The incidence of the emergency calls during the past year cannot be determined since no records of these calls are kept. To the best that can be determined, the incidence of the emergency calls is not as frequent as once per week.

Without a detailed review of the findings of the study group, it is sufficient to state the Minnesota Veterans' Home Infirmary (Hospital) was surveyed by representatives of the U.S. Department of Health, Education and Welfare for the purpose of determining whether the medical facility and its operations met technical and management standards as required for participation in the Health Insurance for the Aged Program of Health, Education and Welfare (Title XVIII of the Social Security Act-Medicare).

The Application was rejected (Details of this rejection may be found in the supporting document Appendix). It is sufficient to state that subsequent to the date of rejection, February 5, 1968, no attempt has been made to improve the conditions found. No attempt has been made to evaluate

the problem and to discuss it with the Board for consideration and change, the Chief Medical Officer, the Chief Nurse, or the Commandant. In fact, the report of rejection, received by the Commandant and Chief Medical Officer was not transmitted to the Board for its information and consideration. The Board was not clear in its understanding that such an application had ever been filed or had been authorized by them.

RECOMMENDATIONS

1. THAT THE BOARD IMMEDIATELY REQUIRE THE CHIEF MEDICAL OFFICER OF THE HOME TO PREPARE A DETAILED PROGRAM OF MEDICAL, NURSING AND HOSPITAL SERVICES FOR THE HOME, INCLUDING BUT NOT LIMITED TO, THE FOLLOWING:
   A. HOSPITAL, MEDICAL AND NURSING SERVICES FOR RESIDENT PATIENTS IN THE HOSPITAL.
   B. OUTPATIENT SERVICES FOR HOME MEMBERS AND THE STAFF.
   C. EXAMINATION SERVICES FOR NEW APPLICANTS.
   D. TRANSFER PROCEDURE FOR INDIVIDUALS FROM THE HOME TO OTHER MEDICAL INSTITUTIONS.
   E. EMERGENCY PROCEDURES, ACUTE ILLNESSES AND ACCIDENTS.
   F. EMERGENCY PROCEDURE, DISASTER PLANS.
   G. MEDICAL INFORMATION AND RECORDS SYSTEM.
   H. MEDICAL REPORTING SYSTEM.
   I. PERSONNEL DEVELOPMENT TRAINING (MEDICALLY ORIENTED EMPLOYEES).

2. THAT THE CHIEF HOME PHYSICIAN BE REQUIRED TO PLAN A SCHEDULE FOR MEDICAL AND NURSING SERVICES IN AGREEMENT WITH THE LICENSE FOR OPERATION, EMPLOYEE CONTRACT, AND THE REQUIREMENTS FOR THE PRACTICE OF GOOD MEDICAL AND MANAGEMENT PROCEDURES.

3. THAT THE CHIEF MEDICAL OFFICER, THE COMMANDANT AND THE APPROPRIATE BOARD OF TRUSTEE COMMITTEES DEVELOP A PLAN ENCOMPASSING THE ATTAINMENT OF A LEVEL OF EXCELLENCE AND STANDARD OF PERFORMANCE IN AGREEMENT WITH RECOMMENDATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE IN THEIR REPORT PREVIOUSLY MENTIONED; THE STANDARDS OF THE

THE STATE OF MINNESOTA; AND THE CURRENT STATE-OF-THE-ART OF MEDICAL, HOSPITAL AND NURSING PRACTICE.

4. THAT THE CHIEF MEDICAL EXAMINER IMMEDIATELY IMPLEMENT A CLOSER INTERACTION BETWEEN HIMSELF AND HIS STAFF WITH THE MEMBERS OF THE HOME. THE STUDY TEAM VERY FREQUENTLY WAS PROVIDED WITH VERBAL AND WRITTEN COMMENT BY THE MEMBERS THAT THEY COULD NOT TALK ABOUT OR DISCUSS THEIR OWN NEEDS WITH THE DOCTOR OR THE NURSES.

5. THAT THE CHIEF MEDICAL OFFICER AND COMMANDANT CONSIDER THE NEED FOR "HUMANIZATION" OF THE INSTITUTION AS OPPOSED TO THE DEHUMANIZATION AND DEPERSONALIZATION WHICH THE INSTITUTION TENDS TO INFLICT UPON MEMBERS OF A LARGE INSTITUTION.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE
Region VI
601 East 12th Street
Kansas City, Mo. 64106

SOCIAL SECURITY
ADMINISTRATION

February 5, 1968

Minnesota Veterans Home
51st and Minnehaha
Minneapolis, Minnesota 55417

Gentlemen:

We regret to inform you that your facility does not meet the requirements for participation in the Health Insurance for the Aged Program (Title XVIII of the Social Security Act).

In order to participate in the Health Insurance for the Aged Program, an extended care facility must be in substantial compliance with the conditions of participation established by the Secretary of Health, Education, and Welfare or must meet the requirements for special certification. On the basis of the deficiencies listed on the enclosed sheet, it has been determined that your facility does not qualify under either basis.

You may, of course, take steps to correct the deficiencies and reapply to establish your eligibility. The State agency is available to provide any consultation or assistance you may need in order to accomplish this.

If you believe that this determination is not correct, you may request that the decision be reconsidered. The request must be submitted in writing to this office within 6 months of the date of this notice. You may submit with the reconsideration request any additional information that you feel may have a bearing on the decision. If you have any questions, please contact this office.

Sincerely yours,

By Marquardt

Roy Marquardt
Regional Representative
Health Insurance, SSA

Enclosure
SSA-L138

STATEMENT OF DEFICIENCIES | DATE: February 2, 1968

FACILITY Name, City, and State:

Minnesota Veterans Home, Minneapolis, Minnesota

The deficiencies listed below were noted during the review of the qualifications of the above-named facility. References shown are to sections of the Conditions of Participation for that type of facility, published by the Department of Health, Education, and Welfare. The State agency will be in touch with you and may visit you to determine the progress made to correct these deficiencies. The State agency will also be available for any consultation or assistance you may need. It will notify you in advance of the date a full survey will be made, which will be ~~xxxxx~~ when requested .

1. Condition II (Administrative Management). It was found that there was no evidence of written personnel policies, practices and procedures pursuant to the requirements of Standard C. It was found that the facility was not in compliance with Standard D which states that there should be appropriate written policies and procedures relating to notification of responsible persons in the event of significant change in patient status, patient charges, billings and other related administrative matters.

2. Condition III (Patient Care Policies). It was found that the facility was not in substantial compliance with Condition III which states that there should be policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses.

3. Condition V (Nursing Services). It was found that the facility did not have written nursing care plans pursuant to the requirements of Standard H.

4. Condition VIII (Pharmacy or Drug Room). It was found that the facility was not in compliance with Standards C and E of Condition VIII. Standard C indicates that all medications should be administered by licensed medical or nursing personnel in accordance with the medical and nurse practice acts of each state. Each dose administered should be properly recorded in the clinical record. Standard E indicates that the extended care facility must comply with all Federal and State laws relating to the procurement, storage, dispensing, administration and disposal of narcotics, hypnotics, amphetamines, certain psychosomatic medications and other legend drugs.

(signed) [signature]

Regional Representative
Bureau of Health Insurance

5. Condition XIV (Transfer Agreement). Condition XIV states that the extended care facility must have in effect a transfer agreement (meeting the requirements of Section 1861(1) of the Social Security Act) with one or more hospitals which have entered into agreements with the Secretary to participate in the program. It was found that no transfer agreement had been submitted.

6. Condition XVII (Disaster Plan). Condition XVII states that the extended care facility should have a written procedure to be followed in case of fire or other disaster. It was found that the facility did not submit a written procedure. The facility is not in compliance with Condition XVII.

7. Condition XVIII (Utilization Review Plan). Condition XVIII states that the extended care facility must have in effect a plan for utilization review which applies at least to the services furnished by the facility to individuals entitled to benefits under the law. It states that an acceptable utilization review plan should provide for: (1) the review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) a review of each case of continuous extended duration. It was found that no utilization review plan was submitted and, therefore, the facility is not in compliance with Condition XVIII.

ACTIVITIES & VOLUNTEER SERVICES

The Director of Activities, a relatively new employee, has demonstrated a deep understanding of the goals of the Home; the need for an understanding of individual desires, hopes, aspirations, wants and the lack of these. She anticipates the need for a closer relationship between the Home and the individual member other than a place for food, clothing and shelter. She has realized the need for a closer relationship between the senior staff and the newly admitted member; an area now almost completely ignored despite her attempts to establish such an environment. She has realized that the provision of activities and recreation for those who do and do not express such a desire is indeed valuable. Although young and rather inexperienced in a job with this responsibility, it is believed that she can be developed, with proper guidance, into a key staff member, one who will be concerned with the individual at the Home for the entire period of time between the periods of eating and sleeping.

She has attempted to establish a program for the individuals confined to the Infirmary (Hospital). This has not yet been authorized. She has been working on a total budget of $5 per month. Other than these funds, she is forced to request each and every item at time of need. No proper planning can be accomplished in this manner.

She is forced to attempt to obtain material things from various Volunteer Service Organizations. She is given no guidelines on what she should request from State funds and what she may try to obtain "gratis" from the volunteers.

RECOMMENDATIONS

IT IS RECOMMENDED THAT:

1. A COMPETENT ASSISTANT TO THE ACTIVITIES DIRECTOR BE RECRUITED IMMEDIATELY TO CONTROL AND PLAN THE ACTIVITIES OF APPROXIMATELY 400 HOME MEMBERS REQUIRES ASSISTANCE.

2. AN ADEQUATE BUDGET BE PLANNED AND JUSTIFIED ON THE BASIS OF A PROGRAM OF ACTIVITIES DESIGNED TO ACCOMODATE ALL TYPES OF INDIVIDUALS AT THE HOME, INCLUDING AND NOT LIMITED TO THOSE WHO EXPRESS THE DESIRES, TO THOSE WHO NEED SUCH ACTIVITIES BUT HAVE NO PARTICULAR WISHES: FOR THOSE WHO HAVE PHYSICAL LIMITATIONS OF VISION, HEARING AND LOCOMOTION; TO THOSE WHO ARE BED-RIDDEN, EITHER IN THE INFIRMARY (HOSPITAL) BY REQUIREMENT OR THOSE WHO ARE SELF-CONFINED TO THEIR ROOM IN ACCORDANCE WITH THEIR OWN DESIRE; TO MEN AND TO WOMEN.

3. THE ACTIVITIES DIRECTOR BE ENCOURAGED TO PARTICIPATE IN SIMILAR PROGRAMS IN OTHER STATE INSTITUTIONS, NEARBY FEDERAL INSTITUTIONS AND OTHER PROGRAMS OF VALUE IN HER TRAINING AND DEVELOPMENT AT ACADEMIC INSTITUTIONS.

4. THE ACTIVITIES DIRECTOR BE ENCOURAGED TO FORM A VOLUNTEERS SERVICE COUNCIL TO ENCOURAGE AND ORGANIZE A MORE USEFUL PROGRAM OF VOLUNTEER SERVICES, BASED ON THE NEEDS OF THE HOME AND ITS MEMBERS.

5. THE ACTIVITIES DIRECTOR BE GIVEN ADDITIONAL, ADEQUATE CLERICAL AND MANPOWER ASSISTANCE TO AID HER AND HER NEW ASSISTANT IN THE ACCOMPLISHMENT OF HER WORK.

PLANT OPERATIONS

Plant operations include maintenance of the buildings and grounds, housekeeping and cleaning of the members living quarters, the Home's community facilities and the hospital.

Due to the poor condition of the physical facilities, it is remarkable how well the buildings and grounds are kept. We are not, for the moment, considering the capability of the staff in maintaining the structural aspects of the facilities, but rather the ability to maintain suitable living conditions with adequate utilities and services.

Chief Engineer

The current Chief Engineer is retiring this year. He has done a very suitable job and the Commandant and the Board should attempt to find an early replacement. There should be some overlap between the Chief Engineer's leaving and the new engineer's arrival. Information on conditions obtained through the prior experience of the current engineer would be of benefit to the new man.

Maintenance Crew

The maintenance crew is good and performs well. They have done a good job of camouflaging the decrepit characteristics of the facilities. The buildings generally are clean and presentable.

RECOMMENDATIONS

1. THAT A NEW CHIEF ENGINEER BE RECRUITED IMMEDIATELY.
2. THAT THE CHIEF ENGINEER BE PLACED IN COMPLETE CHARGE OF PLANT OPERATION.
3. THAT AN EMERGENCY PLAN BE DEVISED IMMEDIATELY TO INCLUDE, BUT NOT LIMIT ITSELF TO FIRE, EXPLOSION, STORMS, ETC.

DIETARY MATTERS

The major user of resources available to the Veterans' Home Board and the Commandant is the dietary function. In reality, there is no one in charge of the dietary function at the Home. Many have a part to play, many have a few words to say. No one person has the decision-making role, other than the normally expected complaints from the members about institutionalized dietary programs, the major area of complaints brought to our attention centered about the question of special diets, diets for the aged, and the participation by the members in preparation of the food and its service. Frequent review of the facilities of the kitchens and food service areas led us to the conclusion that cleanliness is certainly not a problem. Service of the food appears to be well controlled and accepted by the members.

RECOMMENDATIONS

1. THAT THE BOARD AND COMMANDANT RECRUIT A DIETICIAN, FULL TIME CIVIL SERVICE POSITION, WHO WILL BE RESPONSIBLE FOR ALL ASPECTS OF MENU PLANNING, SPECIAL DIETS, STORES, HOUSEKEEPING IN THE FOOD AREAS, FOOD PERSONNEL, INCLUDING COOKS.

2. THAT THE COMMANDANT INSTITUTE A MORE STRINGENT COMMISARY CONTROL PROCEDURE FOR THE PURCHASE, ACQUISITION, STORAGE, UTILIZATION AND ACCOUNTING FOR USE OF FOOD AND SUPPLIES.

3. THAT THE CHIEF MEDICAL OFFICE AND THE DIETICIAN PLAN SPECIAL DIETS, AS REQUIRED AND AUTHORIZED BY THE HOME PHYSICIAN, IN LINE WITH CURRENTLY ACCEPTED MEDICAL PRACTICES AND STATE HEALTH REQUIREMENTS AND RECOMMENDATIONS.

4. THAT THE BOARD CONSIDER THE INSTALLATION OF A NUMBER OF SMALL-SIZED KITCHENS IN A FEW OF THE BUILDINGS TO ALLOW MEMBERS THE OPPORTUNITY TO PREPARE AN OCCASIONAL MEAL FOR THEMSELVES AND THEIR FRIENDS. CONSIDERATION SHOULD BE GIVEN TO THE SIMILAR TYPE OF PLAN AT OTHER INSTITUTIONS, AT PRESENT.

5. THE BOARD AND COMMANDANT SHOULD GIVE CONSIDERATION TO THE PARTICIPATION BY A FEW MEMBERS IN A GROUP (COMMITTEE) FOR THE PURPOSE OF OBTAINING THE VIEWS OF THE MEMBERS, WHO AFTER ALL, PAY FOR SOME OF THE SERVICES AT THE HOME.

BUSINESS MANAGER, CASHIER AND OFFICE ADMINISTRATION

Business Manager

The Business Manager of the Home is on all existing organization charts of the Home as second-in-command of the Home after the Commandant. In reality, he is not. He is rarely, if ever, called upon to act in that capacity. He is relegated to the role of a bookkeeper in the truest sense of the term. He rarely, if ever, is in a decision-making role at the Home. He has been placed in an inferior position as a junior clerk and has been treated and used in that fashion. Whether the individual has the capability to truly be the Business Manager is open to question by the Board, the Commandant and the study group. He does not perform the functions expected of a Business Manager. It is up to the Board and the Commandant to determine the need for and evaluation of the Business Manager, his functions, and his performance. It is also up to the Board and the Commandant to utilize his services if they can, and if they cannot, take appropriate action.

Secretary of the Board

The Secretary of the Board has been placed in the role of clerical assistant. Although responsible to the Board, he does not and has not been given sufficient guidance in his role. The position is not needed if the Home Commandant and Office Manager were able to provide the Home Board with adequate secretarial and clerical help. The administrative control of such clerical assistance can certainly be taken care of by the Office Manager. Assistance provided by the Secretary to the Board needs to be confidential in nature in line with the Board's requirements.

The position of Office Manager in the Home does not exist. It should. There is a real need for a true Office Manager, one who will be able to relieve the Commandant of the numerous details of running an administrative office which would then allow him time for necessary planning. There are sufficient numbers of Home Personnel and concommitant record keeping requirements necessitating the establishment of a position of Office Manager. The office secretary of the Commandant currently functions as Office Manager as well as Second in Command during the absence of the Commandant.

Cashier

The cashier of the Home, responsible for all financial transactions at the Home, is a long-term employee with a good understanding of the requirements of her position. She maintains relatively good records. Only relatively good since she is dependent upon others who are not so well qualified. Errors of recording of cash transactions cannot be tolerated. She should have final say in the evaluation of employees or potential employees during their probationary period, if they are to be responsible to her. She has an unusual understanding of the role of money in the lives of the aged, infirm, indigent members of the Home. Guidance from her should be taken by those others who sometimes treat the members and their requests callously.

Records

The records of the Home are in a poor condition. It is sometimes difficult to reconstruct the series of events that occurred to an individual from application to discharge, transfer or death, including admission or rejection at application.

RECOMMENDATIONS

1. THAT THE ROLE OF THE BUSINESS MANAGER BE WELL DEFINED BY THE BOARD.

2. THAT THERE BE A COMPLETE REVIEW OF THE RECORD-KEEPING SYSTEMS AT THE HOME AND AT THE HOSPITAL FOR THE PURPOSE OF ESTABLISHING A UNIFORM AND REASONABLE RECORD-KEEPING AND REPORTING SYSTEM. THE SYSTEM TO BE DEVELOPED SHOULD BE REVIEWED AND APPROVED BY THE BOARD'S HOME MANAGEMENT COMMITTEE. CONSIDERATION OF INFORMATION AND DATA PROVIDED BY THE DEPARTMENT OF ADMINISTRATION'S 1967 ADMINISTRATIVE STUDY SHOULD BE UTILIZED. DETAILED SYSTEMS ANALYSIS AND DESIGN CHARACTERISTICS WERE PROVIDED IN THE REPORT WHICH SHOULD PROVE USEFUL.

3. THAT THE BOARD AUTHORIZE A POSITION OF OFFICE MANAGER FOR THE HOME IN ACCORDANCE WITH THE STANDARDS OF THE MINNESOTA CIVIL SERVICE COMMISSION. IT SHOULD BE A CLASSIFIED POSITION. THE PRESENT SECRETARY OF THE COMMANDANT OF THE HOME SHOULD BE CONSIDERED FOR THE POSITION.

THE EXISTING SITE AND FACILITIES

Physical Description of Site

The existing site, situated at the confluence of Minnehaha Creek and Park with the Mississippi River in Minneapolis, is very attractive. The site is approximately 48 acres studded with large trees of varieties indigenous to the area. The site is bounded on the East by a high bluff overlooking the Mississippi River; on the West and South by the Minnehaha Creek and Park, and on the North by Minnehaha Park. The surface of the ground undulates gently and slopes toward the Minnehaha Creek on the westerly and southerly boundaries.

Access to Site

The current access to the site is from Wabash Avenue, a major thoroughfare crossing the river connecting the "twin cities". A secondary access is from the arterial to the west of the site, connected by a bridge currently closed and undergoing construction overhaul. The access to the site from Wabash is adequate for all purposes, including fire protection.

Planning Review of the Physical Facilities - Minnesota Veterans' Home

How people are affected by their environment is a paramount consideration in the evaluation of a modern institution. How can the environment be improved to produce an enhancement to life, as it exists now for the indigent aging, to insure them "hope for the future"? The answer may be in comprehensive rehabilitation. Helplessness, a loss of self-determination, physical deterioration (natural), and mental and physical losses externally

imposed by well meaning but unaware institutions, have been shown virtually to "dehumanize" the inhabitants of these institutions. Members of institutions are sometimes thought of as "inmates". To some this "slip of the tongue" suggests a kind of incarceration, especially inhibitive to the non-penal indigent aged. In the readings of leading sociologists,within the field of institutional studies, an institution itself can create erroneous "self images" to the public and its membership, as well. The "negative image" tends to perpetuate individual chronic problems by its very existence as an institution is generally constituted. An environment directly concerned with care for people, not only includes proper physical surroundings, but also a proper program for living.

Physical Description of Existing Facility - Structure

A review of the existing situation at the Veterans' Home, with respect to the physical environment, is as follows:

The members live in varying circumstances as to space, light and ventiliation due to the configuration of the immovable walls and boundaries of the domiciliary "container" buildings. Modern planning would obviate this penalty and inequity. Some members are forced by the existing configuration to live in the interior dark (even basement atmosphere) with poor light and security for their personal effects. The argument that "this is still better than what they had", as individuals at their previous residence, is a callous comment and completely lacking in rationale as it relates to the requirements of the real mission of a State institution for the aging, whether veteran or not.

It remains that from existing recognized minimal modern planning requirements, "it is virtually impossible (as with any management) to create a proper environment from or out of the current facility." The deterioration of the formidable 19th century immovable wall configurations in themselves prevents the development of a workable program for members of this indigent aging institution. This would be so even if these buildings were constructed in this manner as little as six months ago.

The "constriction of space" are due to:

1. Improper and non-productive use of space.
2. Dark and inequitable space that even modern lighting techniques find difficult to solve as proper to environment.
3. Stairways are obstructive for aging persons and, (thus providing opportunity for liabilities to the State) create extreme physical difficulty during the course of traversing the same.
4. Although recently "adequate" patchwork has been done for fire protection and other public safety features, further (future) problems remain.
    a. The structure has wooden stairways, floors, and non-bearing walls. Basically, for this use and/or multi-level usage, they would be considered inadequate according to modern design requirements for public safety under the National Exiting Safety Code.

These wood structural elements, although sprinklered and additionally protected by gypsum (since 1959-61 remodelings), do not constitute permanent fire-safe elements as one would intentionally produce through good purposeful design as part of permanent construction according to modern architectural and engineering construction practices.

b. In absence of "a smoke tower stair" in the existing facility, the patchwork solution (as nearly could be done in this existing situation) was to provide a heavy "B-label" fire door separation and opening under the stair landings between levels. These heavy doors must normally remain closed in order to form smoke separations. The doors are provided with fusible link closings devices, but the members and management must leave the doors open as they are to difficult for the members to operate each time they traverse the stairs.

It is difficult for the aging to climb stairs. The doors then cannot be effective as a smoke separation. There is no other easy means of ingress or egress to many buildings (such as elevators). Institutional exiting and access requirements must receive very careful

consideration without vast modifications to the existing facility. These weighted against other deficiencies as previously pointed out tends to render the alternative of remodelling extensively as useless and impractical. The large amounts of of money needed to do a remodelling as effectively as possible would be wasted since it would not yet produce the necessary flexibilities and facility longevity required to fit a proper program.

Structure

The heavy masonry walls would not appear to be anchored sufficiently for proper engineering design. The heavy storm belt bonding undoweled, and then reinforced, would prove to be extremely critical for public safety in case it were hit by tornadoes or earthquakes. Although the institution has survived these many years, this is no justification for the lack of proper public safety. The lack of proper anchorage of the wood floor structures to the walls would not help this sad situation. The connections of the roof to the walls bear the same difficulties.

CHARACTERISTICS OF MEMBERS OF THE MINNESOTA VETERANS' HOME

A survey of members of the Minnesota Veterans' Home who lived at the Home at any time between January 1, 1967 and June 1, 1968 was conducted by the consulting team. Data collection was carried out in mid-June 1968. Data, descriptive of the Home members, was extracted from the Home records and recorded on Report Form "A" designed for that purpose, by clerks employed by the Home Board under the supervision of the consulting team. Medical data and data relating to the care requirements of members was provided by the Home physician or his representative on his instructions. It was recorded on Report Forms "B" and "C", all of which are signed by the physician or his representative. The Form "A" information was also obtained for applicants to the Home from July 1, 1965 through June 1, 1968 whose applications for admission were rejected. Copies of Report Forms "A", "B" and "C" follow.

Qualifications of the Data

The Home supplied,on request,a list, which will subsequently be referred to as the Master List, of all individuals who were members of the Home between January 1, 1967 and June 1, 1968. The Master List shows the status of each individual on June 1, 1968 in terms of whether he was a member of the Home on that date or had left the Home prior to that date due to discharge or death. The List has been used as though it were a complete and correct enumeration of the target population, although it has been modified by the addition of obvious ommissions. Data has been collected for each individual on the modified Master List.

It is not possible to pretend however, that the Master List is completely definitive of the target population since examination of the list and comparison of it with information contained in several of the Monthly Reports to the Home Board have revealed a number of apparent omissions and several allocations of questionable accuracy. For example, one individual, who is mentioned in the Monthly Report dated April 9, 1968, as being restricted to the Home grounds for 30 days, is not represented on the Master List. Another individual who is shown as a discharge on the same Monthly Report does not appear on the Master List either. In addition, a number of individuals were discovered who are listed as admissions, falling within the period of interest, on Monthly Reports but who are not represented on the Master List. Despite these difficulties, we feel that the population has been defined adequately enough to allow a meaningful description of the members of the Home.

The process of extracting the data required by Form"A"from the Home records was a tedious one, as existing source documents were not amenable to it. Since no complete and concise record containing all information relative to an individual member exists, the information was taken from fragmentary and sometimes conflicting sources. Every effort was made to make the data as correct and complete as possible however, it was necessary to resort to a "no information" category on many of the tabular presentations.

Variables of interest have been cross clasified and are presented in Tables 1 through 31, which follow. The data has been presented in what is essentially raw form because we feel that, as such, it presents the greatest potential for use by the interested consumer.

1 LAST NAME	FIRST NAME	MIDDLE INITIAL	MINNESOTA VETERAN HOME # 2	3 ○ MALE ○ FEMALE	A

4 DATE OF BIRTH (month day year)	PLACE OF BIRTH 5 (city county state)	COUNTY OF RESIDENCE AT TIME OF APPLICATION 6

7 VETERAN STATUS

- ○ veteran
- ○ wife of veteran
- ○ widow of veteran
- ○ mother of veteran

MARITAL STATUS 8

at application	on June 1, 1968
○ never married	○ never married
○ married	○ married
○ widowed	○ widowed
○ separated	○ separated
○ divorced	○ divorced

EVER LIVED WITH SPOUSE AT HOME 9

- ○ no
- ○ yes, at present
- ○ yes, but not now because

MARRIED AFTER ADMISSION TO HOME 10

- ○ no
- ○ yes, to member
- ○ yes, to non-member of home

11 MILITARY SERVICE

date of entrance (month day year)	date of discharge (month day year)

12 RESIDENCE

	city	county	state	year
at time of application				
1yr prior to application				
previous five years				

RELIGION 13

- ○ protestant
- ○ catholic
- ○ jewish
- ○ other _____
- ○ none
- ○ no information

ADMISSION TO HOME (month, day, year) 14

application	admitted	entered home	ejected	reason for rejection

LEFT HOME 15

date	voluntary discharge	involuntary discharge	disappearec	died	reason for discharge

TRANSFERRED FROM HOME 16

date	to hospital	to state institution	to county institution	to private institution	to private home	reason

MONTHLY INCOME ($/month) 17

from	at application	on 6/1/68
compensation		
pension		
social security		
O.A.A.		
unemployment		
retirement		
insurance		
earnings		
other		

MEDICAL AND PHYSICAL CONDITION AT TIME OF APPLICATION 18

rate of disability

character of disability

complications

present condition

requires medical treatment

mental condition

prior confinement to mental institution ○ yes ○ no

		COMPLETED BY DATE	CHECKED BY DATE EBSMC

LAST NAME	FIRST NAME	MIDDLE INITIAL	MINNESOTA VETERAN HOME #	○ MALE ○ FEMALE	B

SELF CARE AND NEED FOR CARE STATUS AS OF JUNE 1, 1968 (established by Minnesota Veteran Home Physician)

NURSING CARE

0--NO SPECIAL CARE PROCEDURES REQUIRED

0--NEEDS SUPERVISION OF SELF ADMINISTERED MEDICATIONS TAKEN ROUTINELY

0--IRRIGATION, CATHERIZATIONS, ENEMAS, OR SPECIAL PHYSICIANS ORDERS

0--USE OF SPECIAL EQUIPMENT

PERSONAL CARE

0--NO AID REQUIRED

0--REQUIRES SOME SUPERVISION OF PERSONAL CARE

0--ROUTINELY REQUIRES SOME HELP IN DRESSING, BATHING, HAIR CARE, NAIL CARE, ETC

0--REQUIRES HELP IN ALL PHASES OF PERSONAL CARE AND HYGIENE

0--PHYSICALLY HELPLESS - REQUIRES COMPLETE CARE

LOCOMOTION

0--NO HELP NEEDED

0--HELP NEEDED ONLY IN SPECIAL CIRCUMSTANCES SUCH AS GOING UP OR DOWN STAIRS OR OUT OF DOORS

0--HELP REQUIRED IN GETTING INTO OR OUT OF BED OR IN CHANGING POSITION IN BED (ONCE OUT OF BED CAN GET ABOUT BE SELF WITH OR WITHOUT APPLIANCE OR REMAINS IN ONE PLACE

0--MUST BE ACCOMPANIED WHENEVER WALKING OR GETTING ABOUT WITH APPLIANCE

0--GENERALLY BEDFAST BUT HELPED TO CHAIR, WHEELCHAIR OR BATHROOM DAILY

0--OPERATES WHEELCHAIR WITHOUT AID

CONTINENCE (check only one)

0--CONTINENT

0--LITTLE OR NO HELP TO BATHROOM

0--GENERALLY CONTINENT - GETS TO BATHROOM WITH HELP

0--GENERALLY INCONTINENT, INVOLUNTARY OR BOTH

0--TOTALLY INCONTINENT AND/OR INVOLUNTARY UNABLE TO USE UTENSILS PROVIDED

0--INCONTINENT AND/OR INVOLUNTARY AND VERY MESSY

0--AMBULATORY BUT VERY MESSY, USUALLY WITH FECAL MATERIAL

MENTAL STATE (check as many as necessary but no more than three)

0--NO SPECIAL ATTENTION NEEDED

0--MAY REQUIRE SPECIAL ATTENTION AT TIMES BECAUSE OF MILD CONFUSION

0--CONSIDERABLE ATTENTION REQUIRED BECAUSE OF FORGETFULLNESS, NOISINESS, OR TENDENCY TO WANDER

0--MUST BE CONFINED TO A GIVEN AREA OF HOME

0--FREQUENTLY UNCOOPERATIVE OR DISAGREEABLE

0--REQUIRES CONSTANT WATCHING OR IS DEMANDING OF ATTENTION

0--EXTREMELY DISAGREEABLE AND UNCOOPERATIVE ALWAYS

EATING

0--NO SUPERVISION OR HELP NEEDED

0--MAY REQUIRE SOME SUPERVISION OF FOOD HABITS

0--REQUIRES MODIFICATION OF NORMAL DIET WITH SPECIAL FOOD AND/OR EXTRA PREPARATION

0--REQUIRES MEALS SERVED INDIVIDUALLY WITH SOME HELP IN EATING (NOT IN BED)

0--BEDFAST, MEALS SERVED IN BED

0--MUST BE FED BY I.V. OR SUBCUTANEOUSLY

0--MUST BE FED, EATS SLOWLY OR MUST BE COAXED TO EAT

SPECIAL REQUIREMENTS (check as many as necessary)

0--NO UNUSUAL HANDICAPS

0--UNABLE TO COMMUNICATE BECAUSE OF MENTAL CONFUSION, LANGUAGE BARRIER, ETC

0--BLIND AND NOT FEASIBLE FOR TRAINING

0--SEVERE ORGANIC BRAIN DAMAGE

0--VERY OBESE

0--ABNORMAL NEED FOR SPECIAL DRESSINGS

0--REQUIRES AND RECEIVES TRAINING TO RETAIN OR REGAIN WALKING SKILL OR TO LEARN TO USE APPLIANCE

0--DRUG HABITUATION

0--CHRONIC ALCOHOLIC

0--_____

0--_____

0--_____

DATE LAST SAW MINNESOTA VETERANS HOME PHYSICIAN FOR TREATMENT, MEDICATION OR EXAMINATION

month-day-year reason

WAS THIS INDIVIDUAL A PATIENT IN THE INFIRMARY ON JUNE 1, 1968

○ yes ○ no

if yes existing conditions/diagnoses

date stay began
month-day-year

therapy and care required

	COMPLETED BY DATE	CHECKED BY DATE M.D.	CHECKED BY DATE EBSMC

LAST NAME	FIRST NAME	MIDDLE INITIAL	MINNESOTA VETERAN HOME #	O MALE O FEMALE	C

CHRONIC DISEASES AND IMPAIRMENTS EXISTING ON JUNE 1, 1968 (check each condition or impairment)

0--MALIGNANT NEOPLASMS, WITHOUT SURGERY

0--MALIGNANT NEOPLASMS, WITH SURGERY

0--BENIGN AND UNSPECIFIED NEOPLASMS

0--ASTHMA

0--DISEASES OF THE THYROID GLAND

0--DIABETES MELLITUS

0--AVITAMINOSIS AND OTHER NUTRITIONAL WEIGHT PROBLEMS

0--MENTAL RETARDATION WITHOUT SENILITY

0--MENTAL RETARDATION WITH SENILITY NOT SPECIFIED AS PSYCHOTIC

0--SENILE PSYCHOSIS WITH OR WITHOUT OTHER MENTAL CONDITIONS

0--SENILITY WITHOUT MENTION OF PSYCHOSIS

0--SPECIFIED MENTAL DISORDERS

_____

0--VASCULAR LESIONS AFFECTING CENTRAL NERVOUS SYSTEM

0--MULTIPLE SCLEROSIS

0--PARKINSONS DISEASE (PARALYSIS AGITANS)

0--EPILEPSY

0--OTHER NERVOUS SYSTEM DISORDERS

_____

0--CATARACT

0--GLAUCOMA

0--OTHER DISEASES OF THE EYE

_____

0--DISEASES OF THE EAR

0--DISEASES OF THE HEART

_____

0--HYPERTENSION WITHOUT MENTION OF HEART

0--GENERAL ARTERIOSCLEROSIS

0--VARICOSE VEINS

0--HEMORRHOIDS

0--OTHER CONDITIONS OF CIRCULATORY SYSTEM

_____

0--CHRONIC SINUSITIS

0--BRONCHITIS WITH EMPHYSEMA

0--BRONCHITIS WITHOUT EMPHYSEMA

0--EMPHYSEMA WITHOUT BRONCHITIS

0--OTHER CHRONIC RESPIRATORY CONDITIONS

_____

0--ULCER OF STOMACH AND DUODENUM

0--HERNIA OF ABDOMINAL CAVITY

0--DISEASES OF GALL BLADDER AND BILE DUCTS

0--OTHER CHRONIC CONDITIONS OF DIGESTIVE SYSTEM

_____

0--INCONTINENCE (URINE OR FECES)

0--DISEASES OF URINARY SYSTEM

0--DISEASES OF MALE GENITAL ORGANS

0--DISEASES OF BREAST AND FEMALE GENITAL ORGANS

0--DISEASES OF SKIN & OTHER SUBCUTANEOUS TISSUS

0--ARTHRITIS

0--RHEUMATISM

0--OTHER SPECIFIED DISEASES OF BONES & ORGANS OF MOVEMENT

_____

0--FRACTURE, FEMUR (OLD)

0--CHRONIC ALCOHOLISM

0--VISUAL IMPAIRMENT, INABILITY TO READ NEWSPAPER WITH GLASSES

0--OTHER VISUAL IMPAIRMENTS

0--HEARING IMPAIRMENTS

0--SPEECH IMPAIRMENTS DUE TO STROKE

0--SPEECH IMPAIRMENTS DUE TO OTHER OR UNSPECIFIED CAUSES

0--PARALYSIS, PALSY DUE TO STROKE

0--PARALYSIS, PALSY DUE TO OTHER UNSPECIFIED CAUSES

0--ABSENCE, FINGERS OR TOES

0--ABSENCE, MAJOR EXTREMITIES

0--IMPAIRMENT, LIMB, BACK, TRUNK

DATE OF DEATH (IF APPLICABLE)(MONTH-DAY-YEAR)

CAUSE OF DEATH

OTHER CHRONIC CONDITIONS, DISEASES OR IMPAIRMENTS

	COMPLETED BY DATE	CHECKED BY DATE M.D.	CHECKED BY DATE EBSMC

LIST OF TABLE SHOWING CHARACTERISTICS OF MEMBERS OF THE MINNESOTA VETERANS' HOME

Table 12. Members of the Minnesota Veterans' Home on June 1, 1968, by age and marital status on June 1, 1968 and by sex.

Table 13. All members of the Minnesota Veterans' Home on June 1, 1968 by sex, age, total monthly income and major source of income on June 1, 1968.

Table 14. Male members of the Minnesota Veterans' Home on June 1, 1968 by sex, age, total monthly income and major source of income on June 1, 1968.

Table 15. Female members of the Minnesota Veterans' Home on June 1, 1968 by sex, age, total monthly income and major source of income on June 1, 1968.

Table 16. Members of the Minnesota Veterans' Home on June 1, 1968, sex and length of most recent stay in the Home.

Table 17. Members of the Minnesota Veterans' Home on June 1, 1968 by age on June 1, 1968, sex, and total number of years spent in the Home.

Table 18. Members of the Minnesota Veterans' Home on June 1, 1968 by age on June 1, 1968 and by level of care score from Form B.

Table 19. Members of the Minnesota Veterans' Home on June 1, 1968, by age on June 1, 1968, and by level of care required.

Table 20. Members of the Minnesota Veterans' Home on June 1, 1968 by age on June 1, 1968, sex and interval in months since last seen by the Home physician for treatment, medication or examination.

Table 21. Members of the Minnesota Veterans' Home from January 1, 1967 thru June 1, 1968 by sex and reason for most recent visit with the Home physician.

Table 22. Members of the Minnesota Veterans' Home on June 1, 1968 by number of times transferred to a medical facility outside the Home and by sex.

Table 23. Members of the Minnesota Veterans' Home from January 1, 1967 thru June 1, 1968 and number of specified care requirements by sex of member.

Table 24. Members of the Minnesota Veterans' Home from January 1, 1967 thru June 1, 1968 and number of specified chronic diseases and impairments from Form C by sex of member.

Table 25. Members of the Minnesota Veterans' Home who were patients in the Home infirmary on June 1, 1968 by age on June 1, 1968 and by length of the current infirmary stay.

Table 26. Existing conditions or diagnoses reported for the 49 members of the Minnesota Veterans' Home who were patients in the Home infirmary on June 1, 1968.

Table 27. New applicants to the Minnesota Veterans' Home from July 1, 1965 thru June 1, 1968 whose applications for membership were rejected, by age at application and by sex.

Table 28. New applicants to the Minnesota Veterans' Home from July 1, 1965 thru June 1, 1968 whose applications for membership were rejected, by reason for rejection.

Table 29. New applicants to the Minnesota Veterans' Home from July 1, 1965 thru June 1, 1968 whose applications for membership were rejected, by sex and length of time in months between application and rejection.

Table 30. New applicants to the Minnesota Veterans' Home from July 1, 1965 thru June 1, 1968 whose applications for membership were rejected, by veteran status and county of residence at time of application.

Table 31. Specified reasons for infirmary stay for the 49 members of the Minnesota Veterans' Home who were patients in the Home infirmary on June 1, 1968.

Table 32. Average monthly membership of the Minnesota Veterans' Home from January 1962 thru April 1968. (Based on man-day data provided by Minnesota Veterans' Home, May 1968).

Table 33. Admission to Minnesota Veterans' Home from 1954-1968.

PROJECTED NURSING HOME CARE REQUIREMENTS FOR THE VETERAN POPULATION OF THE STATE OF MINNESOTA FOR 1970 and 1980

The estimates shown in Table 1 project the number of Minnesota veterans in nursing and personal care homes, the number of Minnesota veterans in Veterans Administration Hospitals requiring nursing home care, and the number of Minnesota veterans who require, but will not receive, nursing home care for the years 1970 and 1980. They, therefore, show the estimated total nursing home care requirements for Minnesota veterans in 1970 and 1980.

In order to make these estimates, it has been assumed that the age specific prevalence rates for the United States veteran population, observed in 1964 in each of these categories, will continue through 1980, and are applicable to the veteran population of the State of Minnesota. These age specific prevalence rates are based on data obtained from the National Center for Health Statistics' Survey of Nursing and Personal Care Homes (Resident Places Survey - 1) conducted in 1964, and upon data collected by the Veterans Administration which identified other potential nursing home veteran patients during the same period of time. They were computed from data presented in Table 2, which was prepared by the Veterans Administration, Department of Medicine and Surgery for use in the evaluation of their nursing home care program.

The age specific rates were applied to the projections of the veteran population for the State of Minnesota prepared by the Section of Vital Statistics, Minnesota Department of Health (see Page IV - A -10 for a description of these projections) to obtain estimates of the number of

Minnesota veterans who will fall into each age/care category in 1970 and 1980. See Table 1 for details of computation.

TABLE 1

TABLE SHOWING COMPUTATION OF PROJECTED NURSING HOME REQUIREMENTS
FOR THE VETERAN POPULATION OF THE STATE OF MINNESOTA FOR 1970 AND 1980

Age	(1) Use Rates Per 1,000 Nursing Home Care 1/	(2) Use Rates Per 1,000 VAH, Requiring Nursing Care 2/	(3) Use Rates Per 1,000 Nursing Home Care Needs Unmet 3/	(4) Estimated Minnesota Veteran Population 4/ 1970	(5) Estimated Minnesota Veteran Population 4/ 1980	ESTIMATED NUMBER OF MINNESOTA VETERANS REQUIRING NURSING HOME CARE 1970 (6) Nursing Home Care (1x4)*	1970 (7) VAH (2x4)*	1970 (8) Needs Unmet (3x4)*	1970 (9) Total Requirements (6+7+8)*	1980 (10) Nursing Home Care (1x5)*	1980 (11) VAH (2x5)*	1980 (12) Needs Unmet (3x5)*	1980 (13) Total Requirements (10+11+12)*
TOTAL	-	-	-	563,030	473,040	987	62	169	1,218	1,009	69	176	1,254
Under 45 Years	0.167533	0.015745	0.038781	276,340	170,597	46	4	11	61	29	3	7	39
45 - 64 Years	0.874135	0.072722	0.139850	180,065	248,671	157	13	25	195	217	18	35	270
65 - 74 Years	5.524366	0.594542	1.303606	27,648	36,969	153	16	36	205	204	22	48	274
75 and over	33.247273	1.527273	5.090909	18,977	16,803	631	29	97	757	559	26	86	671

1/ Computed from Table 2 by forming the ratio of column (1) to column (5)

2/ Computed from Table 2 by forming the ratio of column (2) to column (5)

3/ Computed from Table 2 by forming the ratio of column (3) to column (5)

4/ Source: "Projection of the War Veteran Population of Minnesota, 1960 - 1980" Section of Vital Statistics, Minnesota Department of Health, June, 1968. See page .

* Numbers in parentheses refer to columns, e.g. (1x4) indicates that the data in column (1) have been multiplied by the data in column (4) to compute the data in column (6).

TABLE 2

TABLE PROVIDING THE METHODOLOGY, COMPUTATIONS, AND DATA SOURCES FOR THE DEVELOPMENT OF AGE-SPECIFIC NURSING HOME CARE USE RATES IN CHAPTER II

Age	(1) 1964 Census Data: Vets. in Nursing & Personal Care Homes 1/	(2) 1964 Census Data: Veteran Pts. in VAH Requiring Nursing Home Care 2/	(3) Rejected Hospital Applicants Who Needed Nursing Home Care 3/	(4) Total Requirements (1+2+3)*	(5) Veteran Population (Thousands): June 1964	(6) June 1967	(7) June 1970	(8) June 1975	(9) June 1980	(10) Usage Based on 1964 Rate Per 100,000 Veteran Population: Usage Rate 1964 (4÷5)*	(11) June 1967 (6x10)*	(12) June 1970 (7x10)*	(13) June 1975 (8x10)*	(14) June 1980 (9x10)*
Total	28,577	2,337	5,525	36,439	22,013	25,846	27,436	29,931	31,876	--	47,046	59,820	69,670	67,089
Under 45	2,160	203	500	2,863	12,893	14,228	13,519	13,275	13,725	22	3,130	2,974	2,921	3,020
45 - 64	5,938	494	950	7,382	6,793	9,449	11,957	14,439	15,128	109	10,299	13,033	15,739	16,490
65 - 74	11,336	1,220	2,675	15,231	2,052	1,629	1,058	1,152	2,248	742	12,087	7,850	8,548	16,680
75 & over	9,143	420	1,400	10,963	275	540	902	1,065	775	3,987	21,530	35,963	42,462	30,899

Age	(15) Usage Rate by VA Beneficiaries in 1967	(16) Estimated VA Patient Load Based on 1967 VA Usage Rate**: 1970	(17) 1975	(18) 1980
Total	43	13,532	15,722	15,847
Under 45	5	675	664	686
45 - 64	26	3,109	3,754	3,933
65 - 74	213	2,253	2,454	4,788
75 & over	831	7,495	8,850	6,440

SOURCES

1/ NCHS 1964 Survey of Nursing + Personal Care Homes Unpublished Tables

2/ 1964 VA Census - VA Controller

3/ DM&S Study - Published VA Field Station Summary Sept. 1965 p. 2

** Rates obtained by multiplying usage rate in Column (15) by the veteran population in Columns (7), (8), and (9).

* Numbers within parentheses refer to columns - e.g., (4÷5) indicates that the data in column (4) have been divided by the data in column (5) to compute the data shown in column (10).

Source: The VA Nursing Home Care Program - An Examination Into Quality and Costs. PPB Special Study No. 10-01-11. Department of Medicine and Surgery, Veterans Administration. Washington, D.C. January 1968.

TABLE 3

ESTIMATED NUMBERS OF MINNESOTA VETERANS IN NURSING CARE HOMES BY EXTENT OF DISABILITY IN SELECTED HEALTH CHARACTERISTICS FOR THE YEARS 1970 AND 1980

Health Characteristic and Extent of Disability	Percent Distribution 1/	Estimated Number of Minnesota Veterans In Nursing Care Homes 2/ 1970	1980
Bed Status:			
Total	100.0	988	1,009
No Disability	57.1	564	576
Partial Disability	25.8	255	260
Complete Disability	17.1	169	173
Walking Status:			
Total	100.0	987	1,009
No Disability	58.0	572	585
Partial Disability	18.2	180	184
Complete Disability	23.8	235	240
Continence Status:			
Total	100.0	987	1,010
No Disability	73.2	722	739
Partial Disability	7.8	77	79
Complete Disability	19.0	188	192
Mental Status:			
Total	100.0	987	1,010
No Disability	50.2	495	507
Partial Disability	32.2	318	325
Complete Disability	17.6	174	178

1/ Percent distributions of residents in nursing and personal care homes by extent of disability, observed in the National Center for Health Statistics' Survey of Nursing and Personal Care Homes (Resident Places Survey - 1). See Table 4.

2/ For each health characteristic the distribution observed in the National Center for Health Statistics' Survey was applied to the projected total numbers of Minnesota veterans in nursing care homes in 1970 and 1980, to obtain estimates of the numbers of veterans falling into each disability class by health characteristic. See the explanation accompanying Table 1 for an account of how the population estimates were made. Totals for health characteristics differ due to rounding.

Table 4. Percent distribution of residents in nursing and personal care homes, by extent of disability in selected health characteristics according to sex and age: United States, April-June 1963

Sex and age	Number of residents	Total	Bed status			Walking status			Continence status			Mental status			Hearing status		Vision status		
			Out of bed	In bed part of time	In bed most of time	Walks unassisted	Walks with assistance	Never walks	Continent	Partially continent	Incontinent	Always aware	Confused part of time	Confused most of time	No serious problem	Serious problem or deaf	No serious problem	Serious problem	Blind
Both sexes		Percent distribution							Percent distribution										
All ages----	505,242	100.0	57.1	25.8	17.1	58.0	18.2	23.8	73.2	7.8	19.0	50.2	32.2	17.6	84.1	15.9	80.6	16.0	3.4
Under 65 years----	59,678	100.0	69.7	16.6	13.7	66.3	14.1	19.6	81.6	5.2	13.2	61.7	27.1	11.3	94.3	5.7	89.8	7.7	2.5
65-74 years-------	89,619	100.0	60.8	24.4	14.9	60.8	17.3	21.9	77.0	7.3	15.7	55.0	30.7	14.3	90.7	9.3	86.5	11.0	2.5
75-84 years-------	207,243	100.0	57.8	26.1	16.0	59.8	17.5	22.6	73.0	7.8	19.2	49.9	31.9	18.2	85.6	14.4	82.0	15.2	2.8
85+ years---------	148,702	100.0	49.0	29.9	21.1	50.3	21.4	28.3	67.8	9.1	23.1	43.3	35.5	21.2	73.8	26.2	71.5	23.5	5.0
Male																			
All ages----	173,063	100.0	61.3	24.3	14.4	65.1	16.4	18.5	75.3	8.3	16.4	53.8	30.9	15.2	83.8	16.2	82.5	14.1	3.4
Under 65 years----	32,021	100.0	75.4	13.9	10.7	73.2	12.9	13.9	85.4	4.7	9.9	66.1	23.7	10.2	94.5	5.5	91.1	6.9	2.0
65-74 years-------	35,147	100.0	64.8	22.8	12.5	66.7	16.1	17.2	77.8	7.8	14.3	56.7	30.1	13.2	89.7	10.3	87.4	9.9	2.7
75-84 years-------	65,233	100.0	58.4	26.5	15.1	63.6	16.7	19.7	72.3	9.0	18.6	50.8	32.5	16.7	83.6	16.4	81.9	14.8	3.3
85+ years---------	40,662	100.0	51.8	30.4	17.8	59.6	19.1	21.3	70.0	10.2	19.8	46.4	34.8	18.7	70.8	29.2	72.5	22.3	5.2
Female																			
All ages----	332,179	100.0	55.0	26.6	18.5	54.3	19.1	26.6	72.1	7.5	20.4	48.4	32.8	18.8	84.2	15.8	79.7	17.0	3.3
Under 65 years----	27,657	100.0	63.0	19.7	17.3	58.3	15.6	26.1	77.1	5.7	17.1	56.5	31.0	12.5	94.0	6.0	88.2	8.7	3.1
65-74 years-------	54,472	100.0	58.2	25.4	16.5	57.0	18.1	24.9	76.4	7.0	16.6	53.9	31.0	15.1	91.3	8.7	85.8	11.8	2.4
75-84 years-------	142,010	100.0	57.6	26.0	16.5	58.1	17.9	24.0	73.3	7.2	19.4	49.4	31.6	19.0	86.6	13.4	82.1	15.3	2.6
85+ years---------	108,040	100.0	47.9	29.7	22.4	46.8	22.2	30.9	67.0	8.7	24.4	42.1	35.8	22.1	74.9	25.1	71.2	24.0	4.9

Source: "Characteristics of Residents in Institutions for the Aged and Chronically Ill, United States - April - June 1963", VHS Series 12, Number 2, p.8. DHEW, PHS National Center for Health Statistics. Washington, D. C. Sept. - 1965.

EXPLANATION OF TERMS USED IN TABLES 3 AND 4

The health of the resident is discussed in the National Center for Health Statistics' Report cited in Tables 3 and 4, in terms of six health characteristics. We are concerned with the first four of these. Each resident was classified in one of three categories according to extent of disability in each of the health characteristics described below. "No disability" refers to category (1), "partial disability" refers to category (2), and "complete disability" refers to category (3). An exception to this was hearing status in which only two categories were used.

Bed status:

1. Out of bed means that except for ordinary rest or sleep a person is out of bed most of the time.

2. In bed part of the time means that besides ordinary rest or sleep a person stays in bed part of the time.

3. In bed means that the person usually stays in bed all or most of the time.

Walking status:

1. Walks unassisted means that a person walks unassisted or with a cane or crutch.

2. Walks with assistance means that a person gets about only with a walker, an attendant's help, or by his own efforts in a wheelchair.

3. Never walks means that a person is not able to walk at all or is completely dependent on others to get about.

Continence status:

1. Continent means that a person normally can control feces and urine.

2. Partially incontinent means that a person normally can control either urine or feces but not both.

3. Incontinent means that a person normally cannot control either feces or urine.

Mental status: Mental status refers to a person's awareness of surroundings as follows:

1. Always aware means that a person is not confused, i.e., he is completely aware of his surroundings.

2. Confused part of time means that a person is sometimes not aware of his surroundings but is not confused all or most of the time.

3. Confused means that a person is confused all or most of the time.

Hearing status:

1. No serious problem with hearing.

2. Serious problem with hearing or deaf.

Vision status:

1. No serious problem means that a person has no problem seeing either with or without glasses. If a person is reported to be blind in one eye, he is also included in this category.

Vision status (cont'd.)

2. Serious problem means that a person has a serious problem with seeing even with glasses but is not blind.

3. Blind means that a person is blind in both eyes.

Projection of the War Veteran Population of Minnesota, 1960 - 1980

This report presents a projection of the war veteran population of Minnesota from 1960 to 1970, and to 1980. The projection is based on the following assumptions:

1. There was no loss or gain of veteran population due to migration after April 1, 1960.

2. The age-specific mortality rates for white male residents of Minnesota during the 1959-61 period were identical to the veterans of the corresponding age groups.

3. The veterans discharged after April 1, 1960 were all of the "other service" category and they were under 25 years of age. The annual rates of discharge were assumed to be as follows:

Year	Number per year
1960-1964	10,000
1965-1969	11,000
1970-1974	4,000
1975-1979	3,000

Projections of all veterans living in Minnesota are provided by age. These projections are also given separately for World War I, World War II, Korean War, for veterans who served in both World War II and the Korean War and for veterans who served during other time periods.

Projections of veterans aged 45 and over is provided for each period of war service, by county.

A brief summary is presented below:

	1960	1970	1980
Total Veterans	442,000	503,000	473,000
Korean War	83,000	81,000	78,000
Korean War and World War II	12,000	12,000	11,000
World War II	233,000	218,000	188,000
World War I	60,000	36,000	12,000
Other service	54,000	155,000	185,000
45 years old and over	129,000	227,000	302,000
65 years old and over	37,000	47,000	54,000

It is of some interest to note that while the total veteran population in 1980 is projected as being only about 7 percent greater than the 1960 veteran population, the increase for older veterans, who generally require more services, is substantially greater. Veterans 45 years of age and over increase 134 percent, and veterans 65 years of age and over increase 46 percent.

Section of Vital Statistics
Minnesota Department of Health
June, 1968

Projection of Total War Male Veterans by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All ages	442,587	503,330	473,040
14-24	34,632	54,773	14,938
25-29	64,676	49,381	19,753
30-34	76,077	34,104	53,938
35-39	77,878	63,663	48,607
40-44	60,321	74,419	33,361
45-49	33,708	75,121	61,411
50-54	20,347	56,776	70,046
55-59	11,296	30,602	68,198
60-64	26,183	17,566	49,016
65-69	25,053	9,036	24,483
70-74	9,180	18,612	12,486
75+	3,236	18,977	16,803
45+	129,003	226,690	302,443
65+	37,469	46,625	53,772

Projection of Male Korean War Veterans by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All ages	83,070	81,435	77,802
14-24	6,336	-	-
25-29	50,367	-	-
30-34	24,040	6,240	-
35-39	1,251	49,578	-
40-44	351	23,516	6,104
45-49	205	1,206	47,824
50-54	220	330	22,134
55-59	88	186	1,095
60-64	57	190	285
65-69	87	71	149
70-74	44	41	135
75+	24	77	76
45+	725	2,101	71,698
65+	155	189	360

Projection of Male Veterans of both the Korean War and World War II by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All ages	12,319	11,789	10,608
14-24	-	-	-
25-29	-	-	-
30-34	5,187	-	-
35-39	4,004	-	-
40-44	1,895	5,074	-
45-49	709	3,862	-
50-54	343	1,783	4,776
55-59	78	644	3,506
60-64	58	296	1,539
65-69	33	62	516
70-74	9	41	211
75+	3	27	60
45+	1,233	6,715	10,608
65+	45	130	787

Projection of Male World War II Veterans by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All ages	233,396	218,254	187,815
14-24	-	-	-
25-29	-	-	-
30-34	43,329	-	-
35-39	71,993	-	-
40-44	57,456	42,385	-
45-49	31,769	69,446	-
50-54	18,244	54,080	39,894
55-59	6,405	28,841	63,046
60-64	2,804	15,750	46,688
65-69	706	5,124	23,074
70-74	401	1,993	11,195
75+	289	635	3,918
45+	60,618	175,869	187,815
65+	1,396	7,752	38,187

Projection of Male World War I Veterans by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All Ages	59,898	36,159	11,605
14-24	-	-	-
25-29	-	-	-
30-34	-	-	-
35-39	-	-	-
40-44	-	-	-
45-49	-	-	-
50-54	-	-	-
55-59	2,877	-	-
60-64	22,714	-	-
65-69	23,928	2,301	-
70-74	8,307	16,146	-
75+	2,072	17,712	11,605
45+	59,898	36,159	11,605
65+	34,307	36,159	11,605

Projection of Male Veterans with Other Service by Age
Minnesota 1960 - 1980

AGE	1960	1970	1980
All ages	53,904	155,393	185,210
14-24	28,296	54,773	14,938
25-29	14,309	49,381	19,753
30-34	3,521	27,864	53,938
35-39	630	14,085	48,607
40-44	619	3,444	27,257
45-49	1,025	607	13,587
50-54	1,540	583	3,242
55-59	1,848	931	551
60-64	550	1,330	504
65-69	299	1,478	744
70-74	419	391	945
75+	848	526	1,144
45+	6,529	5,846	20,717
65+	1,566	2,395	2,833

Estimates and Projections of the War Veteran Population Aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
AITKIN				
Veteran Total	1,426	585	826	889
Korean War	166	1	4	143
Korean and World War II	36	4	20	31
World War II	751	195	566	605
World War I	373	373	225	72
Other Service	100	12	11	38
ANOKA				
Veteran Total	12,570	2,665	5,906	9,386
Korean War	3,500	31	88	3,020
Korean and World War II	517	52	282	445
World War II	6,588	1,713	4,967	5,303
World War I	718	718	434	139
Other Service	1,247	151	135	479
BECKER				
Veteran Total	2,593	856	1,282	1,657
Korean War	467	4	12	403
Korean and World War II	52	5	28	45
World War II	1,200	312	905	966
World War I	488	488	295	95
Other Service	386	47	42	148
BELTRAMI				
Veteran Total	2,728	863	1,440	1,808
Korean War	414	4	10	357
Korean and World War II	79	8	43	68
World War II	1,441	375	1,087	1,160
World War I	432	432	261	84
Other Service	362	44	39	139
BENTON				
Veteran Total	1,972	604	1,002	1,303
Korean War	328	3	8	283
Korean and World War II	56	6	31	48
World War II	996	259	751	802
World War I	301	301	181	58
Other Service	291	35	31	112
BIG STONE				
Veteran Total	784	261	392	502
Korean War	139	1	3	120
Korean and World War II	18	2	10	15
World War II	366	95	276	295
World War I	150	150	91	29
Other Service	111	13	12	43

Estimates and Projections of the War Veteran Population Aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
BLUE EARTH				
Veteran Total	5,479	1,478	2,532	3,744
Korean War	1,329	12	33	1,147
Korean and World War II	122	12	66	105
World War II	2,558	665	1,929	2,059
World War I	695	695	420	135
Other Service	775	94	84	298
BROWN				
Veteran Total	2,956	824	1,450	2,016
Korean War	602	5	15	520
Korean and World War II	74	7	40	64
World War II	1,489	387	1,123	1,199
World War I	375	375	227	73
Other Service	416	50	45	160
CARLTON				
Veteran Total	3,572	1,047	1,931	2,475
Korean War	587	5	15	507
Korean and World War II	60	6	33	52
World War II	2,083	542	1,571	1,677
World War I	446	446	269	87
Other Service	396	48	43	152
CARVER				
Veteran Total	2,235	664	1,095	1,499
Korean War	471	4	12	406
Korean and World War II	35	4	19	30
World War II	1,101	286	830	886
World War I	335	335	202	65
Other Service	293	35	32	112
CASS				
Veteran Total	1,960	752	1,090	1,213
Korean War	214	2	5	185
Korean and World War II	28	3	15	24
World War II	1,023	266	771	823
World War I	452	452	273	88
Other Service	243	29	26	93
CHIPPEWA				
Veteran Total	1,717	544	925	1,161
Korean War	279	2	7	241
Korean and World War II	49	5	27	42
World War II	939	244	708	756
World War I	271	271	164	53
Other Service	179	22	19	69

Estimates and Projections of the War Veteran Population Aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
CHISAGO				
Veteran Total	1,479	534	784	949
Korean War	253	2	6	218
Korean and World War II	22	2	12	19
World War II	738	192	556	594
World War I	321	321	194	62
Other Service	145	17	16	56
CLAY				
Veteran Total	5,120	1,425	2,570	3,497
Korean War	965	9	24	833
Korean and World War II	86	9	47	74
World War II	2,717	706	2,049	2,187
World War I	612	612	370	119
Other Service	740	89	80	284
CLEARWATER				
Veteran Total	1,003	341	538	663
Korean War	170	1	4	147
Korean and World War II	17	2	9	15
World War II	532	138	401	428
World War I	189	189	114	37
Other Service	95	11	10	36
COOK				
Veteran Total	527	164	298	353
Korean War	55	-	1	47
Korean and World War II	13	1	7	11
World War II	317	82	239	255
World War I	73	73	44	14
Other Service	69	8	7	26
COTTONWOOD				
Veteran Total	1,697	528	842	1,116
Korean War	324	3	8	280
Korean and World War II	20	2	11	17
World War II	836	217	630	673
World War I	277	277	167	54
Other Service	240	29	26	92
CROW WING				
Veteran Total	3,893	1,296	2,173	2,612
Korean War	555	5	14	479
Korean and World War II	103	10	56	89
World War II	2,204	573	1,662	1,774
World War I	664	664	401	129
Other Service	367	44	40	141

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
DAKOTA				
Veteran Total	10,725	2,820	5,548	7,949
Korean War	2,232	20	56	1,926
Korean and World War II	345	35	188	297
World War II	5,976	1,553	4,506	4,810
World War I	984	984	594	191
Other Service	1,888	228	204	725
DODGE				
Veteran Total	1,261	357	569	825
Korean War	274	2	7	236
Korean and World War II	36	4	20	31
World War II	541	141	408	436
World War I	183	183	110	35
Other Service	227	27	24	87
DOUGLAS				
Veteran Total	2,346	793	1,264	1,518
Korean War	306	3	8	264
Korean and World War II	56	6	30	48
World War II	1,245	324	939	1,002
World War I	422	422	253	82
Other Service	317	38	34	122
FARIBAULT				
Veteran Total	2,447	734	1,277	1,651
Korean War	403	4	10	348
Korean and World War II	52	5	28	45
World War II	1,324	344	998	1,066
World War I	341	341	206	66
Other Service	327	40	35	126
FILLMORE				
Veteran Total	2,304	688	1,129	1,542
Korean War	482	4	12	416
Korean and World War II	24	2	13	21
World War II	1,140	296	860	918
World War I	349	349	211	68
Other Service	309	37	33	119
FREEBORN				
Veteran Total	4,504	1,328	2,321	3,090
Korean War	887	8	22	765
Korean and World War II	49	5	27	42
World War II	2,447	636	1,845	1,970
World War I	618	618	373	120
Other Service	503	61	54	193

Estimates and Projections of the War Veteran Population aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
GOODHUE				
Veteran Total	3,570	1,097	1,782	2,369
Korean War	674	6	17	582
Korean and World War II	96	10	52	83
World War II	1,749	455	1,319	1,408
World War I	567	567	342	110
Other Service	484	59	52	186
GRANT				
Veteran Total	902	276	412	570
Korean War	177	2	4	153
Korean and World War II	11	1	6	9
World War II	386	100	291	311
World War I	152	152	92	29
Other Service	176	21	19	68
HENNEPIN				
Veteran Total	129,723	27,053	66,531	69,557
Korean War	24,823	223	620	1,422
Korean and World War II	4,490	449	2,447	3,866
World War II	68,619	7,841	51,739	55,238
World War I	16,717	16,717	10,097	3,243
Other Service	15,074	1,823	1,628	5,788
HOUSTON				
Veteran Total	1,743	543	894	1,182
Korean War	369	3	9	318
Korean and World War II	11	1	6	9
World War II	916	238	691	737
World War I	281	281	170	54
Other Service	166	20	18	64
HUBBARD				
Veteran Total	1,164	456	684	752
Korean War	149	1	4	129
Korean and World War II	11	1	6	9
World War II	666	173	502	536
World War I	273	273	165	53
Other Service	65	8	7	25
ISANTI				
Veteran Total	1,156	386	597	746
Korean War	188	2	5	162
Korean and World War II	27	3	15	23
World War II	572	149	431	460
World War I	213	213	129	41
Other Service	156	19	17	60

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
ITASCA				
Veteran Total	5,032	1,534	2,832	3,510
Korean War	765	7	19	660
Korean and World War II	123	12	67	106
World War II	3,042	791	2,294	2,449
World War I	672	672	406	130
Other Service	430	52	46	165
JACKSON				
Veteran Total	1,545	454	812	1,046
Korean War	268	2	7	231
Korean and World War II	21	2	11	18
World War II	863	224	651	695
World War I	203	203	123	39
Other Service	190	23	20	73
KANABEC				
Veteran Total	1,047	408	560	644
Korean War	144	1	4	124
Korean and World War II	9	1	-	8
World War II	515	134	388	415
World War I	257	257	155	50
Other Service	122	15	13	47
KANDIYOHI				
Veteran Total	3,198	974	1,689	2,653
Korean War	535	5	13	462
Korean and World War II	63	6	34	542
World War II	1,754	456	1,322	1,412
World War I	460	460	278	89
Other Service	386	47	42	148
KITTSON				
Veteran Total	872	306	462	559
Korean War	140	1	4	121
Korean and World War II	4	-	2	3
World War II	448	116	338	361
World War I	177	177	107	34
Other Service	103	12	11	40
KOOCHICHING				
Veteran Total	2,392	770	1,362	1,651
Korean War	356	3	9	307
Korean and World War II	50	5	27	43
World War II	1,442	375	1,087	1,161
World War I	365	365	220	71
Other Service	179	22	19	69

Estimates and Projections of War Veteran Population Aged 45 and Over By County
1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
LAC QUI PARLE				
Veteran Total	1,242	404	613	814
Korean War	259	2	6	223
Korean and World War II	32	3	17	28
World War II	575	149	434	463
World War I	233	233	141	45
Other Service	143	17	15	55
LAKE				
Veteran Total	1,977	512	992	1,308
Korean War	426	4	11	268
Korean and World War II	100	10	54	86
World War II	1,036	269	781	834
World War I	203	203	123	39
Other Service	212	26	23	81
LAKE OF THE WOODS				
Veteran Total	541	210	311	345
Korean War	72	-	2	62
Korean and World War II	4	-	2	3
World War II	300	78	226	241
World War I	128	128	77	25
Other Service	37	4	4	14
LE SUEUR				
Veteran Total	2,158	687	1,095	1,441
Korean War	399	4	10	344
Korean and World War II	46	5	25	40
World War II	1,071	278	807	862
World War I	361	361	218	70
Other Service	326	39	35	125
LINCOLN				
Veteran Total	944	296	453	616
Korean War	200	2	5	173
Korean and World War II	4	-	2	3
World War II	442	115	333	356
World War I	163	163	98	32
Other Service	135	16	15	52
LYON				
Veteran Total	2,353	674	1,149	1,559
Korean War	421	4	10	363
Korean and World War II	48	5	26	41
World War II	1,168	304	881	940
World War I	312	312	188	60
Other Service	404	49	44	155

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
McLEOD				
Veteran Total	2,633	707	1,246	1,808
Korean War	603	5	15	520
Korean and World War II	58	6	32	50
World War II	1,284	334	968	1,035
World War I	317	317	191	61
Other Service	371	45	40	142
MAHNOMEN				
Veteran Total	721	223	342	461
Korean War	136	1	3	117
Korean and World War II	-	-	-	-
World War II	337	88	254	271
World War I	118	118	71	23
Other Service	130	16	14	50
MARSHALL				
Veteran Total	1,378	499	733	865
Korean War	195	2	5	168
Korean and World War II	12	1	6	10
World War II	696	181	525	560
World War I	293	293	177	57
Other Service	182	22	20	70
MARTIN				
Veteran Total	3,171	938	1,655	2,162
Korean War	562	5	14	485
Korean and World War II	62	6	34	53
World War II	1,729	449	1,304	1,392
World War I	432	432	261	84
Other Service	386	46	42	148
MEEKER				
Veteran Total	1,936	670	1,032	1,255
Korean War	300	3	7	259
Korean and World War II	47	5	26	40
World War II	991	258	747	798
World War I	377	377	228	73
Other Service	221	27	24	85
MILLE LACS				
Veteran Total	1,642	589	859	1,072
Korean War	232	2	6	200
Korean and World War II	44	4	24	38
World War II	787	205	593	678
World War I	350	350	211	68
Other Service	299	28	25	88

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
MORRISON				
Veteran Total	2,438	792	1,288	1,647
Korean War	463	4	12	400
Korean and World War II	91	9	50	78
World War II	1,254	326	945	1,009
World War I	429	429	259	83
Other Service	201	24	22	77
MOWER				
Veteran Total	6,071	1,724	3,142	4,244
Korean War	1,245	11	31	1,074
Korean and World War II	92	9	50	79
World War II	3,367	875	2,539	2,710
World War I	755	755	456	146
Other Service	612	74	66	235
MURRAY				
Veteran Total	1,505	453	747	1,001
Korean War	291	3	7	251
Korean and World War II	8	1	4	7
World War II	767	199	578	617
World War I	224	224	135	43
Other Service	215	26	23	83
NICOLLET				
Veteran Total	2,751	823	1,306	1,866
Korean War	624	56	16	538
Korean and World War II	62	6	34	53
World War II	1,314	342	990	1,058
World War I	373	373	225	72
Other Service	378	46	41	145
NOBLES				
Veteran Total	2,478	689	1,165	1,665
Korean War	544	5	14	469
Korean and World War II	32	3	17	28
World War II	1,188	309	896	956
World War I	325	325	196	63
Other Service	389	47	42	149
NORMAN				
Veteran Total	1,062	349	554	684
Korean War	154	1	4	133
Korean and World War II	16	2	9	14
World War II	547	142	412	440
World War I	185	185	112	36
Other Service	160	19	17	61

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
OLMSTED				
Veteran Total	8,326	2,151	4,074	5,785
Korean War	1,687	15	42	1,456
Korean and World War II	260	26	142	224
World War II	4,310	1,121	3,250	3,470
World War I	840	840	507	163
Other Service	1,229	149	133	472
OTTERTAIL				
Veteran Total	5,220	1,788	2,712	3,348
Korean War	845	8	21	729
Korean and World War II	56	6	30	48
World War II	2,624	682	1,978	2,112
World War I	1,009	1,009	609	196
Other Service	686	83	74	263
PENNINGTON				
Veteran Total	1,432	478	794	961
Korean War	214	2	5	185
Korean and World War II	28	3	15	24
World War II	811	211	611	653
World War I	246	246	149	48
Other Service	133	16	14	51
PINE				
Veteran Total	2,134	723	1,111	1,390
Korean War	375	3	9	324
Korean and World War II	19	2	10	16
World War II	1,090	283	821	877
World War I	405	405	245	79
Other Service	245	30	26	94
PIPESTONE				
Veteran Total	1,334	442	68[illegible]	880
Korean War	250	2	6	216
Korean and World War II	30	3	16	26
World War II	666	173	502	536
World War I	247	247	149	48
Other Service	141	17	15	54
POLK				
Veteran Total	3,881	1,133	1,943	2,615
Korean War	731	7	18	631
Korean and World War II	76	8	41	65
World War II	1,994	518	1,503	1,605
World War I	534	534	322	104
Other Service	546	66	59	210

Estimates and Projections of the War Veteran Population Aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
POPE				
Veteran Total	1,136	389	615	728
Korean War	147	1	4	127
Korean and World War II	4	-	2	3
World War II	618	161	466	497
World War I	208	208	126	40
Other Service	159	19	17	61
RAMSEY				
Veteran Total	61,565	17,604	31,794	42,644
Korean War	11,774	106	294	10,161
Korean and World War II	2,058	206	1,122	1,771
World War II	32,973	8,573	24,862	26,543
World War I	7,888	7,888	4,764	1,530
Other Service	6,872	831	742	2,639
RED LAKE				
Veteran Total	560	147	296	387
Korean War	77	1	2	56
Korean and World War II	6	1	3	5
World War II	335	87	253	270
World War I	46	46	28	9
Other Service	96	12	10	37
REDWOOD				
Veteran Total	2,374	661	1,160	1,602
Korean War	451	4	11	389
Korean and World War II	52	5	28	48
World War II	1,197	311	902	963
World War I	295	295	178	57
Other Service	379	46	41	145
RENVILLE				
Veteran Total	2,296	721	1,138	1,483
Korean War	395	4	10	341
Korean and World War II	28	3	15	24
World War II	1,119	291	844	901
World War I	378	378	228	73
Other Service	376	45	41	144
RICE				
Veteran Total	3,700	1,088	1,786	2,430
Korean War	681	6	17	178
Korean and World War II	98	10	53	94
World War II	1,754	456	1,322	1,813
World War I	540	540	326	105
Other Service	627	76	68	241

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
ROCK				
Veteran Total	1,227	342	613	849
Korean War	266	2	7	230
Korean and World War II	11	1	6	9
World War II	652	169	492	525
World War I	152	152	92	29
Other Service	146	18	16	56
ROSEAU				
Veteran Total	1,110	356	610	750
Korean War	167	1	4	144
Korean and World War II	17	2	9	15
World War II	637	165	480	513
World War I	174	174	105	34
Other Service	115	14	12	44
ST. LOUIS				
Veteran Total	31,571	9,425	17,240	21,663
Korean War	4,634	42	116	3,999
Korean and World War II	812	81	442	699
World War II	18,316	4,762	13,810	14,744
World War I	4,090	4,090	2,470	793
Other Service	3,719	450	402	1,428
SCOTT				
Veteran Total	2,568	760	1,281	1,747
Korean War	552	5	13	450
Korean and World War II	60	6	33	52
World War II	1,291	336	973	1,039
World War I	371	371	224	72
Other Service	348	42	38	134
SHERBURNE				
Veteran Total	1,903	496	758	1,220
Korean War	475	4	12	410
Korean and World War II	35	4	19	30
World War II	698	181	526	562
World War I	254	254	153	49
Other Service	441	53	48	169
SIBLEY				
Veteran Total	1,518	416	680	1,004
Korean War	349	3	9	301
Korean and World War II	8	1	4	7
World War II	684	178	516	551
World War I	201	201	121	39
Other Service	276	33	30	106

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45 +)	1980 (Age 45+)
STEARNS				
Veteran Total	9,472	2,772	4,582	6,182
Korean War	1,635	15	41	1,411
Korean and World War II	237	24	129	204
World War II	4,524	1,176	3,411	3,642
World War I	1,348	1,348	814	261
Other Service	1,728	209	187	664
STEELE				
Veteran Total	3,004	845	1,525	2,079
Korean War	600	5	15	518
Korean and World War II	84	8	46	72
World War II	1,590	413	1,199	1,280
World War I	376	376	227	73
Other Service	354	43	38	136
STEVENS				
Veteran Total	1,099	356	557	711
Korean War	187	2	5	161
Korean and World War II	18	2	10	15
World War II	543	141	409	437
World War I	192	192	116	37
Other Service	159	19	17	61
SWIFT				
Veteran Total	1,401	426	742	953
Korean War	241	2	6	208
Korean and World War II	27	3	15	23
World War II	773	201	583	622
World War I	201	201	121	39
Other Service	159	19	17	61
TODD				
Veteran Total	2,097	685	1,038	1,372
Korean War	432	4	11	373
Korean and World War II	36	4	20	31
World War II	987	257	744	795
World War I	390	390	238	76
Other Service	252	30	27	97
TRAVERSE				
Veteran Total	761	256	380	476
Korean War	116	1	3	100
Korean and World War II	7	1	4	6
World War II	361	94	272	291
World War I	144	144	87	28
Other Service	133	16	14	51

Estimates and Projections of the War Veteran Population Aged 45 and Over By County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
WABASHA				
Veteran Total	1,594	504	826	1,063
Korean War	288	3	7	248
Korean and World War II	28	3	15	24
World War II	832	216	627	670
World War I	260	260	157	50
Other Service	186	22	20	71
WADENA				
Veteran Total	1,249	448	662	805
Korean War	211	2	5	182
Korean and World War II	28	3	15	24
World War II	621	161	468	500
World War I	267	267	161	52
Other Service	122	15	13	47
WASECA				
Veteran Total	1,757	519	844	1,168
Korean War	363	3	9	313
Korean and World War II	50	5	27	43
World War II	823	214	620	662
World War I	266	266	161	52
Other Service	255	31	27	98
WASHINGTON				
Veteran Total	7,798	1,919	3,866	5,638
Korean War	1,813	16	45	1,564
Korean and World War II	335	33	183	288
World War II	4,154	1,080	3,132	3,344
World War I	693	693	419	134
Other Service	803	97	87	308
WATONWAN				
Veteran Total	1,723	484	863	1,145
Korean War	337	3	8	291
Korean and World War II	22	2	12	19
World War II	865	225	652	696
World War I	277	277	167	54
Other Service	222	27	24	85
WILKIN				
Veteran Total	1,116	377	579	726
Korean War	194	2	5	167
Korean and World War II	17	2	9	15
World War II	563	146	424	453
World War I	211	211	127	41
Other Service	131	16	14	50

Estimates and Projections of the War Veteran Population Aged 45 and Over by County
Minnesota 1960 - 1980

	1960 (All Ages)	1960 (Age 45+)	1970 (Age 45+)	1980 (Age 45+)
WINONA				
Veteran Total	4,534	1,384	2,367	3,007
Korean War	679	6	17	586
Korean and World War II	86	9	47	74
World War II	2,434	633	1,835	1,959
World War I	654	654	395	127
Other Service	681	82	73	261
WRIGHT				
Veteran Total	2,929	1,036	1,478	1,824
Korean War	474	4	12	409
Korean and World War II	38	4	21	33
World War II	1,356	353	1,022	1,092
World War I	622	622	376	121
Other Service	439	53	47	169
YELLOW MEDICINE				
Veteran Total	1,555	472	801	1,061
Korean War	314	3	8	271
Korean and World War II	25	2	14	21
World War II	824	214	621	663
World War I	234	234	141	45
Other Service	158	19	17	61

Section of Vital Statistics
Minnesota Department of Health
June, 1968

TABLE 1

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY AGE AND MARITAL STATUS AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME AND BY VETERAN STATUS.

Veteran status and age at application	TOTAL	MARITAL STATUS AT APPLICATION					
		Never married	Married	Widowed	Separated	Divorced	No information
All members							
All ages	354	156	25	83	18	68	4
Under 55 years	106	62	2	4	6	30	2
55 - 64 years	123	61	7	23	8	24	-
65 - 74 years	87	25	11	33	4	12	2
75 - 84 years	34	8	3	21	-	2	-
85 years and over	4	-	2	2	-	-	-
Veteran members							
All ages	291	156	15	30	18	68	4
Under 55 years	104	62	1	3	6	30	2
55 - 64 years	103	61	3	7	8	24	-
65 - 74 years	63	25	6	14	4	12	2
75 - 84 years	18	8	3	5	-	2	-
85 years and over	3	-	2	1	-	-	-
Non-veteran members							
All ages	63	-	10	53	-	-	-
Under 55 years	2	-	1	1	-	-	-
55 - 64 years	20	-	4	16	-	-	-
65 - 74 years	24	-	5	19	-	-	-
75 - 84 years	16	-	-	16	-	-	-
85 years and over	1	-	-	1	-	-	-

TABLE 2

VETERAN MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY AGE AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME AND BY EARLIEST SERVICE IN THE ARMED FORCES OF THE UNITED STATES DURING A PERIOD OF WAR

Age at Application	All Periods Service	PERIOD OF MILITARY SERVICE			
		Spanish American War	World War I	World War II	Korean War
All Ages	291	6	165	119	1
Under 35 Yrs.	1	-	1	-	-
35-39 Years	13	-	7	5	1
40-44 Years	14	-	7	7	-
45-49 Years	27	-	9	18	-
50-54 Years	49	-	20	29	-
55-59 Years	63	-	23	40	-
60-64 Years	40	-	22	18	-
65-69 Years	27	-	25	2	-
70-74 Years	36	-	36*	-	-
75-79 Years	14	1	13	-	-
80-84 Years	4	2	2	-	-
85 Years and Over	3	3	-	-	-

* Includes one female veteran.

TABLE 3a

MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 BY STATE OR COUNTRY OF BIRTH AND BY VETERAN STATUS

PLACE OF BIRTH	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
ALL PLACES	443	367	11	48	17
ARKANSAS	2	2	-	-	-
GEORGIA	1	1	-	-	-
ILLINOIS	13	11	-	1	1
INDIANA	2	2	-	-	-
IOWA	23	16	1	4	2
KANSAS	4	4	-	-	-
KENTUCKY	2	2	-	-	-
MICHIGAN	10	9	-	1	-
MINNESOTA	262	226	6	24	6
MISSOURI	4	3	-	1	-
MONTANA	2	2	-	-	-
NEBRASKA	1	1	-	-	-
NEW MEXICO	1	1	-	-	-
NEW YORK	5	4	-	-	1
NORTH DAKOTA	8	7	-	1	-
OHIO	1	1	-	-	-
OKLAHOMA	1	1	-	-	-
SOUTH DAKOTA	10	7	-	3	-
TENNESSEE	1	-	-	-	1
WASHINGTON	1	1	-	-	-
WISCONSIN	35	25	1	5	4

TABLE 3b (CONT'D)

PLACE OF BIRTH	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
OUTSIDE U.S.					
AUSTRIA	4	4	-	-	-
CANADA	2	1	-	1	-
CZECHOSLOVAKIA	1	1	-	-	-
DENMARK	3	2	-	1	-
ENGLAND	1	-	-	1	-
FINLAND	2	2	-	-	-
GERMANY	1	1	-	-	-
GREECE	1	1	-	-	-
ITALY	1	1	-	-	-
LITHUANIA	1	1	-	-	-
LUXEMBERG	1	1	-	-	-
NORWAY	15	12	1	2	-
POLAND	2	2	-	-	-
RUSSIA	3	3	-	-	-
SWEDEN	8	7	-	1	-
NO DATA	8	2	2	2	2

TABLE 4a

MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 BY COUNTY OF RESIDENCE AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME AND BY VETERAN STATUS.

COUNTIES	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
All counties	443	367	11	48	17
Aitkin	1	1	-	-	-
Anoka	1	1	-	-	-
Beltrami	2	-	-	1	1
Benton	1	1	-	-	-
Big Stone	1	1	-	-	-
Blue Earth	2	2	-	-	-
Brown	7	5	-	2	-
Carlton	3	3	-	-	-
Carver	1	1	-	-	-
Cass	2	1	-	1	-
Clay	4	4	-	-	-
Clearwater	1	1	-	-	-
Cottonwood	1	1	-	-	-
Crow Wing	2	1	1	-	-
Dakota	6	5	-	-	1
Dodge	1	1	-	-	-
Faribault	3	1	-	1	1
Fillmore	2	1	1	-	-
Freeborn	4	3	-	-	1
Goodhue	2	2	-	-	-
Grant	1	1	-	-	-
Hennepin	213	174	3	27	9
Houston	6	5	1	-	-
Hubbard	4	4	-	-	-
Itasca	2	2	-	-	-

TABLE 4b

Continued

COUNTIES	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
Jackson	1	1	-	-	-
Kandiyohi	4	4	-	-	-
Kittson	1	1	-	-	-
Koochiching	1	1	-	-	-
Leseur	5	4	-	-	1
Martin	1	1	-	-	-
Meeker	5	5	-	-	-
Mille Lacs	2	2	-	-	-
Mower	4	4	-	-	-
Murray	2	2	-	-	-
Nobles	1	1	-	-	-
Olmsted	6	6	-	-	-
Pine	3	2	-	1	-
Pipestone	1	1	-	-	-
Polk	1	1	-	-	-
Ramsey	61	51	-	8	2
Redwood	3	3	-	-	-
Renville	1	1	-	-	-
Rice	6	4	-	1	1
Rock	1	1	-	-	-
Roseau	1	-	-	1	-
St. Louis	12	9	1	2	-
Scott	1	1	-	-	-
Sherburne	2	2	-	-	-
Sibley	1	1	-	-	-
Stearns	12	11	1	-	-
Stevens	1	1	-	-	-
Todd	6	4	1	1	-
Wadena	2	2	-	-	-
Waseca	3	2	1	-	-

TABLE 4c

Continued

COUNTIES	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
Washington	5	4	-	1	-
Watonwan	1	1	-	-	-
Winona	3	2	-	1	-
Wright	6	5	1	-	-
Out of State	4	4	-	-	-

TABLE 5

MEMBERS OF THE MINNESOTA VETERANS' HOME
FROM JANUARY 1, 1967 THRU JUNE 1, 1968
BY AGE AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME
LENGTH OF RESIDENCE IN MINNESOTA
IMMEDIATELY PRIOR TO APPLICATION
AND BY VETERAN STATUS

Veteran Status and Age at Application	LENGTH OF RESIDENCE IN MINNESOTA						
	All Lengths or Residence	Less Than One Year	1 to 2 Years	2 to 3 Years	3 to 4 Years	4 to 5 Years	5 Years or More
All Members							
All Ages	443	14	20	15	112	22	260
Under 55 Years	134	2	6	8	39	2	77
55-64 Years	157	5	6	4	40	13	89
65-74 Years	107	5	6	2	23	5	61
75 Years and Over	50	2	2	1	10	2	33
Veteran Members							
All Ages	367	11	17	14	91	18	216
Under 55 Years	132	2	6	7	39	2	76
55-64 Years	136	4	4	4	31	12	81
65-74 Years	73	5	5	2	15	3	43
75 Years and Over	26	-	2	1	6	1	16
Non-Veteran Members							
All Ages	76	3	3	1	21	4	44
Under 55 Years	2	-	-	1	-	-	1
55-64 Years	21	1	2	-	9	1	8
65-74 Years	29	-	1	-	8	2	18
75 Years and Over	24	2	-	-	4	1	17

TABLE 6 ALL MEMBERS OF THE MINNESOTS VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 BY AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME

AGE AND MONTHLY INCOME (DOLLARS) AT APPLICATION	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	443	170	39	142	57	3	-	7	15	3	7
No Income Stated	170	170	-	-	-	-	-	-	-	-	-
00.01 - 50.00	37	-	16	9	7	-	-	-	-	2	3
50.01 - 100.00	93	-	14	62	10	2	-	1	2	-	2
100.01 - 150.00	80	-	7	54	16	-	-	1	-	1	1
150.01 - 200.00	39	-	1	12	21	1	-	2	1	-	1
200.01 or more	24	-	1	5	3	-	-	3	12	-	-
UNDER 65 YEARS											
ALL INCOMES	291	159	32	68	16	-	-	-	9	1	6
No Income Stated	159	159	-	-	-	-	-	-	-	-	-
00.01 - 50.00	31	-	16	7	4	-	-	-	-	1	3
50.01 - 100.00	61	-	13	42	2	-	-	-	2	-	2
100.01 - 150.00	25	-	3	16	6	-	-	-	-	-	-
150.01 - 200.00	6	-	-	1	4	-	-	-	-	-	1
200.01 or more	9	-	-	2	-	-	-	-	7	-	-
65 - 74 YEARS											
ALL INCOMES	102	8	7	49	27	2	-	5	3	1	-
No Income Stated	8	8	-	-	-	-	-	-	-	-	-
00.01 - 50.00	5	-	-	2	2	-	-	-	-	1	-
50.01 - 100.00	19	-	1	13	4	1	-	-	-	-	-
100.01 - 150.00	36	-	4	24	7	-	-	1	-	-	-
150.01 - 200.00	25	-	1	8	13	1	-	2	-	-	-
200.01 or more	9	-	1	2	1	-	-	2	3	-	-
75 YEARS & OVER											
ALL INCOMES	50	3	-	25	14	1	-	2	3	1	1
No Income Stated	3	3	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	-	2	-	-	-	-	-	-
50.01 - 100.00	12	-	-	7	3	1	-	1	-	-	-
100.01 - 150.00	19	-	-	14	3	-	-	-	-	1	1
150.01 - 200.00	8	-	-	3	4	-	-	-	1	-	-
200.01 or more	6	-	-	1	2	-	-	1	2	-	-

TABLE 7a VETERAN MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 BY AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME

AGE AND MONTHLY INCOME (DOLLARS) AT APPLICATION	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	367	159	36	115	36	1	–	4	9	1	6
No Income Stated	159	159	–	–	–	–	–	–	–	–	–
00.01 - 50.00	29	–	16	7	2	–	–	–	–	1	3
50.01 - 100.00	73	–	14	48	6	1	–	–	2	–	2
100.01 - 150.00	57	–	5	44	8	–	–	–	–	–	–
150.01 - 200.00	30	–	–	11	17	–	–	1	–	–	1
200.01 or more	19	–	1	5	3	–	–	3	7	–	–
UNDER 55 YEARS											
ALL INCOMES	132	72	20	27	4	–	–	–	5	–	4
No Income Stated	72	72	–	–	–	–	–	–	–	–	–
00.01 - 50.00	21	–	11	7	1	–	–	–	–	–	2
50.01 - 100.00	22	–	6	14	–	–	–	–	1	–	1
100.01 - 150.00	11	–	3	5	3	–	–	–	–	–	–
150.01 - 200.00	1	–	–	–	–	–	–	–	–	–	1
200.01 or more	5	–	–	1	–	–	–	–	4	–	–
55-64 YEARS											
ALL INCOMES	136	82	12	29	8	–	–	–	2	1	2
No Income Stated	82	82	–	–	–	–	–	–	–	–	–
00.01 - 50.00	8	–	5	–	1	–	–	–	–	1	1
50.01 - 100.00	30	–	7	19	2	–	–	–	1	–	1
100.01 - 150.00	10	–	–	8	2	–	–	–	–	–	–
150.01 - 200.00	4	–	–	1	3	–	–	–	–	–	–
200.00 or more	2	–	–	1	–	–	–	–	1	–	–

TABLE 7b .CONT'D

AGE AND MONTHLY INCOME (DOLLARS) AT APPLICATION	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
65-74 YEARS											
ALL INCOMES	73	4	4	42	17	1	-	3	2	-	-
No Income Stated	4	4	-	-	-	-	-	-	-	-	-
00.01 - 50.00	-	-	-	-	-	-	-	-	-	-	-
50.01 - 100.00	15	-	1	10	3	1	-	-	-	-	-
100.01 - 150.00	27	-	2	22	3	-	-	-	-	-	-
150.01 - 200.00	19	-	-	8	10	-	-	1	-	-	-
200.01 or more	8	-	1	2	1	-	-	2	2	-	-
75 YEARS & OVER											
ALL INCOMES	26	1	-	17	7	-	-	1	-	-	-
No Income Stated	1	1	-	-	-	-	-	-	-	-	-
00.01 - 50.00	-	-	-	-	-	-	-	-	-	-	-
50.01 - 100.00	6	-	-	5	1	-	-	-	-	-	-
100.01 - 150.00	9	-	-	9	-	-	-	-	-	-	-
150.01 - 200.00	6	-	-	2	4	-	-	-	-	-	-
200.01 or more	4	-	-	1	2	-	-	1	-	-	-

TABLE 8a NON-VETERAN MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 BY AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME AT EARLIEST APPLICATION FOR ADMISSION TO THE HOME

AGE AND MONTHLY INCOME (DOLLARS) AT APPLICATION	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	76	11	3	27	21	2	-	3	6	2	1
No Income Stated	11	11	-	-	-	-	-	-	-	-	-
00.01 - 50.00	8	-	-	2	5	-	-	-	-	1	-
50.01 - 100.00	20	-	-	14	4	1	-	1	-	-	-
100.01 - 150.00	23	-	2	10	8	-	-	1	-	1	1
150.01 - 200.00	9	-	1	1	4	1	-	1	1	-	-
200.01 or more	5	-	-	-	-	-	-	-	5	-	-
UNDER 65 YEARS											
ALL INCOMES	23	5	-	12	4	-	-	-	2	-	-
No Income Stated	5	5	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	-	2	-	-	-	-	-	-
50.01 - 100.00	9	-	-	9	-	-	-	-	-	-	-
100.01 - 150.00	4	-	-	3	1	-	-	-	-	-	-
150.01 - 200.00	1	-	-	-	1	-	-	-	-	-	-
200.01 or more	2	-	-	-	-	-	-	-	2	-	-
65-74 YEARS											
ALL INCOMES	29	4	3	7	10	1	-	2	1	1	-
No Income Stated	4	4	-	-	-	-	-	-	-	-	-
00.01 - 50.00	5	-	-	2	2	-	-	-	-	1	-
50.01 - 100.00	4	-	-	3	1	-	-	-	-	-	-
100.01 - 150.00	9	-	2	2	4	-	-	1	-	-	-
150.00 - 200.00	6	-	1	-	3	1	-	1	-	-	-
200.01 or more	1	-	-	-	-	-	-	-	1	-	-

TABLE 8b CONT'D

AGE AND MONTHLY INCOME (DOLLARS) AT APPLICATION	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
75 YEARS & OVER											
ALL INCOMES	24	2	-	8	7	1	-	1	3	1	1
No Income Stated	2	2	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	-	2	-	-	-	-	-	-
50.01 - 100.00	6	-	-	2	2	1	-	1	-	-	-
100.01 - 150.00	10	-	-	5	3	-	-	-	-	1	1
150.01 - 200.00	2	-	-	1	-	-	-	-	1	-	-
200.01 or more	2	-	-	-	-	-	-	-	2	-	-

TABLE 9.

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY RELIGIOUS PREFERENCE AT TIME OF APPLICATION.

Religious preference	Members	
	Number	Percent
All preferences	354	100.0
Protestant	229	64.7
Catholic	106	29.9
Hebrew	-	-
Other	5	1.4
No information	14	4.0

TABLE 10

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY NUMBER OF MONTHS FROM DATE OF MOST RECENT APPLICATION FOR ADMISSION TO THE HOME TO DATE MEMBER ENTERED HOME AND BY VETERAN STATUS.

INTERVAL, APPLICATION TO ENTRANCE	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
All intervals	354	291	10	41	12
Less than 1 month	199	180	1	14	4
One month	92	68	5	16	3
Two months	22	17	2	1	2
Three months	13	10	-	2	1
Four months	12	4	1	6	1
Five months	5	3	-	2	-
Six or more months	9	7	1	-	1
Entrance Date Unavailable	2	2	-	-	-

TABLE 11

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY INTERVAL FROM DATE OF MOST RECENT ADMISSION TO DATE ENTERED HOME, AND BY WHETHER THIS WAS AN INITIAL ENTRANCE OR A READMISSION TO THE HOME

INTERVAL, ADMISSION TO ENTRANCE	ALL ADMISSIONS	INITIAL ENTRANCE	READMISSION
All Intervals	354	297	57
Entered Home Prior to Date Admitted	120	93	27
Entered Home After Official Admission Date	221	198	23
No Information	13	6	7

TABLE 12
MEMBERS OF THE MINNESOTA VETERANS' HOME
ON JUNE 1, 1968 BY AGE AND MARITAL STATUS
ON JUNE 1, 1968 AND BY SEX

Sex and Current Age	MARITAL STATUS ON JUNE 1, 1968						
	Total	Never Married	Married	Widowed	Separated	Divorced	No Information
All Members							
All Ages	354	156	21	84	16	72	5
Under 55 Years	30	15	-	1	4	10	-
55-64 Years	76	41	2	8	3	21	1
65-74 Years	133	57	10	27	7	31	1
75-84 Years	93	41	8	30	2	10	2
85 Years and Over	22	2	1	18	-	-	1
Male Members							
All Ages	290	155	11	31	16	72	5
Under 55 Years	30	15	-	1	4	10	-
55-64 Years	70	41	-	4	3	21	1
65-74 Years	110	57	5	9	7	31	1
75-84 Years	73	41	5	13	2	10	2
85 Years and Over	7	1	1	4	-	-	1
Female Members							
All Ages	64	1	10	53	-	-	-
Under 55 Years	-	-	-	-	-	-	-
55-64 Years	6	-	2	4	-	-	-
65-74 Years	23	-	5	18	-	-	-
75-84 Years	20	-	3	17	-	-	-
85 Years and Over	15	1	-	14	-	-	-

TABLE 13a — ALL MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY SEX, AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME ON JUNE 1, 1968

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	354	45	15	206	76	-	-	8	-	-	4
No Income Stated	45	45	-	-	-	-	-	-	-	-	-
00.01 - 50.00	15	-	4	1	10	-	-	-	-	-	-
50.01 - 100.00	42	-	6	17	17	-	-	2	-	-	-
100.01 - 150.00	148	-	5	125	15	-	-	1	-	-	2
150.01 - 200.00	83	-	-	54	27	-	-	2	-	-	-
200.01 or more	21	-	-	9	7	-	-	3	-	-	2
UNDER 55 YEARS											
ALL INCOMES	30	11	6	9	4	-	-	-	-	-	-
No Income Stated	11	11	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	2	-	-	-	-	-	-	-	-
50.01 - 100.00	5	-	3	2	-	-	-	-	-	-	-
100.01 - 150.00	9	-	1	7	1	-	-	-	-	-	-
150.01 - 200.00	3	-	-	-	3	-	-	-	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-
55-64 YEARS											
ALL INCOMES	76	20	7	39	9	-	-	-	-	-	-
No Income Stated	20	20	-	-	-	-	-	-	-	-	-
00.01 - 50.00	4	-	2	-	2	-	-	-	-	-	-
50.01 - 100.00	10	-	3	3	4	-	-	-	-	-	-
100.01 - 150.00	39	-	2	33	3	-	-	-	-	-	1
150.01 - 200.00	3	-	-	3	-	-	-	-	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-

TABLE 13b CONT'D

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
65-74 YEARS											
ALL INCOMES	133	9	-	83	37	-	-	3	-	-	1
No Income Stated	9	9	-	-	-	-	-	-	-	-	-
00.01 - 50.00	5	-	-	-	5	-	-	-	-	-	-
50.01 - 100.00	16	-	-	7	8	-	-	1	-	-	-
100.01 - 150.00	49	-	-	42	7	-	-	-	-	-	-
150.01 - 200.00	47	-	-	31	15	-	-	1	-	-	-
200.01 or more	7	-	-	3	2	-	-	1	-	-	1
75 YEARS & OVER											
ALL INCOMES	115	5	2	75	26	-	-	5	-	-	2
No Income Stated	5	5	-	-	-	-	-	-	-	-	-
00.01 - 50.00	4	-	-	1	3	-	-	-	-	-	-
50.01 - 100.00	11	-	-	5	5	-	-	1	-	-	-
100.01 - 150.00	51	-	2	43	4	-	-	1	-	-	1
150.01 - 200.00	30	-	-	20	9	-	-	1	-	-	-
200.01 or more	14	-	-	6	5	-	-	2	-	-	1

TABLE 14a — MALE MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY SEX, AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME ON JUNE 1, 1968

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	290	41	14	181	47	-	-	4	-	-	3
No Income Stated	41	41	-	-	-	-	-	-	-	-	-
00.01 - 50.00	9	-	4	1	4	-	-	-	-	-	-
50.01 - 100.00	27	-	6	11	10	-	-	-	-	-	-
100.01 - 150.00	122	-	4	110	7	-	-	-	-	-	1
150.01 - 200.00	71	-	-	51	19	-	-	1	-	-	-
200.01 or more	20	-	-	8	7	-	-	3	-	-	2
UNDER 55 YEARS											
ALL INCOMES	30	11	6	9	4	-	-	-	-	-	-
No Income Stated	11	11	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	2	-	-	-	-	-	-	-	-
50.01 - 100.00	5	-	3	2	-	-	-	-	-	-	-
100.01 - 150.00	9	-	1	7	1	-	-	-	-	-	-
150.01 - 200.00	3	-	-	-	3	-	-	-	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-
55-64 YEARS											
ALL INCOMES	70	20	7	35	7	-	-	-	-	-	1
No Income Stated	20	20	-	-	-	-	-	-	-	-	-
00.01 - 50.00	3	-	2	-	1	-	-	-	-	-	-
50.01 - 100.00	7	-	3	1	3	-	-	-	-	-	-
100.01 - 150.00	37	-	2	31	3	-	-	-	-	-	1
150.01 - 200.00	3	-	-	3	-	-	-	-	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-

TABLE 14b CONT'D

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
65-74 YEARS											
ALL INCOMES	110	7	-	78	23	-	-	1	-	-	1
No Income Stated	7	7	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	-	2	-	-	-	-	-	-
50.01 - 100.00	12	-	-	6	6	-	-	-	-	-	-
100.01 - 150.00	42	-	-	39	3	-	-	-	-	-	-
150.01 - 200.00	40	-	-	30	10	-	-	-	-	-	-
200.01 or more	7	-	-	3	2	-	-	1	-	-	1
75 YEARS & OVER											
ALL INCOMES	80	3	1	59	13	-	-	3	-	-	1
No Income Stated	3	3	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	1	1	-	-	-	-	-	-
50.01 - 100.00	3	-	-	2	1	-	-	-	-	-	-
100.01 - 150.00	34	-	1	33	-	-	-	-	-	-	-
150.01 - 200.00	25	-	-	18	6	-	-	1	-	-	-
200.01 or more	13	-	-	5	5	-	-	2	-	-	1

TABLE 15a — FEMALE MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY SEX, AGE, TOTAL MONTHLY INCOME AND MAJOR SOURCE OF INCOME ON JUNE 1, 1968

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
ALL AGES											
ALL INCOMES	64	4	1	25	29	-	-	4	-	-	1
No Income Stated	4	4	-	-	-	-	-	-	-	-	-
00.01 - 50.00	6	-	-	-	6	-	-	-	-	-	-
50.01 - 100.00	15	-	-	6	7	-	-	2	-	-	-
100.01 - 150.00	26	-	1	15	8	-	-	1	-	-	1
150.01 - 200.00	12	-	-	3	8	-	-	1	-	-	-
200.01 or more	1	-	-	1	-	-	-	-	-	-	-
55-64 YEARS											
ALL INCOMES	6	-	-	4	2	-	-	-	-	-	-
No Income Stated	-	-	-	-	-	-	-	-	-	-	-
00.01 - 50.00	1	-	-	-	1	-	-	-	-	-	-
50.01 - 100.00	3	-	-	2	1	-	-	-	-	-	-
100.01 - 150.00	2	-	-	2	-	-	-	-	-	-	-
150.01 - 200.00	-	-	-	-	-	-	-	-	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-
65-74 YEARS											
ALL INCOMES	23	2	-	5	14	-	-	2	-	-	-
No Income Stated	2	2	-	-	-	-	-	-	-	-	-
00.01 - 50.00	3	-	-	-	3	-	-	-	-	-	-
50.01 - 100.00	4	-	-	1	2	-	-	1	-	-	-
100.01 - 150.00	7	-	-	3	4	-	-	-	-	-	-
150.01 - 200.00	7	-	-	1	5	-	-	1	-	-	-
200.01 or more	-	-	-	-	-	-	-	-	-	-	-

TABLE 15b CONT'D

CURRENT AGE AND MONTHLY INCOME (DOLLARS)	ALL SOURCES	NO SOURCE STATED	COMPENSATION	PENSION	SOCIAL SECURITY	OAA	UNEMPLOYMENT	RETIREMENT	INSURANCE	EARNINGS	OTHER
75 YEARS & OVER											
ALL INCOMES	35	2	1	16	13	-	-	2	-	-	1
No Income Stated	2	2	-	-	-	-	-	-	-	-	-
00.01 - 50.00	2	-	-	-	2	-	-	-	-	-	-
50.01 - 100.00	8	-	-	3	4	-	-	1	-	-	-
100.01 - 150.00	17	-	1	10	4	-	-	1	-	-	1
150.01 - 200.00	5	-	-	2	3	-	-	-	-	-	-
200.01 or more	1	-	-	1	-	-	-	-	-	-	-

TABLE 16a — MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY AGE ON JUNE 1, 1968, SEX AND LENGTH OF MOST RECENT STAY IN THE HOME

SEX AND CURRENT ACE	ALL LENGTHS OF STAY	LESS THAN 1 YEAR	1-2 YEARS	2-3 YEARS	3-4 YEARS	4-5 YEARS	5-6 YEARS	6-7 YEARS	7-8 YEARS	8-9 YEARS	9-10 YEARS	10-11 YEARS	11-12 YEARS	12 OR MORE YEARS
ALL MEMBERS														
ALL AGES	354	47	48	35	27	23	22	13	18	13	14	6	7	81
35-39 years	1	1	-	-	-	-	-	-	-	-	-	-	-	-
40-44 years	4	2	1	1	-	-	-	-	-	-	-	-	-	-
45-49 years	9	4	2	2	-	-	-	-	-	-	-	-	-	-
50-54 years	16	7	2	1	1	2	1	-	1	1	-	-	-	
55-59 years	31	6	4	6	4	4	1	1	1	1	2	1	-	-
60-64 years	45	3	10	4	4	4	8	4	2	2	1	-	-	3
65-69 years	31	4	6	2	2	2	2	1	1	5	1	-	-	5
70-74 years	102	10	12	11	9	3	3	1	6	2	6	2	4	33
75-79 years	67	8	9	6	4	5	1	3	2	2	-	1	2	24
80-85 years	26	1	1	1	2	2	4	1	2	-	2	1	-	9
85 or more years	22	1	1	1	1	1	1	2	3	-	2	1	1	7
MALE MEMBERS														
ALL AGES	290	39	40	30	24	17	19	8	15	11	7	4	6	70
35-39 years	1	1	-	-	-	-	-	-	-	-	-	-	-	-
40-44 years	4	2	1	1	-	-	-	-	-	-	-	-	-	-
45-49 years	9	4	2	2	-	-	1	-	-	-	-	-	-	-
50-54 years	16	7	2	1	1	2	1	-	1	1	-	-	-	-
55-59 years	30	6	4	6	3	4	1	1	1	1	2	1	-	-
60-64 years	40	1	9	3	4	4	8	3	2	2	1	-	-	3
65-69 years	24	3	5	2	1	1	2	1	1	4	-	-	-	4
70-74 years	86	6	9	9	9	3	2	-	5	2	3	2	4	32
75-79 years	56	8	7	4	3	3	1	3	2	1	-	-	2	22
80-84 years	17	1	-	1	2	-	3	-	1	-	1	1	-	7
85 or more years	7	-	1	1	1	-	-	-	2	-	-	-	-	2

TABLE 16b CONT'D

SEX AND CURRENT AGE	ALL LENGTHS OF STAY	LESS THAN 1 YEAR	1-2 YEARS	2-3 YEARS	3-4 YEARS	4-5 YEARS	5-6 YEARS	6-7 YEARS	7-8 YEARS	8-9 YEARS	9-10 YEARS	10-11 YEARS	11-12 YEARS	12 OR MORE YEARS
FEMALE MEMBERS														
ALL AGES	64	8	8	5	3	6	3	5	3	2	7	2	1	11
55-59 years	1	-	-	-	1	-	-	-	-	-	-	-	-	-
60-64 years	5	2	1	1	-	-	-	1	-	-	-	-	-	-
65-69 years	7	1	1	-	1	1	-	-	-	1	1	-	-	1
70-74 years	16	4	3	2	-	-	1	1	1	-	3	-	-	1
75-79 years	11	-	2	2	1	2	-	-	-	1	-	1	-	2
80-84 years	9	-	1	-	-	2	1	1	1	-	1	-	-	2
85 or more years	15	1	-	-	-	1	1	2	1	-	2	1	1	5

TABLE 17

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968
BY AGE ON JUNE 1, 1968, SEX AND TOTAL NUMBER OF YEARS SPENT IN THE HOME.

SEX AND CURRENT AGE	ALL LENGTHS OF STAY	LESS THAN 1 YEAR	1 TO 2 YEARS	2 TO 3 YEARS	3 TO 4 YEARS	4 TO 5 YEARS	5 TO 6 YEARS	6 TO 7 YEARS	7 TO 8 YEARS	8 TO 9 YEARS	9 TO 10 YEARS	10 TO 15 YEARS	15 TO 20 YEARS	20 TO 25 YEARS	25 YEARS OR MORE
ALL MEMBERS															
ALL AGES	354	40	43	31	27	26	17	18	17	12	16	41	28	18	20
35 - 39 years	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-
40 - 44 years	4	2	1	1	-	-	-	-	-	-	-	-	-	-	-
45 - 49 years	9	5	1	1	-	-	1	-	-	1	-	-	-	-	-
50 - 54 years	16	6	2	-	1	3	-	-	1	1	-	2	-	-	-
55 - 59 years	31	3	4	6	5	3	3	2	1	1	1	1	1	-	-
60 - 64 years	45	3	8	4	4	5	5	5	4	2	1	2	1	1	-
65 - 69 years	31	3	5	2	2	3	-	2	1	2	6	3	2	-	-
70 - 74 years	102	9	10	10	9	3	2	3	5	2	3	19	11	6	10
75 - 79 years	67	6	10	6	3	5	1	3	-	2	1	7	8	7	8
80 - 84 years	26	1	1	-	2	3	4	2	2	-	2	1	2	4	2
85 or more years	22	1	1	1	1	1	1	1	3	1	2	6	3	-	-
MALE MEMBERS															
ALL AGES	290	33	35	26	25	18	14	15	13	9	9	33	23	17	20
35 - 39 years	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-
40 - 44 years	4	2	1	1	-	-	-	-	-	-	-	-	-	-	-
45 - 49 years	9	5	1	1	-	-	1	-	-	1	-	-	-	-	-
50 - 54 years	16	6	2	-	1	3	-	-	1	1	-	2	-	-	-
55 - 59 years	30	3	4	6	4	3	3	2	1	1	1	1	1	-	-
60 - 64 years	40	1	7	3	4	5	5	5	3	2	1	2	1	1	-
65 - 69 years	24	2	4	2	2	1	-	2	1	1	5	2	2	-	-
70 - 74 years	86	6	7	8	9	2	1	2	4	2	-	19	10	6	10
75 - 79 years	56	6	8	4	2	3	1	3	-	1	1	5	7	7	8
80 - 84 years	17	1	-	-	2	1	3	1	1	-	1	-	2	3	2
85 or more years	7	-	1	1	1	-	-	-	2	-	-	2	-	-	-
FEMALE MEMBERS															
ALL AGES	64	7	8	5	2	8	3	3	4	3	7	8	5	1	-
55 - 59 years	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-
60 - 64 years	5	2	1	1	-	-	-	-	1	-	-	-	-	-	-
65 - 69 years	7	1	1	-	-	2	-	-	-	1	1	1	-	-	-
70 - 74 years	16	3	3	2	-	1	1	1	1	-	3	-	1	-	-
75 - 79 years	11	-	2	2	1	2	-	-	-	1	-	2	1	-	-
80 - 84 years	9	-	1	-	-	2	1	1	1	-	1	1	-	1	-
85 or more years	15	1	-	-	-	1	1	1	1	1	2	4	3	-	-

TABLE 18

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY AGE ON JUNE 1, 1968 AND BY LEVEL OF CARE SCORE FROM FORM B.

LEVEL OF CARE SCORE	ALL AGES	CURRENT AGE				
		UNDER 55 YEARS	55 - 64 YEARS	65 - 74 YEARS	75 - 84 YEARS	85 YEARS AND OVER
All levels of care	354	30	76	133	93	22
0	75	5	22	22	25	1
1	125	14	25	52	31	3
2	29	5	11	5	5	3
3	56	4	10	26	13	3
4	22	1	3	8	7	3
5	6	-	-	3	2	1
6	11	-	2	3	5	1
7	8	1	-	5	1	1
8	7	-	1	3	2	1
9	4	-	-	1	2	1
10	3	-	1	1	-	1
11	-	-	-	-	-	-
12	-	-	-	-	-	-
13	2	-	1	1	-	-
15	1	-	-	1	-	-
19	2	-	-	1	-	1
20	1	-	-	-	-	1
21	1	-	-	1	-	-
23	1	-	-	-	-	1

TABLE 19

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1,1968
BY AGE ON JUNE 1, 1968 AND BY LEVEL OF CARE REQUIRED

LEVEL OF CARE REQUIRED	ALL AGES	CURRENT AGE				
		UNDER 55 YEARS	55 - 64 YEARS	65 - 74 YEARS	75 - 84 YEARS	85 years AND OVER
All Levels of Care	354	30	76	133	93	22
Boarding Home Care	285	28	68	105	74	10
Minimum Nursing Home Care	47	2	5	19	15	6
Moderate Nursing Home Care	14	-	2	5	4	3
Maximum Nursing Home Care	3	-	1	2	-	-
Exceptional Nursing Home Care	5	-	-	2	-	3

TABLE 20 MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY AGE ON JUNE 1, 1968, SEX AND INTERVAL IN MONTHS SINCE LAST SEEN BY THE HOME PHYSICIAN FOR TREATMENT, MEDICATION OR EXAMINATION.

SEX AND CURRENT AGE	ALL INTERVALS	LESS THAN 1 MONTH	1 TO 2 MONTHS	2 TO 3 MONTHS	3 TO 4 MONTHS	4 TO 5 MONTHS	5 TO 6 MONTHS	6 TO 12 MONTHS	1 TO 2 YEARS	2 TO 3 YEARS	3 TO 4 YEARS	4 TO 5 YEARS	5 YEARS OR MORE
All members													
All ages	354	145	46	24	20	18	13	46	16	17	4	-	5
Under 65 years	106	44	16	8	6	4	5	14	5	3	1	-	-
65 - 74 years	133	55	10	9	7	9	4	18	6	11	2	-	2
75 - 84 years	93	37	17	5	5	4	4	10	4	3	1	-	3
85 years and over	22	9	3	2	2	1	-	4	1	-	-	-	-
Male members													
All ages	290	123	35	17	16	11	10	39	13	17	4	-	5
Under 65 years	100	42	14	8	6	3	4	14	5	3	1	-	-
65 - 74 years	110	49	7	5	5	6	3	16	4	11	2	-	2
75 - 84 years	73	28	14	3	4	2	3	8	4	3	1	-	3
85 years and over	7	4	-	1	1	-	-	1	-	-	-	-	-
Female members													
All ages	64	22	11	7	4	7	3	7	3	-	-	-	-
Under 65 years	6	2	2	-	-	1	1	-	-	-	-	-	-
65 - 74 years	23	6	3	4	2	3	1	2	2	-	-	-	-
75 - 84 years	20	9	3	2	1	2	1	2	-	-	-	-	-
85 years and over	15	5	3	1	1	1	-	3	1	-	-	-	-

TABLE 21

MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968, BY SEX AND REASON FOR MOST RECENT VISIT WITH THE HOME PHYSICIAN

REASON FOR LAST VISIT	ALL MEMBERS	MALE MEMBERS	FEMALE MEMBERS
All Reasons	443	366	77
Medical Examination at Admission.	47	44	3
Medical Examination Prior to Transfer	25	24	1
Medical Examination Prior to Discharge	28	21	7
Medical Examination Prior to Dental Appointment	8	8	-
Medical Examination Prior to Optic Examination	9	9	-
Routine Medical Examination	135	93	42
Hospital Patient	60	49	11
Death	6	5	1
Prescription of Medication	16	9	7
Refill of Previously Prescribed Medication	106	101	5
No Information	3	3	-

TABLE 22

MEMBERS OF THE MINNESOTA VETERANS' HOME ON JUNE 1, 1968 BY NUMBERS OF TIMES TRANSFERRED TO A MEDICAL FACILITY OUTSIDE THE HOME AND BY SEX.

Numbers of times transferred	All members	Male members	Female members
TOTAL	354	290	64
0	177	140	37
1	75	60	15
2	40	35	5
3	19	17	2
4	18	16	2
5	7	6	1
6	10	9	1
7	2	1	1
8	2	2	-
9	-	-	-
10 or more	4	4	-

TABLE 23a

MEMBERS OF THE MINNESOTA VETERANS' HOME FROM JANUARY 1, 1967 THRU JUNE 1, 1968 AND NUMBER OF SPECIFIED CARE REQUIREMENTS BY SEX OF MEMBER. NUMBERS IN PARENTHESES ARE RATE PER 100 MEMBERS.

CARE REQUIREMENTS	BOTH SEXES	MALE	FEMALE
NUMBER OF MEMBERS	443	366	77
Nursing Care			
No special care procedures required	179 (40.4)	175 (47.8)	4 (5.2)
Needs supervision of self administered medications taken routinely	243 (54.9)	176 (48.1)	67 (87.0)
Irrigation, Catheterizations, enemas, or special physician's orders	30 (6.8)	21 (4.7)	9 (11.7)
Use of special equipment	9 (2.0)	8 (2.2)	1 (1.3)
Personal Care			
No aid required	163 (36.8)	128 (35.0)	35 (45.5)
Requires some supervision of personal care	178 (40.2)	166 (45.4)	12 (15.6)
Routinely requires some help in dressing, bathing, hair care, nail care, etc.	64 (14.4)	43 (11.7)	21 (27.3)
Requires help in all phases of personal care and hygiene	27 (6.1)	22 (6.0)	5 (6.5)
Physically helpless - requires complete care	7 (1.6)	5 (1.4)	2 (2.6)
Locomotion			
No help needed	377 (85.1)	317 (86.6)	60 (77.9)
Help needed only in special circumstances such as going up or down stairs or out of doors	19 (4.3)	12 (3.3)	7 (9.1)
Help required in getting into or out of bed or in changing position in bed (once out of bed can get about by self with or without appliance or remains in one place)	8 (1.8)	7 (2.0)	1 (1.3)
Must be accompanied whenever walking or getting about with appliance	13 (2.9)	8 (2.2)	5 (6.5)
Generally bedfast but helped to chair, wheelchair or bathroom daily	11 (2.5)	8 (2.2)	3 (3.9)
Operates wheelchair without aid	14 (3.2)	10 (2.7)	4 (5.2)

TABLE 23b Continued

CARE REQUIREMENTS	BOTH SEXES	MALE	FEMALE
Continence			
Continent	416 (93.9)	345 (94.3)	71 (92.2)
Little or no help to bathroom	4 (0.9)	3 (0.8)	1 (1.3)
Generally continent - gets to bathroom with help	6 (1.4)	4 (1.1)	2 (2.6)
Generally incontinent, involuntary or both	5 (1.1)	4 (1.1)	1 (1.2)
Totally incontinent and/or involuntary unable to use utensils provided	2 (0.5)	2 (0.5)	- -
Incontinent and/or involuntary and very messey	2 (0.5)	1 (0.3)	1 (1.3)
Ambulatory but very messy, usually with fecal matter	3 (0.7)	2 (0.5)	1 (1.3)
Mental State			
No special attention needed	315 (71.1)	261 (71.3)	54 (70.1)
May require special attention at times because of mild confusion	67 (15.1)	55 (15.0)	12 (15.6)
Considerable attention required because of forgetfulness, noisiness, or tendency to wander	26 (5.9)	20 (5.5)	6 (7.8)
Must be confined to a given area of home	37 (8.4)	34 (9.3)	3 (3.9)
Frequently uncooperative or disagreeable	45 (10.2)	36 (9.8)	9 (11.7)
Requires constant watching or is demanding of attention	9 (2.0)	6 (1.6)	3 (3.9)
Extremely disagreeable and uncooperative always	12 (2.7)	8 (2.2)	4 (5.2)
Eating			
No supervision or help needed	42 (9.5)	41 (11.2)	1 (1.3)
May require some supervision of food habits	77 (17.4)	73 (19.9)	4 (5.2)
Requires modification of normal diet with special food and/or extra preparation	323 (72.9)	253 (69.1)	70 (90.9)
Requires meals served individually with some help in eating (not in bed)	13 (2.9)	13 (3.6)	- -
Bedfast, meals served in bed	7 (1.6)	5 (1.4)	2 (2.6)
Must be fed by I.V. or subcutaneously	- -	- -	- -
Must be fed, eats slowly or must be coaxed	6 (1.4)	4 (1.1)	2 (2.6)

TABLE 23c Continued

CARE REQUIREMENTS	BOTH SEXES	MALE	FEMALE
Special requirements			
No unusual handicap	329 (74.3)	274 (74.9)	55 (71.4)
Unable to communicate because of mental confusion, language barrier, etc.	12 (2.7)	11 (3.0)	1 (1.3)
Blind or not feasible for training	6 (1.4)	3 (0.8)	3 (3.9)
Severe organic brain damage	- -	- -	- -
Very obese	80 (18.1)	57 (15.6)	23 (29.9)
Abnormal need for special dressings	3 (0.7)	2 (0.5)	1 (1.3)
Requires and receives training to retain or regain walking skill or to learn to use appliance	7 (1.6)	3 (0.8)	4 (5.2)
Drug habituation	- -	- -	- -
Chronic Alcoholic	38 (8.6)	36 (9.8)	2 (2.6)
Other	30 (6.8)	25 (6.8)	5 (6.5)
No information	3 (0.7)	3 (0.8)	- -

TABLE 24a

MEMBERS OF THE MINNESOTA VETERANS' HOME
FROM JANUARY 1, 1967 THRU JUNE 1, 1968
AND NUMBER OF SPECIFIED CHRONIC DISEASES AND
IMPAIRMENTS FROM FORM C BY SEX OF MEMBER.

NUMBERS IN PARENTHESES ARE RATES PER 100 MEMBERS

CHRONIC DISEASE OR IMPAIRMENT	BOTH SEXES	MALE	FEMALE
NUMBER OF MEMBERS	443	366	77
Malignant Neoplasms, Without Surgery	1 (0.2)	1 (0.3)	- (-)
Malignant Neoplasms, With Surgery	29 (6.5)	23 (6.3)	6 (7.8)
Benign and Unspecified Neoplasms	5 (1.1)	5 (1.4)	- (-)
Asthma	9 (2.0)	9 (2.5)	- (-)
Diseases of the Thyroid Gland	6 (1.4)	3 (0.8)	3 (3.9)
Diabetes Mellitus	43 (9.7)	35 (9.6)	8 (10.4)
Avitaminosis and Other Nutritional Weight Problems	23 (5.1)	19 (5.2)	4 (5.2)
Senile Psychosis With or Without Other Mental Conditions	11 (2.5)	- (-)	11 (14.3)
Senility Without Mention of Psychosis	47 (10.6)	25 (6.8)	22 (28.6)
Specified Mental Disorders	48 (10.8)	45 (12.3)	3 (3.9)
Vascular Lesions Affecting Central Nervous System	6 (1.4)	6 (1.6)	- (-)
Multiple Sclerosis	2 (0.5)	1 (0.3)	1 (1.3)
Parkinsons Disease (Paralysis Agitans)	8 (1.8)	7 (1.9)	1 (1.3)
Epilepsy	5 (1.1)	5 (1.4)	- (-)
Other Nervous System Disorders	57 (12.9)	51 (13.9)	6 (7.8)
Cataract	17 (3.8)	12 (3.3)	5 (6.5)
Glaucoma	3 (0.7)	2 (0.5)	1 (1.3)
Other Diseases of the Eye	3 (0.7)	3 (0.8)	- (-)
Diseases of the Ear	2 (0.5)	2 (0.5)	- (-)

TABLE 24b (Cont'd.)

Members of the Minnesota Veterans' Home From January 1, 1967 thru June 1, 1968 and Number of Specified Chronic Diseases and Impairments From Form C by Sex of Member (Cont'd.)

CHRONIC DISEASE OR IMPAIRMENT	BOTH SEXES	MALE	FEMALE
Diseases of the Heart	98 (22.1)	77 (21.0)	21 (27.3)
Hypertension Without Mention of Heart	172 (38.8)	126 (34.4)	46 (59.7)
General Arteriosclerosis . .	73 (16.5)	67 (18.3)	6 (7.8)
Varicose Veins	85 (19.2)	73 (19.9)	12 (15.6)
Hemorrhoids	42 (9.5)	35 (9.6)	7 (9.1)
Other Conditions of Circulatory System.	32 (7.2)	23 (6.3)	9 (11.7)
Chronic Sinusitis	7 (1.6)	7 (1.9)	- (-)
Bronchitis With Emphysema . .	21 (4.7)	21 (5.7)	- (-)
Bronchitis Without Emphysema	26 (5.9)	26 (7.1)	- (-)
Emphysema Without Bronchitis	15 (3.4)	13 (3.6)	2 (2.6)
Other Chronic Respiratory Conditions	45 (10.2)	41 (11.2)	4 (5.2)
Ulcer of Stomach and Duodenum	27 (6.1)	26 (7.1)	1 (1.3)
Hernia of Abdominal Cavity .	34 (7.7)	34 (9.3)	- (-)
Diseases of Gall Bladder and Bile Ducts	3 (0.7)	3 (0.8)	- (-)
Other Chronic Conditions of Digestive System	44 (9.9)	40 (10.9)	4 (5.2)
Incontinence (Urine or Feces)	6 (1.4)	5 (1.4)	1 (1.3)
Diseases of Urinary System .	21 (4.7)	20 (5.5)	1 (1.3)
Diseases of Male Genital Organs	22 (5.0)	22 (6.0)	- (-)
Diseases of Breast and Female Genital Organs	6 (1.4)	6 (1.6)	- (-)
Diseases of Skin & Other Subcutaneous Tissues . . .	21 (4.7)	17 (4.6)	4 (5.2)
Arthritis	225 (50.8)	180 (49.2)	45 (58.4)
Other Specified Diseases of Bones & Organs of Movement	21 (4.7)	19 (5.2)	2 (2.6)
Fracture, Femur (old)	15 (3.4)	10 (2.7)	5 (6.5)
Chronic Alcoholism	44 (9.9)	44 (12.0)	- (-)

TABLE 24c(Cont'd.)

Members of the Minnesota Veterans' Home from January 1, 1967 thru June 1, 1968 and Number of Specified Chronic Diseases and Impairments From Form C by Sex of Member. (Cont'd.)

CHRONIC DISEASE OR IMPAIRMENT	BOTH SEXES	MALE	FEMALE
Visual Impairment, Inability to Read Newspaper With Glasses	15 (3.4)	7 (1.9)	8 (10.4)
Other Visual Impairments . .	84 (19.0)	60 (16.4)	24 (31.2)
Hearing Impairments	78 (17.6)	62 (16.9)	16 (20.8)
Speech Impairments Due to Stroke	3 (0.7)	3 (0.8)	- (-)
Speech Impairments Due to Other or Unspecified Causes . . .	4 (0.9)	4 (1.1)	- (-)
Paralysis, Palsy Due to Stroke	2 (0.5)	1 (0.3)	1 (1.3)
Absence, Fingers or Toes . .	9 (2.0)	8 (2.2)	1 (1.3)
Absence, Major Extremities .	9 (2.0)	9 (2.5)	- (-)
Impairment, Limb, Back, Trunk	22 (5.0)	19 (5.2)	3 (3.9)
Other Chronic Conditions, Diseases or Impairments . .	319 (72.0)	255 (69.7)	64 (83.1)
No Information	1 (0.2)	1 (0.3)	- (-)

TABLE 25

MEMBERS OF THE MINNESOTA VETERANS' HOME WHO WERE PATIENTS IN THE HOME INFIRMARY ON JUNE 1, 1968, BY AGE ON JUNE 1, 1968 AND BY LENGTH OF THE CURRENT INFIRMARY STAY.

LENGTH OF INFIRMARY STAY	ALL AGES	UNDER 65 YEARS	65 TO 74 YEARS	75 YEARS AND OVER
All lengths of stay	49	6	23	20
Less than 1 month	4	2	1	1
1 to 4 months	7	1	2	4
4 to 6 months	6	2	2	2
6 to 12 months	12	1	6	5
1 to 2 years	7	-	3	4
2 to 5 years	5	-	4	1
5 to 7 years	2	-	-	2
7 years or more	6	-	5	1

TABLE 26a

EXISTING CONDITIONS OR DIAGNOSES REPORTED FOR THE 49 MEMBERS OF THE MINNESOTA VETERANS' HOME WHO WERE PATIENTS IN THE HOME INFIRMARY ON JUNE 1, 1968.

CONDITION OR DIAGNOSIS	NUMBER OF TIMES REPORTED
Abdominal Resection	1
Amputation	5
Anemia	4
Arteriosclerosis	6
Arthritis	12
Blindness	1
Bowel Fixation	1
Bronchitis	5
Brain Tumor	2
Cardiac	4
Cataracts	4
Cerebelar Degeneration	2
Chronic Alcoholism	3
Chronic Brain Syndrome	2
Cholecystitis	1
Colostomy	1
Cancer	1
Cardiovascular accident	4
Dermatitis	1
Diabetis	8
Diarrhea	1
Edema	1
Emphysema	3
Epilepsy	1
Esohogeal Varices	1
Facial Paralysis	1
Glaucoma	1

TABLE 26b
Continued

CONDITION/DIAGNOSES	NUMBER OF TIMES REPORTED
Hearing	3
Hemiparesis	1
Hernia	1
Hypertension	9
Hypertrophy Prostate	1
Lung Disease	1
Macrosepticemia	1
Malnutrition	6
Mental Deficiency	4
Mitral Insufficiency	1
Myocarditis	2
Obliterans	1
Parkinsons	2
Partial Paralysis	2
Pelvic Fracture	2
Peripheral Neuropathy	1
Pes Planus	1
Obesity	1
Obliterans Vascular Disease	2
Osteomalacia	2
Scoliosis	3
Senility	12
Skull Fracture	1
Strabismus	1
Suicidal	2
Surgery	5

TABLE 26c
Continued

CONDITION/DIAGNOSES	NUMBER OF TIMES REPORTED
Retinopathy	1
Arrested Tuberculosis	4
Upper Respiratory Infection	1
Vision	1

TABLE 27

NEW APPLICANTS TO THE MINNESOTA VETERANS' HOME FROM JULY 1, 1965 THRU JUNE 1, 1968 WHOSE APPLICATIONS FOR MEMBERSHIP WERE REJECTED, BY AGE AT APPLICATION AND BY SEX.

AGE AT APPLICATION	BOTH SEXES	MALE	FEMALE
All ages	61	48	14
40 - 44 years	3	3	-
45 - 49 years	1	1	-
50 - 54 years	5	5	-
55 - 59 years	5	5	-
60 - 64 years	2	2	-
65 - 69 years	7	6	1
70 - 74 years	20	18	2
75 - 79 years	6	4	2
80 - 84 years	8	4	4
85 years and over	3	-	3
No Birth Date Supplied	1	-	1

TABLE 28

NEW APPLICANTS TO THE MINNESOTA VETERANS' HOME FROM JULY 1, 1965 THRU JUNE 1, 1968 WHOSE APPLICATIONS FOR MEMBERSHIP WERE REJECTED BY REASON FOR REJECTION

REASON FOR REJECTION	NUMBER OF APPLICANTS REJECTED
TOTAL REASONS	61
No Facilities	19
No Medical Facilities	9
No Facilities and Needs Supervision	2
No Facilities and Sufficient Income	2
Sufficient Income	10
Sufficient Income and Assets	6
Son is Employable	1
Needs Supervision	5
Needs Special Care	1
Not Medically Qualified	1
Nonresident of Minnesota	3
Questionable Service Dates	1
Not blood-related to Veteran	1

TABLE 29

NEW APPLICANTS TO THE MINNESOTA VETERANS' HOME
JULY 1, 1965 THRU JUNE 1, 1968
WHOSE APPLICATIONS FOR MEMBERSHIP WERE REJECTED,
BY SEX AND LENGTH OF TIME IN MONTHS BETWEEN
APPLICATION AND REJECTION.

Interval between application and rejection	Both sexes	Male	Female
All intervals	61	48	13
Less than 1 month	3	1	2
1 to 2 months	29	23	6
2 to 3 months	19	17	2
3 to 4 months	5	3	2
4 to 5 months	1	1	-
5 or more months	1	1	-
No information	3	2	1

TABLE 30

NEW APPLICANTS TO THE MINNESOTA VETERANS' HOME FROM JULY 1, 1965 THRU JUNE 1, 1968 WHOSE APPLICATIONS FOR MEMBERSHIP WERE REJECTED, BY VETERAN STATUS AND COUNTY OF RESIDENCE AT TIME OF APPLICATION.

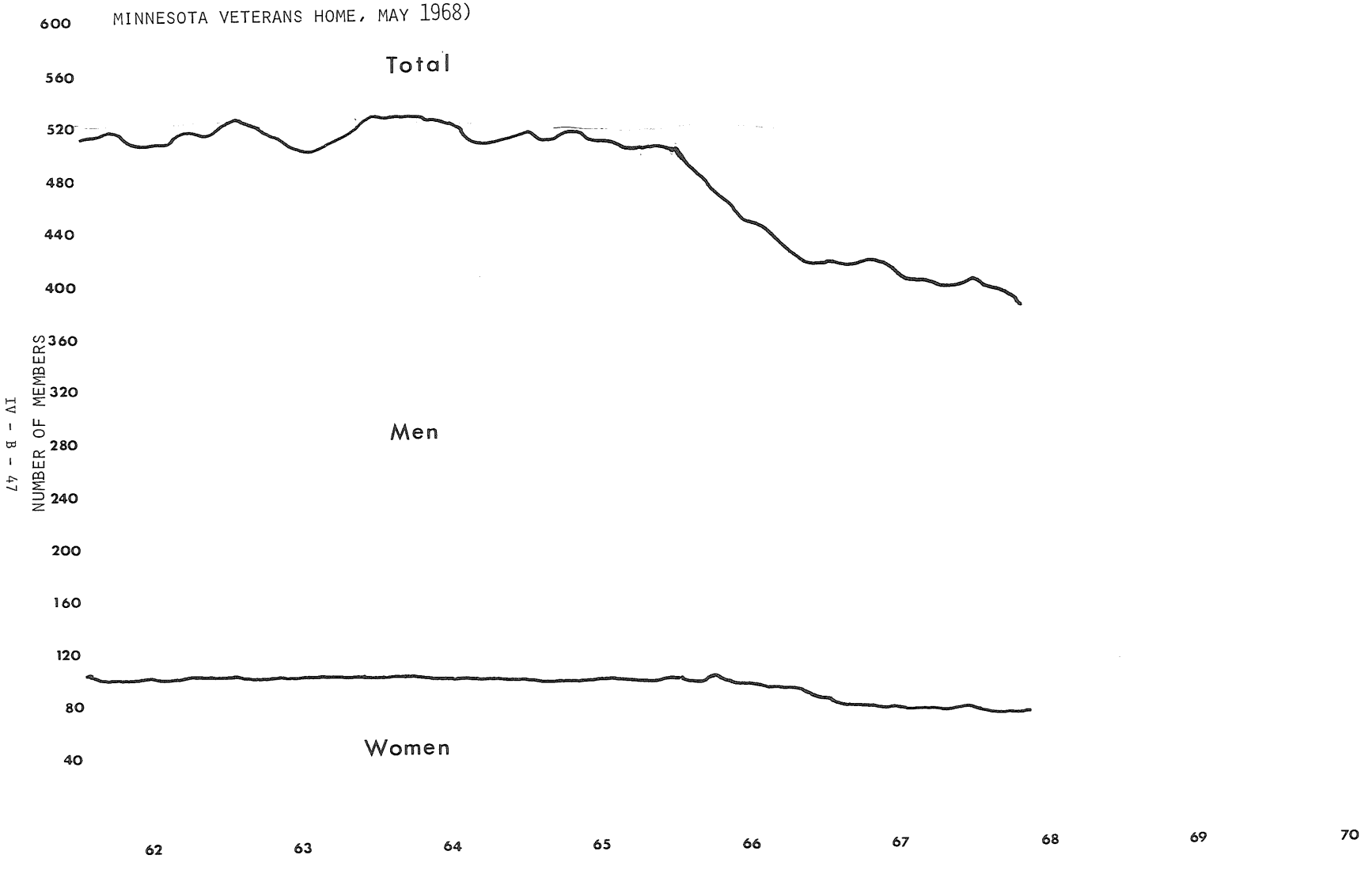
	TOTAL	VETERAN	WIFE OF VETERAN	WIDOW OF VETERAN	MOTHER OF VETERAN
All counties	61	48	1	8	4
Becker	1	-	-	-	1
Cass	1	1	-	-	-
Dakota	2	1	-	1	-
Freeborn	1	1	-	-	-
Hennepin	24	15	1	5	3
Lac Qui Parle	1	1	-	-	-
Morrison	1	1	-	-	-
Norman	1	1	-	-	-
Otter Tail	2	2	-	-	-
Ramsey	6	5	-	1	-
Renville	1	1	-	-	-
St.Louis	4	4	-	-	-
Stearns	2	2	-	-	-
Todd	1	1	-	-	-
Washington	2	1	-	1	-
Watonwan	2	2	-	-	-
Wright	3	3	-	-	-
No Information	6	6	-	-	-
			-	-	-

TABLE 31. SPECIFIED REASONS FOR INFIRMARY STAY FOR THE 49 MEMBERS OF THE MINNESOTA VETERANS' HOME WHO WERE PATIENTS IN THE HOME INFIRMARY ON JUNE 1, 1968.

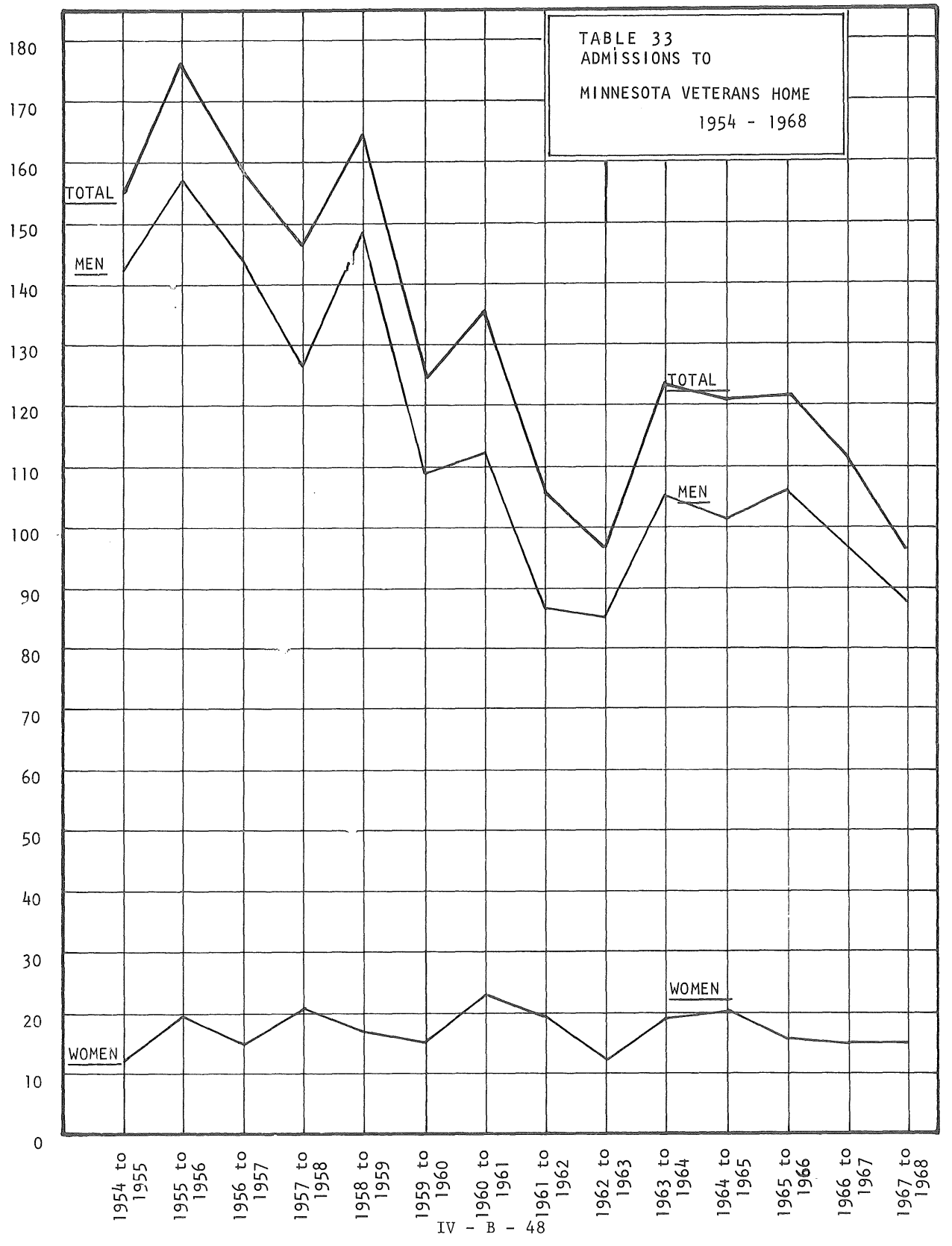
Reasons for Infirmary Stay	Number of Times Reported
Acute Conditions	1
Aged	2
Amputee	5
Arithritis (Crippled)	2
Blindness	3
Cancer	2
Can't Function on Grounds	16
Cardiac Decompensation	1
Cardiovascular Accident	3
Complete Bed Patient	1
Debility	5
Diabetic	3
Drinking Problem	2
Hypertension	1
Mentally Incompetent	7
Needs Bennett Treatments	2
Obesity	1
Parkinson Disease	1
Partial Paralysis	1
Post Fracture	1
Psychoneurotic	1
Senile	4
Stroke	1
Terminal Stages Artercosetosis	1
Upper Respiratory Infection	1
Weak	13
Wheelchair	2

Table 32

AVERAGE MONTHLY MEMBERSHIP OF THE MINNESOTA VETERANS HOME FROM JANUARY 1962 - APRIL 1968 (BASED ON MAN-DAY DATA PROVIDED BY THE MINNESOTA VETERANS HOME, MAY 1968)



Source: Minnesota Veterans' Home Monthly Reports



COSTS OF MINNESOTA VETERANS' HOME CARE

The purpose of this section is to analyze and compare the declared* costs of providing care to members of the Minnesota Veterans' Home with other institutions engaged in similar activities. We are not concerned with providing an audit of the Home's financial accounts or operating costs per se.

As an initial point of discussion it is of interest to compare Minnesota's per diem costs for domiciliary care with those of Veterans' Homes in other indigenous states.

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*Source: Office of the Commandant, Minnesota Veterans' Home, Minneapolis, Minnesota.

V.A. FEDERAL AID PAYMENTS MADE FOR MEMBER CARE PROVIDED BY STATE VETERANS HOMES, FISCAL YEAR 1967 1/

State	Average Daily No. Census	Days of Care	Per Diem Costs	Total Cost	Cost Shared by VA & State Veterans Homes			
					By VA	By State	By VA	By State
Minnesota	318	116,232	$5.68	$660,198*	$290,785	$369,413*	44.0%	56.0%
North Dakota	95	34,662	4.11	142,461	71,244	71,217	50.0	50.0
Illinois	361	131,767	6.39	841,991	329,418	512,573	39.1	60.9
South Dakota	99	36,102	7.83	282,674	90,255	192,424	31.9	68.1
Michigan	318	115,977	8.53	989,284	292,245	697,039	29.5	70.5
Iowa	384	140,285	8.58	1,203,645	350,678	852,967	29.1	70.9
Wisconsin	345	125,902	10.50	1,321,971	314,755	1,007,216	23.8	76.2

1/ Extracted from Congressional Record. "VA Federal Aid Payments Made for Member and Nursing Care Provided By State Veterans Homes," Fiscal 1967. May 20, 1968 p. H3977.

* Balances from Non-State and Non-Federal Funds inclusive.

As can be noted from the aforementioned table, Minnesota spends the second lowest amount of per diem dollars ($5.68) for domiciliary care among its six neighboring states. Only North Dakota spends a lower per diem amount ($4.11) for the domiciliary care of its veteran population. North Dakota has only 30 percent of Minnesota's veteran population and days of care, yet it spends 74 percent of Minnesota's per diem costs - or only a $1.57 less per diem. Among the five remaining neighboring states the per diem costs range from $6.39 in Illinois to $10.50 in Wisconsin. The amount of dollars shared by the five states with the VA for veterans' domiciliary care ranges from 61 percent in Illinois to 76 percent in Wisconsin. On the other hand, Minnesota ranks second among the seven comparative states in terms of the amount of dollars (44.0%) spent by the Veterans Administration in providing domiciliary care for its veteran population.* Only North Dakota receives more VA assistance (50.0%)than does Minnesota.

Of the five states which spend more per diem, Michigan has approximately the same amount of patient days and veteran membership as Minnesota, yet it spends $2.85 a day more while South Dakota which has only approximately 31 percent of both Minnesota's membership and days of care spends $2.15 more per day. Thus, it would seem that Minnesota is not spending as much for the care of its Veteran Home population as it might be capable of doing, but rather seems more dependent upon the Federal Government than all of its neighboring states, with the exception of North Dakota, to help pay for such domiciliary care.

* Balance due to Minnesota Veterans' Home members not recognized by the U.S. Veterans Administration for reimbursement e.g. wives, mothers, and widows.

Another approach in analyzing the costs of operating the Veterans' Home is examining the per diem costs of these operations which contribute to its daily activity. Ideally, the most valid point of comparison is between the Minnesota Veterans' Home and Veteran Homes in other states which provide domiciliary care. Unfortunately, however, there are no known existing studies pertaining to statistically valid analyses of the operating costs of a series of State veteran homes. This is due to wide differences in allocation of costs to various cost-categories. In addition, there are no standard formats in existence which prescribe or suggest uniform cost analyses throughout the various states for State veteran homes. Consequently the most useful comparison which can be made at present is between the Minnesota Veterans' Home and other nursing homes, county, private, and those of the U.S. Veterans Administration. The constraints in such a comparitive analyses are that the cost data for varying kinds of nursing homes were gathered in different years under the particular criteria of a given study and that nursing homes, due to their higher level of care, programs, skills of personnel, etc., can be expected to have higher per diem costs than a facility which primarily provides domiciliary care. However, with these limitations in mind, the following tables and analyses are considered to be useful in further understanding of the Minnesota Veterans' Home problem.

AVERAGE OPERATING COSTS PER DIEM OF MINNESOTA VETERANS' HOME
VERSUS PUBLIC, PRIVATE, AND VA NURSING HOMES

Service Provided	Minn. Vet.* Home 1/ FY 1967-68	Minn. County 2/ Nursing Home 1967	Minn. County 2/ Nursing Home St. Cloud June 1967	Wisc. VA 3/ Nursing Home Tomah, Wisc. June 1967	Mich. VA 3/ Nursing Home Dearborn June 1967	Mich. VA 3/ Nursing Home Battle Creek June 1967	State Nursing Homes, Studies 100 Beds & Over 4/ Calif. 1966	Mass. 1966	Colo. 1965
Administrative and General	1.07	.74	.44	.16	.40	.55	1.30	1.49	1.11
Nursing and Medicine	1.26	2.52	11.13	7.13	6.42	14.07	3.87	2.54	2.72
Dietary	1.74	1.66	2.55	1.50	2.53	3.05	1.63	1.51	1.45
Social Services and Activities (includes Chaplain)	.17	-	.24	.02	.30	.33	.14	-	-
Clothing	.01	-	-	-	-	-	-	-	-
Housekeeping	.42	.71	.44	.53	.59	.76	.50	.34	.30
Property & Related Expense	-	-	-	-	-	-	2.04	2.27	1.67
Plant Operation	1.51	.79	-	-	-	-	.56	.42	.42
Laundry & Linen	.10	-	1.43	.59	.16	.54	.33	.21	.22
Other	-	-	.68	.26	.54	.29	.35	-	.16
Total Per Diem	6.28	6.42	16.91	10.19	10.94	19.69	10.72	8.78	8.05

* Includes all non-state, and non-Federal funds used in operating the Minnesota Veterans' Home, and distributed for various facility services.

Sources: 1/ Data made available by Minnesota State Veterans' Home. Fiscal Year 1967-1968.
2/ Minnesota State Department of Public Welfare. Statement of Comparative Operating Costs of County Nursing Homes-Calendar Yr. 1967 - St.Paul,Minn.
3/ Veteran Administration. The VA Nursing Home Care Program. An Examination Into Quality And Cost. Dept. of Medicine & Surgery,Wash. DC.-Jan.1968.
4/ Dept. of Health, Education, and Welfare, Public Health Service. Nursing Home Utilization And Costs In Selected States. Division of Medical Care Admin. Wash. D.C. March 1968

AVERAGE OPERATING COSTS PER DIEM OF MINNESOTA VETERANS' HOME
VERSUS PUBLIC, PRIVATE, AND VA NURSING HOMES
(In percentage of total per diem cost)

Service Provided	Minn. Vet. Home * 1/ FY 1967-68	Minn. County 2/ Nursing Home 1967	Minn. County 2/ Nursing Home St. Cloud June 1967	Wisc. Va. 3/ Nursing Home Tomah, Wisc. June 1967	Mich. VA 3/ Nursing Home Dearborn June 1967	Mich. VA 3/ Nursing Home Battle Creek June 1967	State Nursing Homes, Studies 100 Beds & Over 4/ Calif. 1966	Mass. 1966	Colo. 1965
Administrative and General	17.0	11.5	2.6	1.6	3.7	2.8	12.1	17.0	13.8
Nursing and Medicine	20.1	39.3	65.8	70.0	58.7	71.8	36.1	28.9	33.8
Dietary	27.7	25.9	15.1	14.7	23.1	15.6	15.2	17.2	18.0
Social Services and Activities (includes Chaplain)	2.7	-	1.4	.2	2.7	1.7	1.3	-	-
Clothing	.2	-	-	-	-	-	-	-	-
Housekeeping	6.7	11.0	2.6	5.2	5.4	3.9	4.7	3.9	3.7
Property & Related Expense	-	-	-	-	-	-	19.0	25.8	25.8
Plant Operation	24.0	12.3	-	-	-	-	5.2	4.8	5.2
Laundry & Linen	1.6	-	8.5	5.8	1.5	2.7	3.1	2.4	2.7
Other	-	-	4.0	2.5	4.9	1.5	3.3	-	2.0
Total Per Diem	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Includes all non-state, and non-Federal funds used in operating the Minnesota Veterans' HOme, and distributed for various facility services.

Sources: 1/ Data made available by Minnesota State Veterans' Home. Fiscal Year 1967-1968.
2/ Minnesota State Department of Public Welfare. Statement of Comparative Operating Costs of County Nursing Homes-Calendar Yr. 1967-St. Paul, Minn.
3/ Veterans Administration - The VA Nursing Home Care Program. An Examination Into Quality And Cost. Dept. of Medicine & Surgery, Wash.DC-Jan.1968
4/ Dept. of Health, Education, and Welfare, Public Health Service. Nursing Home Utilization And Costs In Selected States. Division of Medical Care Administration, Washington, D.C. March 1968.

Another important component in analyzing the finances of nursing home care is what such care costs the State. This is a difficult estimate to make because of the different variables which must be taken into account, and each State, county or private institution may use different charts of accounts which lead to different classification of costs. For example, the level of nursing home care may vary among individuals. Thus, the State of Minnesota distinguishes among four kinds of nursing care in its Medicaid program, minimum, moderate, exceptional, and maximum, each of which has its own payment schedule, either on a per diem or monthly basis. Each of the payment levels within a particular care category has a range of payments which varies from county to county within that category of care. In addition, the State of Minnesota pays only 21 percent of the cost for nursing home care within a county, with the county paying 21 percent and the Federal Government paying 58 percent.

It should be noted that in comparison to county, U. S. Veterans Administration, and private nursing homes, the Minnesota State Veterans' Home has the highest percentage of per diem costs in the area of dietary functions (27.7%), plant operation (24.0%), and administration (17.0%) along with Massachusetts (17.0%). On the other hand, Minnesota Veterans Home devotes the lowest percentage of its per diem costs to nursing and medical functions (20.1%) compared to county, U. S. Veterans Administration, and private nursing homes, even though approximately 23 percent of its residents need varying levels of nursing care and the incidence of such diseases among them are as follows: 20 percent have diseases of the heart, 51% have arthritis, and so forth. These figures reflect the nature of the

Minnesota Veterans' Home operation, namely the provision of domiciliary care. The amount of per diem costs that are spent for medical and nursing services in VA facilities is due to the fact that the VA nursing homes utilize considerable personnel and equipment such as physicians, professional registered nurses, licensed practical nurses, radiologists, laboratories, pharmacies, physical medicine, and dentists. Such an array of personnel and equipment does not exist at the Minnesota Veterans' Home since domiciliary care is emphasized here, nor do they exist to any extent in all private or public nursing home facilities. Because of the different purposes of care between a veteran domiciliary facility and a county,Veterans Administration, or private nursing home, direct cost comparisons are not possible, but rather the figures do lend emphasis to internal operations which each facility considers important.

Commencing on July 1, 1967 and ending on May 31, 1968 the State of Minnesota appropriated $305,250 for the operation and maintenance of the State Veterans' Home. The question now arises as to the cost of providing nursing care to the Home's residents should they be transferred to other facilities in the State. In order to determine such costs, it was necessary for the study contractor to survey the health care status of the Home's residents. The survey utilized the level of care criteria established by the Minnesota Department of Public Welfare. The study revealed that 65 residents required minimum care; 23 needed moderate care; 4 required maximum care; and 10 needed exceptional care. Using the number of residents in each category of care as a basis and assuming all qualify for welfare medical care assistance

in the plan which the State must adopt by 1975 for all of its population who require medical care but cannot afford it according to the Title XIX requirements of the Social Security Law or otherwise the risk losing present Federal Government contributions to its present welfare programs, the following costs to the State were determined at present welfare rates for each level of care should all the residents be transferred to other boarding care and nursing homes from the Minnesota Veterans' Home.

NURSING HOME COSTS*
OF MINNESOTA VETERAN HOME MEMBERS TO STATE

Level of Care	Number of Residents Receiving Care	Maximum Total Cost 1/ Per Year	Maximum Cost To State Per Year 1/ (21% of Total)
Boarding Care 2/	341	$613,800	$128,900
Minimum	65	301,000	63,200
Moderate	23	106,400	22,400
Maximum	4	18,500	3,900
Exceptional	10	52,800	11,100
Total	443	1,092,500	229,500 ~~2,295,500~~

1/ Numbers rounded to nearest hundreds.
2/ Average monthly payment rate in 1968 is $150

* Total cost figures derived by multiplying highest maximum monthly payment rate within each welfare care category by total number of months in year to obtain a yearly cost per individual. Total yearly cost then multiplied by number of residents who qualified for that particular care level to obtain total yearly cost of care for all qualifying veterans in that category. Twenty one percent of that latter total cost was taken as State of Minnesota's share. See Chapter No. 8 E for Minnesota's welfare payments by county and by level of care.

By estimating the highest maximum yearly welfare payments within each category of care for the total number of residents in the Minnesota Veterans' Home who need such care, the total cost figure which includes county, State, and Federal contributions, should not exceed a maximum of $1,092,500 a year and can very well be below it. The State's share of this total cost for nursing home care should not exceed $229,500 per year and also can be less than this maximum figure.

The next problem which arises is concerned with the question as to the costs which the State of Minnesota might incur should it provide nursing care services to the veterans in a State nursing home. If the nursing care facilities were operated by the Department of Public Welfare, and if the veteran was eligible for medical assistance under the welfare laws, and required intensive care, he could be placed in a State nursing home at a rate, as of July 1968, of $330 per month, or $3,690 per year.

When the number of residents who require nursing care are categorized according to their yearly income, it was found that approximately 63 of the residents met the qualifying income limitation of the State's Medicaid Law. More specifically, the number of residents could be categorized within the following health care classifications:

MINNESOTA VETERAN HOME RESIDENTS
MEETING MEDICAID INCOME LIMITATIONS

Nursing Care	Number of Residents	Maximum Total Cost Per Year 1/ (Fed., State & County)	Maximum Cost to State Per Year 1/ (20% of Total)
Minimum	43	$199,200	$41,800
Moderate	10	46,300	9,700
Maximum	4	18,500	3,900
Exceptional	6	27,800	5,800
Total	63	$291,800	$61,200

1/ Number rounded to nearest hundred.

With approximately 63 of the residents qualifying under the present income limitation of the State's Medicaid Law, the total cost (Federal, State, and County contribution) would be approximately a maximum of $291,800 per year and could well be lower than this amount, of which the state's share would be approximately $61,200 and possibly less than this amount.

In the health care survey, conducted by the study contractor at the Minnesota Veterans' Home in June, 1968, it was found that four residents required maximum care and 10 required exceptional care -- the kind of intensive care furnished at the State nursing homes. The total cost per year to the State in furnishing the care would be $55,440 at the present charge rate.

If the State Veterans' Home has a State facility for furnishing nursing care, the formula for reimbursement would be determined by the law as enacted by the State Legislature. For example, if the welfare payment rate to the veterans nursing home was the same as existed in Hennepin County in March, 1968, the following maximum costs would be incurred by the State, assuming all the residents requiring nursing home care qualified for welfare.

NURSING HOME WELFARE COSTS IN HENNEPIN COUNTY

Level of Care	Number of Residents Requiring Care	Maximum Total Cost 1/ Per Year (Fed., State and County)	State Per Year 1/ (21% of Total
Minimum	65	$171,600	$36,000
Moderate	23	85,500	17,900
Maximum	4	14,900	3,100
Exceptional	10	52,800	11,100
Total	102	$324,800	$68,100

1/ Number rounded to nearest hundred.

These, in summary, are the various methods by which nursing home costs may be interpreted. The field of determining such institutional costs to a precise degree is still in its infancy because of the lack of uniform accounting procedures. However, the estimates made here can provide a framework within which rationale policy decision-making can be made pertaining to the health care of the veteran.

STATEMENT OF INCOME AND EXPENDITURE PER STATE OF MINNESOTA RECORDS
FOR THE 11 MONTHS COMMENCING JULY 1, 1967 AND ENDING MAY 31, 1968

	TOTAL PER DIEM	State	Canteen	Interest Account	Chaplain Fund	Endowment	Total
Admissions	1.07	134,903	5,197	206	-	-	140,306
Nurses & Medicine	1.26	165,178	-	-	-	-	165,178
Dietary	1.74	228,815	-	-	-	-	228,815
Laundry and Linen	.10	13,517	-	-	-	-	13,517
Housekeeping	.42	54,318	296	25	-	-	54,639
Plant Operations	1.51	159,782	17,235	15,826	-	4,895	197,738
Activities	.10	7,409	3,962	1,458	-	23	12,852
Chaplain	.07	8,622	-	-	208	-	8,830
Clothing	.01	929	-	-	-	-	929
Total in dollars	6.28	773,473	26,690	17,515	208	4,418	822,804

Source: Derived from data furnished by Office of Commandant. Minnesota State Veterans' Home, Minneapolis, Minnesota.

STATEMENT OF INCOME AND EXPENDITURES
PER STATE OF MINNESOTA RECORDS
FOR THE 11 MONTHS
COMMENCING JULY 1, 1967 AND ENDING May 31, 1968

RECEIPTS:	AMOUNT
State Appropriation	$305,250.88
Federal Aid	259,299.81
Member Maintenance	213,208.12
Employees Maintenance	12,283.08
Miscellaneous Receipts	2,007.40
TOTAL	$792,049.29

DISBURSEMENTS:	PERIOD	DAILY
Administrative & General	134,903.46	1.03
Nurses & Medical	165,177.73	1.26
Dietary	228,815.11	1.74
Laundry & Linens	13,516.65	.10
Housekeeping	54,318.47	.41
Plant Operation	159,781.79	1.21
Activities	7,408.56	.05
Chaplain	8,621.82	.07
Clothing	929.22	.01
TOTAL	$773,472.81	5.88

Average Daily Membership	391.17
Daily Per Capita Cost	5.88

STATE APPROPRIATION & DEDICATED RECEIPTS

			1 TOTAL	2	3 Admin & General	4 Nurses & Medical	5 Dietary	6 Laundry & Linens	7 House Keeping	8 Plant Operation	9 Activities	10 Chaplain	11 Clothing	12	13	
1	01	Salaries - Full time	4545339		689468	1108845	1151896	90000	463600	915434	55485	70656				1
2	04	Salaries - Board	36750		36750											2
3	07	Salaries - Unclassified	467865				135955			73191						3
4																4
5	10	Rentals	89416		89416											5
6	11	Advertising	770		770											6
7	12	Repairs & Maintenance	83197						83197							7
8	13	Bonds & Insurance	39778		39778											8
9	15	Pow State Employee Service	264377		44500	217500				2860		15562				9
10																10
11	20	Communications	37834		37834											11
12	21	Travel Expense	37745		37745											12
13	22	Freight & Express	6445				6445									13
14	23	Utility Service	1487534				488349			99185						14
15	24	Care of Persons	704370			704370										15
16	27	Liability Insurance	17850		17850											16
17	29	Laundry Service	67760			67795		45165								17
18																18
19	30	Stationery & Office Supplies	154487		154487											19
20	31	Gasoline & Oil	86467			86467										20
21	32	Medical & Hospital Supplies	1689378			1689378										21
22	33	Scientific & Educational Supplies	2300		2300											22
23	34	Clothing & Sewing	99795										9795			23
24	35	Provisions	9332705				9332705									24
25	37	Fuel - Heating & Cooking	2103031				110000			199363						25
26	38	Maint & Construction Materials	501085						27881	27889						26
27	39	Misc. Material & Supplies	132644			290610			30307	73255						27
28																28
29	41	Grants & Subsidies	186000								186000					29
30	43	Contributions	3989309		3989309											30
31	48	Employees Insurance	1136733		1136733											31
32																32
33	52	Motor Vehicles	9975							9975						33
34	53	Furniture & Fixtures	41000		41000											34
35	56	Other Equipment	118033			15543			33290	69200						35
36																36
37																37
38																38
39			77347781		1749034	1651773	2298151	1351665	543184	1597817	740856	86718	9795			39
40																40
			5.88		1.03	1.76	1.74	.10	.11	1.11	.05	.01	.01			

Canteen Account.

		1 Total	2 Food	3 Clothing	4 Shelter	5 Medical Care	6 Rec + Activities	7 Misc + Bldgs	8 Misc + Grounds	9 Misc + Furn + Equip	10 Admin Personnel	11 Admin All Other	12 Spiritual
01	Salaries - Full Time												
02	" - Part "												
03	" - Seasonal												
04	" - Board												
05	" - Med. Part Time	545066					135331				409735		
10	Rents	61752					61752						
11	Cdn + Publ												
12	Repairs	79677								79677			
13	Bond												
14	Prtg + Binding	60856					60856						
15	Non State Employee Serv.	65062			65062								
17	Tabulating												
20	Communications	8730					8730						
21	Travel Exp.												
22	Fuel Exp.												
23	Utility Service												
24	Care of Persons												
27													
29	Other Contractual Serv.	1100000									1100000		
30	Sta + Office	1017					1017						
31	Gas + Oil												
32	Med + Hosp Supp.												
33	Scientific + Educ.												
34	Clothing + Sewing												
35	Provisions												
37	Fuel												
38	Maint + Constr. Material	9673						9673					
39	Misc Materials + Supp	39678					39678						
40	Retail - Confections												
41	Grants	40000					40000						
43	Contributions	698464					698464						
51	Bldgs + Improvements												
52	Motor Vehicles												
53	Furniture + Furn.	1688776			1688776								
54	Educ + Scientific												
56	Other Equip	15000					15000						
82	Returns + Refunds												
		2669031			1713838		396158	9673		79677	409735	1100000	

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Chas E Thurman
6/7/68

Canteen & Coffee Shop

		1	2	3	4
7/1/67	Cash on hand and in bank			3015363	
	Receipts to 5/31/68			4466021	
				7481384	
7/1/67	Inventory		225725		
	Purchased to 5/31/68		2887383		
			3108108		
5/31/68	Inventory (Closing)		270110		
			7837998		
	Fixtures		266731		
	Cash on hand & in bank		1974635	7481364	

Interest Account

			1 Total	2 Food	3 Clothing	4 Shelter	5 Medical Care	6 Rec & Activities	7 Misc Gds	8 Misc Gds	9 Misc Equip	10 Admin Personnel	11 Admin all other	12 Spiritual	13
1	01	Salaries Full Time													
2	02	" Part Time													
3	03	" Seasonal													
4	04	" Board													
5	07	" Med.													
6	10	Rents													
7	11	Adv & Publ.													
8	12	Repairs													
9	13	Bonds													
10	14	Prtg & Bind.	1056					1056							
11	15	Non State Empl Serv.										Interest Acct			
12	17	Intel Clearing													
13	20	Communications										Bal 7/1/67	733901		
14	21	Travel Exp.										Seasonal	**		
15	22	Fuel & Exp.											733901		
16	23	Utility Service										Misc Income	17516 38		
17	24	Care of Persons										Cash Bal 5/31/68	583263		
18	27														
19	29	Other Contr. Servs	1500					1500							
20	30	Sta & Office													
21	31	Gas & Oil													
22	32	Med & Hosp Supplies													
23	33	Scientific & Educ Supp													
24	34	Clothing & Sewing													
25	35	Provisions													
26	37	Fuel													
27	38	Maint & Constr Materials	39080				15159							20621	
28	39	Misc Materials & Supp	133798				38971	92287			2536				
29	40	Retirement - Comptrs.													
30	41	Grants													
31	43	Contributions													
32															
33	51	Bldgs & Improvements													
34	52	Motor Vehicles													
35	53	Furniture & Furn.	12 11638				12 01393	4 0245							
36	54	Educ. & Scientific	10751					10751							
37	56	Other Equip	12350				12350								
38	84	Return of Advances											Clerk Statement 6/7/68		
39															
40		Total	175 1638				155 7613	115538			2536		20621		

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Chaplains Fund

			1 Total	2 Food	3 Clothing	4 Shelter	5 Medical Care	6 Rec. & Activities	7 Mtce of Bldgs	8 Mtce & Overhead	9 Mtce of Furn & Equip	10 Educ Personnel	11 Admn All Other	12 Spiritual	13
01	Salaries	Full Time													
02	"	Part Time													
03	"	Seasonal													
04	"	Board													
07	"	Unclass. Part Time													
10	Rents														
11	Adv & Publications														
12	Repairs														
13	Bonds														
14	Prtg & Binding														
15	Non State Employee Serv.														
17	Tabulating														
20	Communications														
21	Travel Expenses		9160											9160	
22	Frt & Express														
23	Utility Services														
24	Care of Persons														
27															
29	Other Contractual Serv														
30	Sta & Office Supps														
31	Gas & Oil														
32	Med & Hosp Supplies														
33	Scientific & Educ Supps		6012											6012	
34	Clothing & Sewing														
35	Provisions														
37	Fuel														
38	Maint & Constr. Materials														
39	Misc Material & Supplies		5600											5600	
40	Retirement - Compensation														
41	Grants														
43	Contributions														
51	Bldgs & Improvements														
52	Motor Vehicles														
53	Furniture & Furn														
54	Educ & Scientific														
56	Other Equipment														
82	Refunds of Deposits														
			20772											20772	

Balance 7/1/67 21233
Receipts 148772
140005
Disbursements to 5/31/68 20772
Cash Balance 5/31/68 169233

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Otto Sherman 6/12/68

			1 Total	2 Food	3 Clothing	4 Shelter	5 Medical Care	6 Rec. & Activities	7 Mtce of Bldg	8 Mtce of Grounds	9 Mtce of Furn. & Equip	10 Adm Personnel	11 Adm All other	12 Spiritual	13
1	01	Salaries Full Time													1
2	02	" Part Time													2
3	03	" Seasonal													3
4	04	" Board													4
5	07	" Ut. & Part Time													5
6	10	Rentals													6
7	11	Adv & Publications													7
8	12	Repairs													8
9	13	Bonds													9
10	14	Ortg & Binding													10
11	15	Non State Employee Svcs													11
12	17	Tabulating													12
13	20	Communications													13
14	21	Travel Expense													14
15	22	Freight & Exp.													15
16	23	Utility Service													16
17	24	Care & Persons													17
18	27														18
19	29	Other Contractual Svcs													19
20	30	Sta & Office Supplies													20
21	31	Gas & Oil													21
22	32	Med & Hosp													22
23	33	Laund Sew & Reduc													23
24	34	Clothing & Sewing													24
25	35	Provisions													25
26	37	Fuel													26
27	38	Maint & Constr Materials													27
28	39	Misc Materials & Supp	2375					2325							28
29	40	Retirement - Compensation													29
30	41	Grants													30
31	43	Contributions													31
32															32
33	51	Bldgs & Improvements													33
34	52	Motor Vehicles													34
35	53	Furniture & Furn	48960			48960									35
36	54	Educ & Scientific													36
37	56	Other Equipment													37
38	82	Returns of Deposits													38
39															39
40															40
			51785			48960		2325							

Cash Balance 7/1/69	86863
Deposits to 5/31	59553
	146386
Disbursed to 5/31	49785
Cash Balance 5/31/68	96601

V - A - 20

Ethel Sherman 6/27/68

This section of the report is concerned with the analysis of the tentative projection costs in the Minnesota Veterans' Home Study.

These alternatives include the following:

1. The Minnesota Veterans' Home and its actual cost as of now.
2. The Minnesota Veterans' Home in 1970.
3. An existing State facility as a veterans' nursing care home in 1970.
4. An existing State facility as a State nursing care home in 1970.
5. New construction of a veterans' home.
6. New construction of State nursing care home.
7. Sending all the residents in nursing care homes, assuming all need such care.
8. Sending all the residents to either boarding care or nursing care homes as their needs dictate.

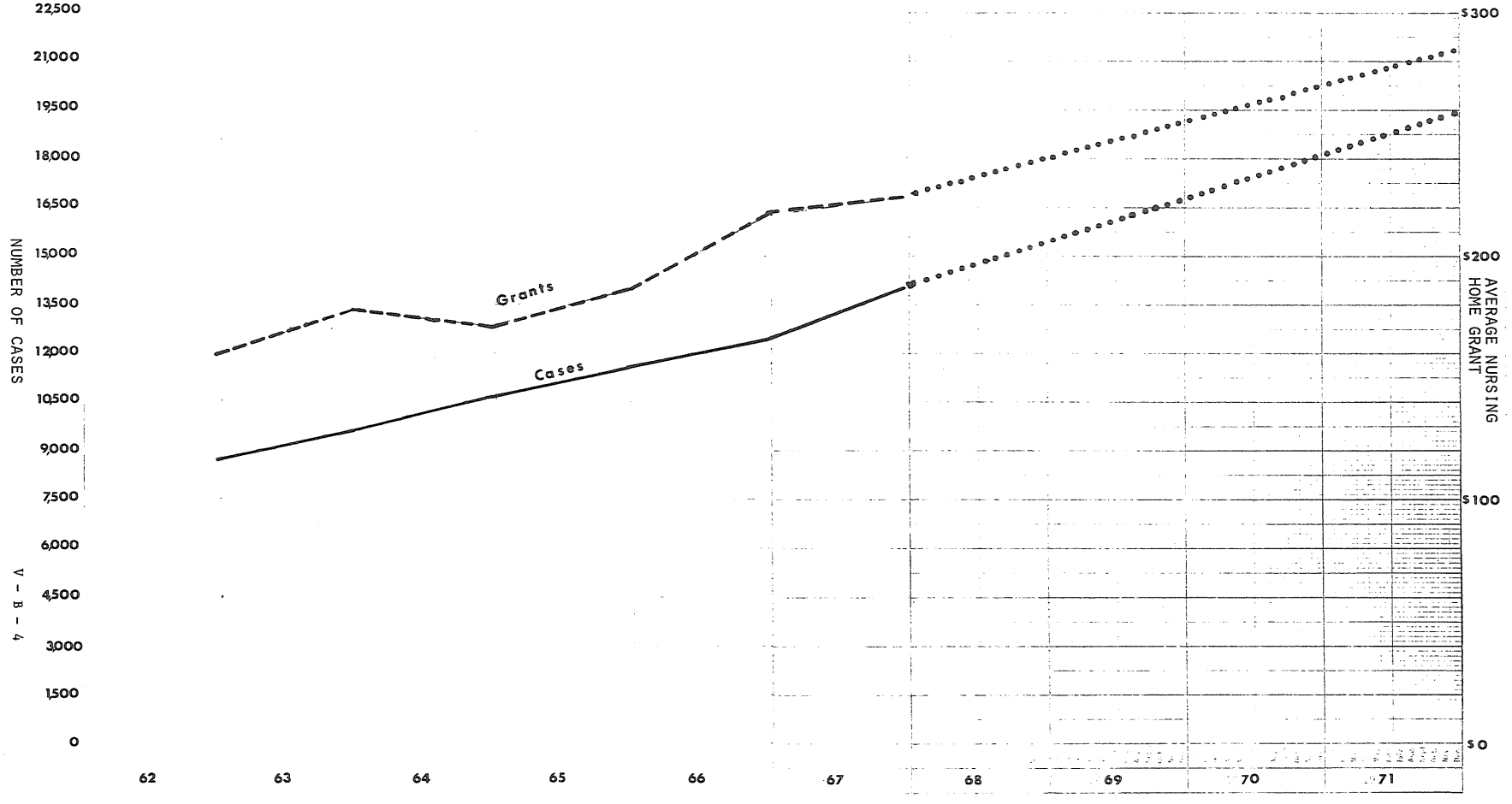
The greatest maximum cost ($2,348,400) which is shared among the various contributors as noted in the attached table, are encumbered by sending the residents to private nursing homes. The reason for this is because of the high range of welfare payments in each of the levels of care as defined by the Minnesota State Department of Welfare. These payments range from a high of $386 per month among minimum, moderate, and maximum care, and $440 per month in exceptional care in comparison to the $330 per month charged by the Minnesota Department of Public Welfare in its two State nursing homes and the average of a $150 a month which is paid for boarding home care, as of the spring 1968. As the attached graph demonstrates, the number of cases and grants for nursing home care has been

increasing at a high rate since 1963 in Minnesota. As can be noted from the attached table, the second greatest total cost ($1,980,000) are assumed among those alternatives pertaining to new construction of a State nursing home and/or veterans' home as well as making an existing State facility a Veterans' nursing home or a State nursing home. From the viewpoint of the State its greatest share of the cost ($1,169,200) is borne by the construction of a new veterans' home and making an existing State home into a veterans' nursing care facility. The least cost to the state is in sending the residents to a boarding care home or nursing home according to their need. The reason, as already mentioned, for these low costs is due to the fact that according to the forms still valid by the Minnesota Veterans' Home medical personnel, 77 percent of residents require boarding home care and only 23 percent require nursing home care. Under the Medicaid formula by which the state shares 21 percent of the payment cost and the county shares 21 percent of the payment cost with the Federal Government assuming 58 percent of the remaining cost of these welfare payments for those who qualify, the State has the second lowest cost burden in regard to an existing State facility as a nursing care home. The cost of constructing a new State home and new veterans' home will add to the State's share of $352,800 and $1,169,200, expended respectively for welfare patients and thus the figure is not comparable to the $352,800 and $1,169,200 incurred by the State for providing payments to patients in an existing State facility which serves either as a veteran or as a nursing care home. The U.S. Veterans Administration will contribute up to 50 percent of the construction costs for a State veterans' nursing care home which meets its

requirements and the Department of Health, Education, and Welfare will share up to 45 percent of the construction costs for a State nursing home. Similarly, the counties also experience the greatest financial burden where they must share 21 percent of the payment to private nursing care homes. On the other hand, they have the lowest cost when sharing in payments for residents who must go to either boarding care homes or nursing care homes according to their need, again because of the proportion of the residents (77 percent) who require boarding home care. Under the aforementioned formula the Department of Health, Education, and Welfare, of course, experiences the greatest financial burdens. This essentially is the summary of the implication of the various costs among the alternatives presented in this report.

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

TREND IN NURSING HOME CASES AND GRANTS
FROM DECEMBER 1962 THROUGH DECEMBER 1967
(PROJECTED THROUGH 1971)



PROJECTED COSTS OF ALTERNATIVES IN MINNESOTA VETERANS' HOME STUDY

Alternatives	COSTS: Total Yearly Cost	COSTS: Cost 1/ Per Person Per Year	COSTS: Cost 2/ Per Diem	SHARE OF COST CONTRIBUTED BY: State	U.S.-V.A.	HEW	Individual	County	Miscellaneous
MVH "As is" now (actual cost)	($) 822,400	($) 2,292	($) 6.28	($) 305,250	($) 259,300	($) -	($) 213,200	($) -	($) 44.650
MVH "As is" 1970	1,161,600 6/			434,100	364,800 7/	-	300,000	-	62,700
Existing State Facility As Veterans NCH 1970	1,980,000 8/	3,960 8/	10.85	1,169,200	510,800 9/	-	300,000	-	-
State Nursing Home Care 1970	1,980,000			352,800 10/	-	974,400 10/	300,000	352.800 10/	-
New Construction Veterans' Home	1,980,000 8/	3,960 8/	10.85	1,169,200	510,800 9/	-	300,000	-	-
New Construction State Nursing Home	1,980,000 11/			352,800 10/	-	974,400 10/	300,000	352,800 10/	-
Private Nursing Home Care	2,348,400 13/	4,632-5,280	12.69-14.47	367,200	-	1,014,000	600,000 12/	367,200	-
Private Nursing Home Care and BHC	1,232,800 14/	1,800-5,280	4.93-14.46	132,900	-	367,024	600,000 12/	132,900	-

Alternatives	U.S.-V.A. 3/ Boarding Care @ $2.50 Per Diem	U.S.-V.A. 3/ Nursing Home Care @ $3.50 Per Diem	Status of Minnesota 4/ Veteran Residents (%) Boarding Care	Nursing Care	Average Maintenance 5/ Charge To Minnesota Veterans' Home Resident Per Year	Minnesota Veterans' Home Residents: V.A. Authorized	Non V.A. Authorized	Total
MVH "As is" now (actual cost)	($) 912	($) 1,277	77%	23%	($) 600	291	63	354
MVH "As is" 1970	912	1,277	77%	23%	600	400	100	500
Existing State Facility As Veterans NCH 1970	-	1,277	-	100%	600	400	100	500
State Nursing Home Care 1970	-	-	-	100%	600	400	100	500
New Construction Veterans' Home	-	1,277	-	100%	600	400	100	500
New Construction State Nursing Home	-	-	-	100%	600	400	100	500
Private Nursing Home Care	-	-	-	100%	1,200	400	100	500
Private Nursing Home Care and BHC	-	-	77%	23%	1,200	400	100	500

MVH - Minnesota Veterans' Home
NCH - Nursing Care Home
BCH - Boarding Care Home
U.S.-V.A. - U.S. Veterans Administration
HEW - U.S. Department of Health, Education, and Welfare

PROJECTED COSTS OF ALTERNATIVES IN MINNESOTA VETERANS' HOME STUDY
FOOTNOTES

1/ Total cost per person per year derived by multiplying payments per month x 12 months per year.

2/ Per diem costs derived by dividing total costs per year by 365 days a year.

3/ Yearly payments for U.S. Veterans Administration domiciliary care ($2.50 per diem) and nursing care ($3.50 per diem) derived by multiplying the $2.50 and $3.50 per diem, respectively, by 365 days per year.

4/ Percent of boarding care residents and those requiring nursing home care derived from Minnesota Veterans' Home survey made by study contractor, June 1968 and tables cited on section pages V - A - 9 and V - A - 11.

5/ Average maintenance charges per resident derived by dividing total member maintenance payments, $213,208 (July - May 31, 1968) by number of members in home (354).

6/ Yearly cost derived under assumption cost per person would be proportionately the same in 1970 as in 1968.

7/ Represents $912 per domiciliary resident per year x 400 VA authorized residents per year.

8/ Yearly cost derived by multiplying $330, average charge to residents in Minnesota State Nursing Homes (spring, 1968) x 12 months = $3,960 per person per year. $3,960 multiplied by 500 persons to get $1,980,000.

9/ VA cost derived by multiplying $1,277 per year payments to VA authorized residents by 400 VA authorized residents.

10/ State, HEW, and County payments allocated by multiplying remaining amount to be paid by State, HEW and County upon deduction of $300,000 individuals' contribution to care according to formula of 21 percent State, 21 percent County, 58 percent HEW.

11/ Minimum costs will increase upon the addition of the construction costs when they are known.

12/ Individual cost determined by arbitrarily selecting $100 contribution by the individual per month for his care. The $100 per month x 12 months x 500 people = $600,000 per year.

Continued

FOOTNOTES (Cont'd.)

13/ Dollar amount of $2,348,400 determined as follows:

Level of Nursing Care	No. of Residents Receiving Care	% of Residents Receiving Care	Maximum Welfare Payment by Level of Care Per Month	Per Year	Total Costs by Level of Care
Minimum	318	63.7	$386	$4,632	$1,473,000
Moderate	112	22.5	386	4,632	518,800
Maximum	20	3.9	386	4,632	92,600
Exceptional	50	9.9	440	5,280	264,000
				Total	$2,348,400

14/ Dollar amount of $1,232,800 determined as follows:

Level of Nursing Care	No. of Residents Receiving Care	% of Residents Receiving Care	Maximum Welfare Payment by Level of Care Per Month	Per Year	Total Costs by Level of Care
Boarding Care	385	77.0	$150*	$1,800	$ 693,000
Minimum	74	14.7	386	4,632	342,800
Moderate	26	5.2	386	4,632	120,400
Maximum	4	0.9	386	4,632	18,500
Exceptional	11	2.2	440	5,280	58,100
				Total	$1,232,800

*Average Minnesota Boarding Care payments as of spring 1968.

SELECTION CRITERIA - STATE VETERANS' HOME OF MINNESOTA: OVERVIEW REQUIREMENTS OF THE CRITERIA

What is "Criteria for Selection"?

It is the frame of reference upon which optimal decisions are based and are determined or selected from a range of alternatives available to the decision-maker(s).

Basic Requirements for Functional Criteria:

Premises

1. That all elements or paramenters (boundaries) for the selection are based upon a range of long term, short term, or interim needs best suited to the situation or optimum goals.
2. That the goals are expressed in terms of the nature of master planning which requires a large amount of flexibility to allow for unforeseen environmental requirements change. The desirable premise is that all decisions taken together, based upon a scientific platform and methodology, optimally will generate a controllable situation in a given future time frame.
3. That the decisions are based upon the State of the Art, in terms of requirements, as to what is best for people. People are the basis of consideration for the institutions validity; e.g., patient care is a goal incorporated into a Health Delivery system. Included in what is best for people is the functional descriptions from each of the multi-disciplinary inputs for the existence of the institution and its populations synthesis into a proper working system.

(a) Psychological and Sociological

Does this institution provide dignity, intimacy and hope for the individual member? What is the level of Social Freedom and constraint? The System selected (depending upon the level of care to be provided) by policy of the state as mission (or goals) for people to achieve must answer affirmatively the following questions:

(1) Is it the best social unit of configuration, by number and function, for this goal?

e.g.: If it is determined to be the best social unit by configuration, number, and function, it must achieve the following State of the Art level in flexibility:

FACILITIES
PROGRAM
SITE
OPERATIONS

(1-a) Can the individual have privacy?

(1-b) Can small intimate groups be achieved?

(1-c) Can these small intimate groups have social intercourse with larger social groups easily?

(1-d) Can these larger social groups share a social intercourse with the central system easily?

(1-e) Does the individual (as a social unit) have privacy? (yes) (dignity) (How) Single room space for the same total dollar cost via trade off systems; e.g., proper use of productive footage by reduction of circulation footage to composite (double-duty) common

spaces that also provide circulation as well as other functions per (State of the Art in modern planning).

(1-f) Does the individual feel not lost by location and status? Does he feel equality and sensitivity to a desirable environment in his accomodations?

(1-g) Does he have good light, air, view (physical outlook) by scientific function and aesthetic need?

(1-h) Does he have an adequate place for his memorabilia and personal effects?

(1-i) Does he have a living program capability and function in this configuration that includes his ability to live as normally as he is able? This incorporates the medio-psychological aspects of living. i.e.: Can he have access in, say a small group, to bake a cake or to prepare a sandwich in an improved controlled food service system. (Food is a known important therapy factor particularly with respect to its freedom in choice and use). This is in addition to programmed hot food systems. Can he get together with two or three instead of several hundred?

(1-j) Do the facilities lend themselves to flexibility as to future and interim recreation demands on the ambulatory from a proper program of living?

i.e.: Shuffleboard, cards, green houses and gardens, exercising constructs for therapy in games, bowling greens, etc.) without long distances and are the members protected and able to function in inclement weather?

(1-k) Does the facility program provide for ease of achieving health care? Are the members able to have a "progressive" concept easily implemented?

e.g.: Because a concept has individual spaces or places a member may call his own he also has isolation for semi-ambulatory or a half-way situation that is better than his being at this unnecessary stage moved to the health unit. Disease control is immensely aided as well.

(1-l) Does the location, name and function of the institution not degrade his status or hope for the future (dignity)?

i.e.: Some institutions or sites, by use or function by history and lack of proper public education provides an obstacle for aiding his program for living by stigma, etc.

4. What are the goals and policy, in terms of the level of care, that ought to be provided the members of the Veterans' Home? The following are alternative levels of care the state could provide:

   (a) Just a minimum facility for eating and sleeping. (Domiciliary minimum).

   (b) A facility that has a modified program for living that offers some recreational program as well as rehabilitative or, somewhere, interim to extremes. It includes a nursing home facility and includes all members.

   (c) A complete restorative (and rehabilitative) program for living in addition to domicilliary. This program includes an expanded medical program (nursing home), in addition to contracted, and for affiliated services with other institutions covering all categories of care for the aging eligible members.

   (d) Any level in-between these extremes as defined by a program for living.

   In the context of either of the above the foregoing elements of criteria must be considered:

Community: (F.P.S. & O.)*

1. Does the concept meet the requirements of good planning by function of land use in the community? (Why by narrative?)

*Facilities, Program, Site and Operations.

i.e.: The zoning allows this use by history and the fact that it fits the maximum limiting program by master plan as to not overburden the community by uncontrolled expansions and misuses. Is this use acceptable to the community?

Transportation: (F.P.S. & O)

1. Is this site adequately served by public transportation? Is it the kind of transportation usable by the aging?
2. Does this site have adequate parking available for its optimal master plan?
3. Does it have easy access to autos?
4. Are automobiles restricted to special area site use? or, Is it designed for the people intended?
5. What changes are anticipated in future transportation systems?
6. Does the program of the home provide adequate service transportation and does it have proper access and control?

Master Planning: (F.P.S. & O.)

1. Does the maximum absorption of people and space requirements, by function, stay below the limits of proper site utilization? (Yes).

   i.e.: Proper site utilization is here defined as the use of the land to its maximum capabilities or potential without detriment to flow of people, nature (green spaces), services, autos, public access and transportation, operations, utilities, mission service to people by function and the development of an optimal physical and mental environment.

2. Can the facilities be properly phased (operationally sound) in a construction time frame by manageable units for an institutional psycho-social (program for living) need?
3. Are all segments of involvement and members and staff least affected by the phasing of construction in this concept?

   i.e.: Least means people, time, money and program affected in the minimum way to greatest overall cost effectiveness.
4. Can the service and support (medical) areas be expanded to meet additional program developments not anticipated?
5. Can the domiciliary areas be expanded easily to the optimal site absorption level?
6. Can the facilities planned in this concept be changed to meet any reasonable future need? To what level of flexibility is the space to be planned? Is it helped in this concept?
7. Does the land planning allow for retention of park-line qualities and a de-institutionalized atmosphere (potential for design)?
8. Can the program be changed and leave the facilities generally unaffected? What other uses could this concept serve if implemented?
9. Does the limitation of this site by maximum number (absorption) space, and function harm the master planned program of overall service area need or would a larger site best serve?
10. Is the site able to take several concepts or one or two? (Alternative limiting)
11. Does the land configuration of the site help or limit this concept (due to the change in levels)?

Cost Effectiveness - Trade-Off System

The criteria for cost effectiveness of a given concept for the Home shall include the following parameters for consideration:

1. Cost of operations for the approved program of consideration projected for first year; second year. These costs shall include all fees, all expenses, all costs of maintenance, replacement, incidental and related, legal, consultative, start-up, financing, downtime, etc.
2. The cost of operations of each alternative shall be compared on all overall basis for cost effectiveness. The alternative that satisfies the approved level of care program of requirements that can be produced for the most cost effective alternative shall be recommended.
3. The costs of facilities shall not be regarded for selection only upon its own cost merits but upon all considerations valid for site, facilities, program, and operations taken together as an integrated system.
4. "Pay-back". It is expected that the highest "yield" for "return" on the states' "investment" shall consider the approved level-of-care program of requirements, psycho-social, political constraints and implications as well as the other cost effective considerations. "Pay-back" must be considered on all levels and answer the posed questions affirmatively. "Does the state, by this recommended alternative, effect a step forward economically, socially, politically, medically,

and as a contribution to aging simultaneously? If the answer is "no" then what level of compromise is acceptable?

The selected level of compromise shall be weighted to the cost effective and pay-back basis in terms of these priorities:

A. Operations (.40)

B. Program (.30)

C. Facilities (.20)

D. Site (.10)

The criterial judgement for weighting shall be done by professional concensus based upon statistical analysis of need.

Trade-Off System

The level of care mission achievement often is determined out of the distribution of the total dollars available for expenditure in a given time frame.

Much of the success of this trading of "shifting" of dollars within the economics of operations, program, facilities, and site comes within the detailed determination of concepts:

Example: A trade-off item relating to facilities but affecting operations and program is the achievement of say carpeting (an an "acoustical environment") over asphalt tile within the same overall cost budgeting (programmed). The maintenance is 1/3 less (if more areas are carpeted) with properly specified material, installation factor, and maintenance, thus affecting operations. The achievement of "acoustical environment"

aids the program for living materially psychologically and socially. The dollar shift required to achieve this involves the quantifying of all items within the facility and program in a proper synthesis in order to meet the mission requirements.

The weighting for decisions shall be the same as above for the determination (on an overall cost effective basis) as it applies to trade-off systems. The selection of say "carpeting" over asphalt tile is dependent, therefore, upon the operational cost (.40) out of 1.0; program benefit (.30) out of 1.0; facilities (acoustical environment concept) (.20) out of 1.0; and site affect (if applicable .10 out of 1.0).

GENERAL AREAS OF INDUCTIVE CONCERN

Five general areas of evaluation were utilized in connection with determining the most appropriate alternative or set of alternative recommendations. Each area was assigned a numerical value* as determined by the degree of its particular importance to the overall evaluation. They are:

Area I - Program

Area II - Facility

Area III - Operations

Area IV - Site

Area V - Secondary Determinants

Area I

"Program" deals with the established program of the institution as it relates to the long-range planning on the care of the aging Minnesota veteran.

The existence and utilization of a program is and must be a prime requisite of any institution dealing with the varying aspects of geriatrics.

Relating to Charts A through D, Area I includes:

Column 1. Degree of "Flexibility in the Level of Care Capabilities" within the selected facility. (This portion answers the question: Are there

* These weights were assigned by the consulting team and are based upon extensive practical experience with evaluations of this kind.

sufficient unfettered avenues allotted for change from one level of care to another (i.e., domiciliary to rehabilitation) in accordance with changing requirements including maintenance of the dignity of the individual member?

Column 2. "Time to Implementation" refers to that period of time required to change or incorporate a particular level of care into an established program. (In essence, this portion complements the "flexibility" of the program.)

Column 3. "Existing Program" refers to the existence or non-existence of a program of action as it relates to the institution and/or individual member.

Area II

Column 4. "Facility" deals with the "one time" cost of a facility to the State.

If a usable facility currently exists, it would be considered "most desirable" to the State economically, as opposed to "least desirable" if the State was required to build a new one.

A proper facility is important in carrying out the specificities of the overall program.

Area III

"Operations" is concerned with the day-to-day activities

necessary to any on-going organization. More specifically, this area refers to the "current experience" of the alternative policy-making originators (i.e., the Veterans' Home Board, Department of Public Welfare, Department of Veterans' Affairs) under the following headings:

Column 5. "Existing Experience in Welfare Programs"

Column 6. "Existing Experience in Veterans' Affairs"

Column 7. "Existing Experience in Nursing Home Care"

Column 8. "Existing Experience in Domiciliary Care"

Column 9. "Existing Personnel Capability" (sufficient number and degree of proficiency each employed person has in carrying out the requirements of the program).

Column 10. "Difficulty of Conversion" (refers to the degree of effort required to incorporate or modify all operations, procedures, rules and regulations in line with any new policy formulation).

"Operations" are not as heavily weighted for the purpose of this evaluation as is the "program." Its value approximates that of "facility," but to a somewhat lesser degree.

Area IV

Column 11. "Site" refers to 'one-time cost' of a particular site to the State.

If the site is existent, it would be "most desirable" to the State economically, as opposed to "least desirable," if the State was required to purchase an alternate site at a new location.

Area V

Secondary determinants necessarily include those informal factors relevant to the decision-making processes concerning the selection of a particular course of action.

The following key items have been included in the overall evaluation as determined by the consulting teams' observations, interviews, and correspondence received during the course of this investigation. They are:

Column 12. "Political Impact," which includes evaluation from those other than veteran service organizations.

Column 13. "Political Impact," as perceived by veteran service organizations and related interested parties.

Column 14. "Public Transportation," refers to the level of availability to members desirous of limited travel to close-by business, cultural, or recreational areas.

Column 15. "Vox Populi," refers to the views of the individual members as received in response to the individual member's request for comments on the existing Home, as well as personal interviews with selected members.

Assignment of Numerical Values

Two steps were utilized to determine the final numerical value of each of the listed potential plans of actions.

The value system of step one (Charts A, B, C, D) is indicated below:

(a)	(b)	(c)
Least	5	most desirable
Degree	4	very good
of	3	acceptable
Difficulty	2	usable or bearable
Maximum	1	least desirable or not acceptable for alternative

The "Degree of Difficulty" column, (a), refers primarily to the two columns of "Implementation" and "Conversion" in Areas I and III, respectively. The greater the score, the less difficulty in "implementing" or "converting."

Column (c) is self-explanatory; the greater the numerical value, the greater the desirability of the particular item's utility and/or acceptance.

The value system of step 2 (Charts A, B, C, D) is based on the following scale:

Program 8

Facility 5

Operations 4

Site 2

Secondary Determinants 1

The "program" is of primary importance but not the total answer. It necessarily received the heaviest weighting.

The "facility" is considered the next item of importance but is closely assessed as being equivalent to operations. The point value difference between "program" and "facility" is not as great as that between "program" and "operations", which indicates the former is twice the importance of the latter.

The same evaluation is evident in the difference in the comparison of "operations" to "site" to "secondary determiants."

Program Descriptors

Four major overall program descriptors as related to the Program, Operations, Site, and Facility aspects of this study, were utilized in deriving the listed potential courses of action.

These major headings consist of the following:

A. "Domiciliary only" with nursing home care operations being handled by the Department of Public Welfare or Department of Veterans' Affairs.

B. "Mixed" program undertakes a combined geriatrics service-oriented methodology, i.e., both domiciliary and nursing home care operations.

C. "Restorative-Rehabilitative" program which would provide a total approach to the care of the aging.

D. "Refranchised" program which would infer the phasing out of the Home, through systematic relocation of the entire aging "Home population" in line with individual physiological and psychological needs, to existing or planned programs under the control of a publically

controlled organization (i.e., Public Welfare, Veterans' Affairs) or that of a privately owned and operated (i.e., Veterans' service organization) establishment.

With the exception of the refranchised program, each of the above major program descriptors received further individual evaluation.

Each potential policy-making and overall controlling body or agent received appropriate consideration by the same program, operations, facility, site and secondary determinant criteria.

Those controlling and policy-making agents were four in number:

I. Veterans' Home Board

II. Department of Public Welfare

III. Department of Veterans' Affairs

IV. Veterans' Service Organizations

Responsible Agents - Subareas of Facility and Site

Eight subareas directly concerned with facility and site relationships were developed and evaluated according to the criteria established in the five general areas (program, facility, operations, site, secondary determinants).

Referring to Chart A - Domiciliary (Only), subitems 1 through 8 represent the developed relationships indicated above. The same eight subitems appear under each of the four policy-making bodies or agents being evaluated. A brief interpretation of each is in order.

1. "Same Building and Site - As Is" - refers to the existing structures at the Minnesota Veterans Home without an improvement or relocation.
2. "New Building" - "Whole Site" - refers to construction of a new building (s) utilizing the entire site at the Minnesota Veterans Home.
3. "New Building" - "Half-Site" - refers to the same as item 2 except only half the existing site is utilized with the remainder being turned back to the State for supplemental utilization.
4. "New Building" - "New Existing State Land" - refers to items 2 and 3 above, except the present site would be abandoned with relocation and new construction on currently owned State Land elsewhere in the State.
5. "New Building" - "New Land Acquisition" - would necessitate acquisition of land not currently owned by the State upon

which a new building(s) would be constructed. Naturally, this would require considerable expenditures on the part of the State.

6. "Another Existing Building and Site - (i.e., Anoka, etc.) - Äs Is" - refers to the utilization of an existing building and site, such as Anoka, Hastings, etc., in an "as is" condition. No structural changes or alterations of the building or site would be considered. This item necessarily implies a total relocation of the Minnesota Veterans' Home members to the selected area. The existing facility and site of the Home would be abandoned and turned over to the State for other purposes.
7. "Another Existing Building and Site - Modernize" refers to item 6 above, except the existing building would require certain renovations or modernization of existing facilities.
8. "Another Existing Building and Site - Additions" - refers to items 6 and 7 above, except the existing buildings would receive certain structural and/or architectual additions or enlargements as deemed necessary.

Additional Chart Data - Assumptions

The following series of charts represent evaluated alternatives from various points of view. Two basic assumptions have been made based on professional evaluation of two of the series of alternatives that are possible.

First - Alternate number 1 - The use of the same "facility" and site in its "As Is" condition, under the control of any policy-making agents (Veterans' Home Board, Public Welfare, etc.), is not feasible because of the economics of repair involved. In its present condition it is unusable for any program which should provide "proper and dignified care" for the Minnesota Veteran. It is our recommendation that this alternative not be considered.

Second - On-site examinations of "alternative sites-facilities" currently existant within the State, have resulted in the final determination that they are unusable in their "As Is" condition. (Two of the sites visited and evaluated are located at Hastings and Anoka.) Ideally, if a suitable facility-site interface exists, these alternatives should be reevaluated according to the indicated selection criteria. Appropriate consideration, however, should be given to an alternative facility provided one could be found within a reasonable period of time, to enable the State to carry out its implied policy to the aged veteran population.

We have, therefore, ruled out the set of alternatives dealing with the "As Is" conditions of known existing facilities within the State.

Other Comments and Determining Factors

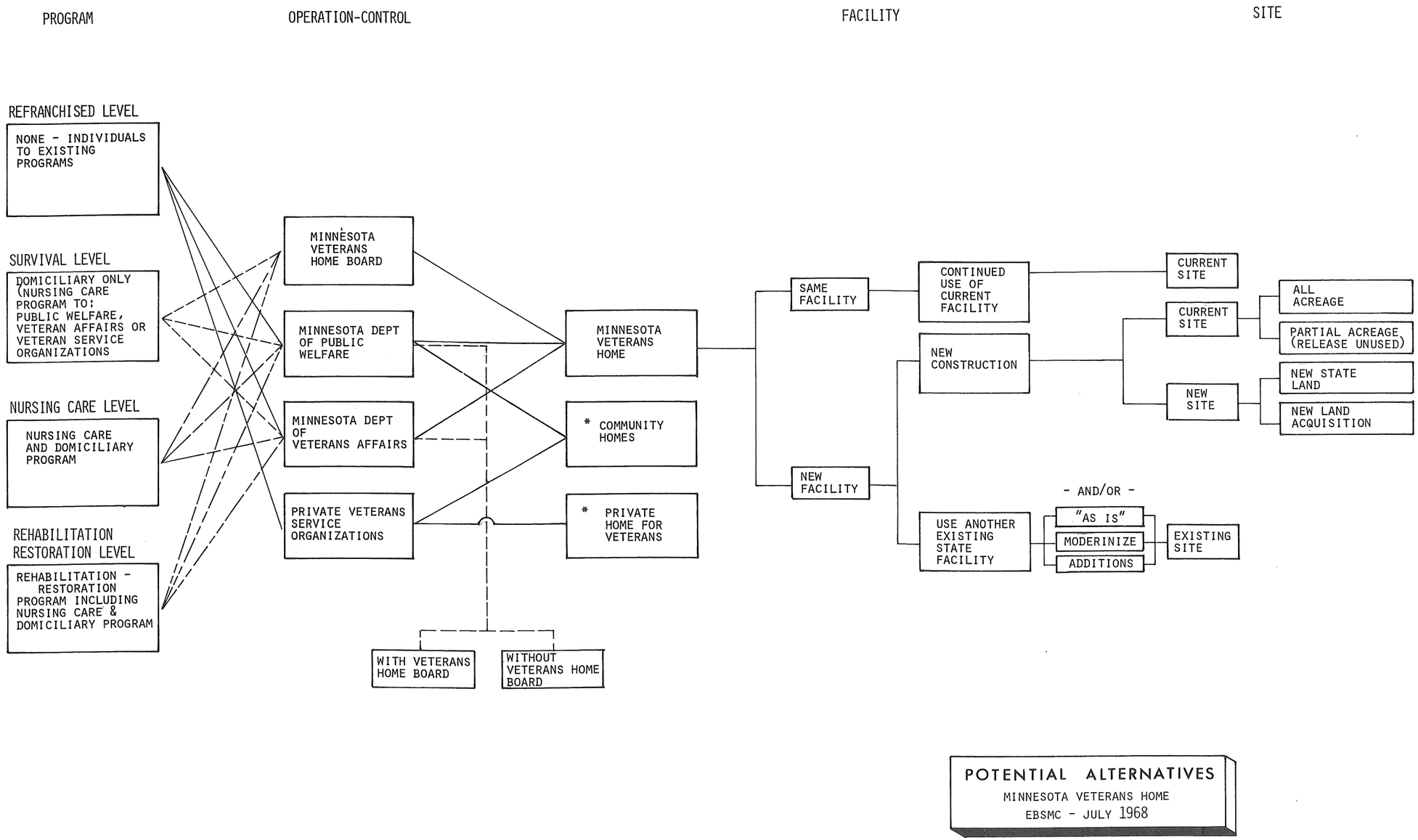
If the State of Minnesota decides there should no longer be a dedicated Minnesota Veterans' Home, it is assumed the present Board of Trustees would be eliminated and the "refranchised" program would go into effect.

The "Home" members would, thus, revert to the control and jurisdiction of one of three groups:

1. The Department of Public Welfare;
2. Department of Veterans' Affairs; or the
3. Veterans' Service Organizations.

The individual who is now a member of the Home, or a potential member of the Home, in its current state, would then have a choice to seek aid from the Department of Public Welfare, or the Department of Veterans' Affairs, or from his own Veterans' Service Organization. Under no circumstances should it be considered that the individuals would be totally abandoned per se by the State. Rather, it would be incumbent upon the State to provide guidance for the individuals (as they do at the present time) for each who has expressed the desire and need for aid and assistance.

Concerning the control of members by the Veterans' Service Organizations, this group may wish to consider this alternative as part of a new program they may wish to develop: one in which they would erect and operate a private facility for the care of the aging veteran according to existing State and Federal regulations. This, in essence, would be a return to an earlier philosophy of a "family taking care of its own". Under this form of program, reimbursement from the Federal Government and the State could be expected, provided existing regulations incumbent upon such a private facility were adhered to. This type of action would be a return to the philosophy of "individual responsibility", and a move away from the sphere of governmental paternalism.



*STATE NOT RESPONSIBLE FOR OPERATION.

ALTERNATIVES

Introduction

The format utilized in the determination of the alternative approaches effecting the future of the Home has been discussed previously in Chapter VI. Charts included in the latter section of that portion of the report identified the four major programs and final numerical values received by each alternative plan-of-action listed under each major section.

The four major areas were concerned with the following types of programs:

A. Domiciliary Only

B. Mixed - Nursing Home/Domiciliary Care

C. Rehabilitative - Restorative

D. Refranchised

A. Domiciliary Only

A.		Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
		PROGRAM (3)			FACILITY (5)	OPERATIONS (4)						SITE (2)	SECONDARY (1)				
I.	(Veterans' Home Board)																
1.	Same Bldg./Site - "As Is"	8	40	16	5	12	12	8	12	8	20	10	1	1	4	2	159
2.	New Bldg. - "Whole-Site"	40	24	8	10	12	12	8	12	4	8	8	3	5	4	5	163
3.	New Bldg. - "Half-Site"	40	24	8	10	12	12	8	12	4	8	8	4	2	4	5	161
4.	New Bldg. - "New Existing State Land"	40	24	8	10	12	12	8	12	4	8	2	2	2	3	2	149
5.	New Bldg. - "New Land Acquisition"	40	16	8	10	12	12	8	12	4	4	2	1	2	3	2	136
6.	Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	40	8	5	12	12	8	12	4	12	10	4	1	2	1	163
7.	Another Existing Bldg./Site - "Modernize"	32	32	8	20	12	12	8	12	4	12	10	4	1	2	1	170
8.	Another Existing Bldg./Site - "Additions"	40	32	8	15	12	12	8	12	4	8	10	4	1	2	1	169
II.	(Department of Public Welfare)																
9.	Same Bldg./Site - "As Is"	8	32	32	5	20	12	20	20	16	12	10	1	1	4	2	195
10.	New Bldg. - "Whole-Site"	40	24	32	10	20	12	20	20	16	8	8	1	1	4	4	220
11.	New Bldg. - "Half-Site"	40	24	32	10	20	12	20	20	16	8	8	1	1	4	4	220
12.	New Bldg. - "New Existing State Land"	40	24	32	10	20	12	20	20	16	8	2	1	1	3	2	211
13.	New Bldg. - "New Land Acquisition"	40	8	32	10	20	12	20	20	16	4	2	1	1	3	2	191
14.	Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	32	32	25	20	12	20	20	16	16	10	5	1	2	1	244
15.	Another Existing Bldg./Site - "Modernize"	32	32	32	20	20	12	20	20	16	12	10	4	1	2	1	234
16.	Another Existing Bldg./Site - "Additions"	40	32	32	15	20	12	20	20	16	12	10	3	1	2	1	236

A.-continued

A. III. (Department of Veterans' Affairs)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
17. Same Bldg./Site - "As Is"	8	32	8	5	8	16	4	4	8	8	10	3	5	4	4	127
18. New Bldg. - "Whole-Site"	40	24	8	10	8	16	4	4	4	4	8	3	5	4	5	147
19. New Bldg. - "Half-Site"	40	24	8	10	8	16	4	4	4	4	8	3	5	4	5	147
20. New Bldg. - "New Existing State Land"	40	24	8	10	8	16	4	4	4	4	2	3	5	3	2	137
21. New Bldg. - "New Land Acquisition"	40	16	8	10	8	16	4	4	4	4	2	3	5	3	2	129
22. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	24	8	25	8	16	4	4	4	4	10	3	2	2	2	148
23. Another Existing Bldg./Site - "Modernize"	32	24	8	20	8	16	4	4	4	4	10	3	2	2	2	143
24. Another Existing Bldg./Site - "Additions"	40	16	8	15	8	16	4	4	4	4	10	3	2	2	2	138

B. Mixed (Nursing Home Care and "A")

	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
B.I. (Veterans' Home Board)																
25. Same Bldg./Site - "As Is"	8	16	8	10	12	12	8	12	8	4	10	1	1	4	2	116
26. New Bldg. - "Whole-Site"	40	24	8	10	12	12	8	12	8	8	8	3	5	4	5	167
27. New Bldg. - "Half-Site"	40	24	8	10	12	12	8	12	8	8	8	4	3	4	5	166
28. New Bldg. - "New Existing State Land"	40	24	8	10	12	12	8	12	8	8	6	2	2	3	2	157
29. New Bldg. - "New Land Acquisition"	40	8	8	10	12	12	8	12	8	4	2	1	2	3	2	132
30. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	32	8	25	12	12	8	12	8	12	10	4	1	2	1	179
31. Another Existing Bldg./Site - "Modernize"	32	32	8	20	12	12	8	12	8	12	10	4	1	2	1	174
32. Another Existing Bldg./Site - "Additions"	40	24	8	15	12	12	8	12	8	8	10	4	1	2	1	165
B.II. (Department of Public Welfare)																
33. Same Bldg./Site - "As Is"	8	32	32	10	20	12	20	20	16	16	10	1	1	4	2	204
34. New Bldg. - "Whole-Site"	40	24	32	10	20	12	20	20	16	8	8	1	1	4	3	219
35. New Bldg. - "Half-Site"	40	24	32	10	20	12	20	20	16	8	8	1	1	4	3	219
36. New Bldg. - "New Existing State Land"	40	24	32	10	20	12	20	20	16	8	6	1	1	1	2	213
37. New Bldg. - "New Land Acquisition"	40	8	32	10	20	12	20	20	16	4	2	1	1	3	2	191
38. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	32	32	25	20	12	20	20	16	16	10	5	1	2	1	244
39. Another Existing Bldg./Site - "Modernize"	32	32	32	20	20	12	20	20	16	12	10	4	1	2	1	234
40. Another Existing Bldg./Site - "Additions"	40	24	32	15	20	12	20	20	16	12	10	3	1	2	1	228

B.- continued

B.III. (Department of Veterans' Affairs)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
41. Same Bldg./Site - "As Is"	8	24	8	10	8	16	4	4	4	8	10	3	5	4	4	120
42. New Bldg. - "Whole-Site"	40	24	8	10	8	16	4	4	4	4	8	3	5	4	5	147
43. New Bldg. - "Half-Site"	40	24	8	10	8	16	4	4	4	4	8	3	5	4	5	147
44. New Bldg. - "New Existing State Land"	40	24	8	10	8	16	4	4	4	4	6	3	5	3	2	141
45. New Bldg. - "New Land Acquisition"	40	8	8	10	8	16	4	4	4	4	2	3	5	3	2	121
46. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	32	32	8	25	8	16	4	4	4	4	10	3	2	2	2	156
47. Another Existing Bldg./Site - "Modernize"	32	32	8	20	8	16	4	4	4	4	10	3	2	2	2	151
48. Another Existing Bldg./Site - "Additions"	40	24	8	15	8	16	4	4	4	4	10	3	2	2	2	146

C. Rehabilitation and Restoration

	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
C.I. (Veterans' Home Board)																
49. Same Bldg./Site - "As Is"	8	8	8	5	4	4	4	4	4	4	2	1	1	1	1	59
50. New Bldg. - "Whole-Site"	40	24	8	10	12	12	4	12	4	4	8	4	4	4	5	155
51. New Bldg. - "Half-Site"	40	24	8	10	12	12	4	12	4	4	8	3	3	4	5	153
52. New Bldg. - "New Existing State Land"	40	24	8	10	12	12	4	12	4	4	6	2	2	3	2	145
53. New Bldg. - "New Land Acquisition"	40	8	8	10	12	12	4	12	4	4	2	1	2	3	2	124
54. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	24	32	8	20	12	12	4	12	4	4	10	4	1	2	1	150
55. Another Existing Bldg./Site - "Modernize"	32	32	8	15	12	12	4	12	4	4	10	3	1	2	1	152
56. Another Existing Bldg./Site - "Additions"	40	24	8	10	12	12	4	12	4	4	10	3	1	2	1	147
C.II. (Department of Public Welfare)																
57. Same Bldg./Site - "As Is"	8	8	8	5	4	4	4	4	4	4	2	1	1	1	1	59
58. New Bldg. - "Whole-Site"	40	24	40	10	20	12	16	20	16	12	8	1	1	4	5	229
59. New Bldg. - "Half-Site"	40	24	40	10	20	12	16	20	16	12	8	1	1	4	5	229
60. New Bldg. - "New Existing State Land"	40	24	40	10	20	12	16	20	16	12	6	1	1	3	2	223
61. New Bldg. - "New Land Acquisition"	40	8	40	10	20	12	16	20	16	12	2	1	1	3	2	203
62. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	24	32	40	20	20	12	16	20	16	12	10	4	1	2	1	230
63. Another Existing Bldg./Site - "Modernize"	32	32	40	15	20	12	16	20	16	12	10	3	1	2	1	232
64. Another Existing Bldg./Site - "Additions"	40	24	40	10	20	12	16	20	16	12	10	2	1	2	1	226

C. - continued

C.III. (Department of Veterans' Affairs)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
65. Same Bldg./Site - "As Is"	8	8	8	5	4	4	4	4	4	4	2	1	1	1	1	59
66. New Bldg. - "Whole-Site"	40	24	8	10	8	16	4	4	4	4	8	1	5	4	5	145
67. New Bldg. - "Half-Site"	40	24	8	10	8	16	4	4	4	4	8	1	5	4	5	145
68. New Bldg. - "New Existing State Land"	40	24	8	10	8	16	4	4	4	4	6	1	5	3	2	139
69. New Bldg. - "New Land Acquisition"	40	8	8	10	8	16	4	4	4	4	2	1	5	3	2	119
70. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	24	32	8	20	8	16	4	4	4	4	10	1	5	2	1	143
71. Another Existing Bldg./Site - "Modernize"	32	32	8	15	8	16	4	4	4	4	10	1	5	2	1	146
72. Another Existing Bldg./Site - "Additions"	40	24	8	10	8	16	4	4	4	4	10	1	5	2	1	141
D. Refranchised Program																
D.I. 73. Public Welfare		40	40	25	20	12			20	20	10	5	1		2	195
D.II. 74. Veterans' Affairs		32	40	25	12	20			20	12	10	3	4		2	180
D.III. 75. Veterans' Service Organizations		24	32	25	8	20			20	12	10	4	5		2	162

A'

	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
A. I. (Veterans' Home Board)	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
1. Same Bldg./Site - "As Is"	1	5	2	1	3	3	2	3	2	5	5	1	1	4	2	40
2. New Bldg. - "Whole-Site"	5	3	1	2	3	3	2	3	1	2	4	3	5	4	5	46
3. New Bldg. - "Half-Site"	5	3	1	2	3	3	2	3	1	2	4	4	2	4	5	44
4. New Bldg. - "New Existing State Land"	5	3	1	2	3	3	2	3	1	2	1	2	2	3	2	35
5. New Bldg. - "New Land Acquisition"	5	2	1	2	3	3	2	3	1	1	1	1	2	3	2	32
6. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	4	5	1	1	3	3	2	3	1	3	5	4	1	2	1	39
7. Another Existing Bldg./Site - "Modernize"	4	4	1	4	3	3	2	3	1	3	5	4	1	2	1	41
8. Another Existing Bldg./Site - "Additions"	5	4	1	3	3	3	2	3	1	2	5	4	1	2	1	40
A. II. (Department of Public Welfare)																
9. Same Bldg./Site - "As Is"	1	4	4	1	5	3	5	5	4	3	5	1	1	4	2	48
10. New Bldg. - "Whole-Site"	5	3	4	2	5	3	5	5	4	2	4	1	1	4	4	52
11. New Bldg. - "Half-Site"	5	3	4	2	5	3	5	5	4	2	4	1	1	4	4	52
12. New Bldg. - "New Existing State Land"	5	3	4	2	5	3	5	5	4	2	1	1	1	3	2	46
13. New Bldg. - "New Land Acquisition"	5	1	4	2	5	3	5	5	4	1	1	1	1	3	2	43
14. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	4	4	4	5	5	3	5	5	4	4	5	5	1	2	1	52
15. Another Existing Bldg./Site - "Modernize"	4	4	4	4	5	3	5	5	4	3	5	4	1	2	1	54
16. Another Existing Bldg./Site - "Additions"	5	4	4	3	5	3	5	5	4	3	5	3	1	2	1	53

A'

A. III. (Department of Veterans' Affairs)	PROGRAM			FACILITY	OPERATIONS					SITE	SECONDARY				Total
	Existing Program	Time to Implementation	Flexibility in Level of Care Capability in Facility	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	
17. Same Bldg./Site - "As Is"	1	4	1	1	2	4	1	1	2	2	5	3	5	4	4	40
18. New Bldg. - "Whole-Site"	1	3	5	2	2	4	1	1	1	1	4	3	5	5	5	42
19. New Bldg. - "Half-Site"	1	3	5	2	2	4	1	1	1	1	4	3	5	4	5	42
20. New Bldg. - "New Existing State Land"	1	3	5	2	2	4	1	1	1	1	1	3	5	3	2	35
21. New Bldg. - "New Land Acquisition"	1	2	5	2	2	4	1	1	1	1	1	3	5	3	2	34
22. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	1	3	4	5	2	4	1	1	1	1	5	3	2	2	2	37
23. Another Existing Bldg./Site - "Modernize"	1	3	4	4	2	4	1	1	1	1	5	3	2	2	2	36
24. Another Existing Bldg./Site - "Additions"	1	2	5	3	2	4	1	1	1	1	5	3	2	2	2	35

B'

	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
B.I. (Veterans' Home Board)																
25. Same Bldg./Site - "As Is"	1	2	1	2	3	3	2	3	2	1	5	1	1	4	2	33
26. New Bldg. - "Whole-Site"	5	3	1	2	3	3	2	3	2	2	4	3	5	4	5	47
27. New Bldg. - "Half-Site"	5	3	1	2	3	3	2	3	2	2	4	4	3	4	5	46
28. New Bldg. - "New Existing State Land"	5	3	1	2	3	3	2	3	2	2	3	2	2	3	2	38
29. New Bldg. - "New Land Acquisition"	5	1	1	2	3	3	2	3	2	1	1	1	2	3	2	32
30. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	4	4	1	5	3	3	2	3	2	3	5	4	1	2	1	43
31. Another Existing Bldg./Site - "Modernize"	4	4	1	4	3	3	2	3	2	3	5	4	1	2	1	42
32. Another Existing Bldg./Site - "Additions"	5	3	1	3	3	3	2	3	2	2	5	4	1	2	1	40
B.II. (Department of Public Welfare)																
33. Same Bldg./Site - "As Is"	1	4	4	2	5	3	5	5	4	4	5	1	1	4	2	50
34. New Bldg. - "Whole-Site"	5	3	4	2	5	3	5	5	4	2	4	1	1	4	3	51
35. New Bldg. - "Half-Site"	5	3	4	2	5	3	5	5	4	2	4	1	1	4	3	51
36. New Bldg. - "New Existing State Land"	5	3	4	2	5	3	5	5	4	2	3	1	1	1	2	46
37. New Bldg. - "New Land Acquisition"	5	1	4	2	5	3	5	5	4	1	1	1	1	3	2	43
38. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	4	4	4	5	5	3	5	5	4	4	5	5	1	2	1	57
39. Another Existing Bldg./Site - "Modernize"	4	4	4	4	5	3	5	5	4	3	5	4	1	2	1	54
40. Another Existing Bldg./Site - "Additions"	5	3	4	3	5	3	5	5	4	3	5	3	1	2	1	52

B'

B.III. (Department of Veterans' Affairs)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
41. Same Bldg./Site - "As Is"	1	3	1	2	2	4	1	1	1	2	5	3	5	4	4	39
42. New Bldg. - "Whole-Site"	5	3	1	2	2	4	1	1	1	1	4	3	5	4	5	42
43. New Bldg. - "Half-Site"	5	3	1	2	2	4	1	1	1	1	4	3	5	4	5	42
44. New Bldg. - "New Existing State Land"	5	3	1	2	2	4	1	1	1	1	3	3	5	3	2	37
45. New Bldg. - "New Land Acquisition"	5	1	1	2	2	4	1	1	1	1	1	3	5	3	2	33
46. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	4	4	1	5	2	4	1	1	1	1	5	3	2	2	2	38
47. Another Existing Bldg./Site - "Modernize"	4	4	1	4	2	4	1	1	1	1	5	3	2	2	2	37
48. Another Existing Bldg./Site - "Additions"	5	3	1	3	2	4	1	1	1	1	5	3	2	2	2	36

C'

C.I. (Veterans' Home Board)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
49. Same Bldg./Site - "As Is"	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15
50. New Bldg. - "Whole-Site"	5	3	1	2	3	3	1	3	1	1	4	4	4	4	5	44
51. New Bldg. - "Half-Site"	5	3	1	2	3	3	1	3	1	1	4	3	3	4	5	42
52. New Bldg. - "New Existing State Land"	5	3	1	2	3	3	1	3	1	1	3	2	2	3	2	35
53. New Bldg. - "New Land Acquisition"	5	1	1	2	3	3	1	3	1	1	1	1	2	3	2	30
54. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	3	4	1	4	3	3	1	3	1	1	5	4	1	2	1	37
55. Another Existing Bldg./Site - "Modernize"	4	4	1	3	3	3	1	3	1	1	5	3	1	2	1	36
56. Another Existing Bldg./Site - "Additions"	5	3	1	2	3	3	1	3	1	1	5	3	1	2	1	35
C.II. (Department of Public Welfare)																
57. Same Bldg./Site - "As Is"	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15
58. New Bldg. - "Whole-Site"	5	3	5	2	5	3	4	5	4	3	4	1	1	4	5	54
59. New Bldg. - "Half-Site"	5	3	5	2	5	3	4	5	4	3	4	1	1	4	5	54
60. New Bldg. - "New Existing State Land"	5	3	5	2	5	3	4	5	4	3	3	1	1	3	2	49
61. New Bldg. - "New Land Acquisition"	5	1	5	2	5	3	4	5	4	3	1	1	1	3	2	45
62. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	3	4	5	4	5	3	4	5	4	3	5	4	1	2	1	53
63. Another Existing Bldg./Site - "Modernize"	4	4	5	3	5	3	4	5	4	3	5	3	1	2	1	52
64. Another Existing Bldg./Site - "Additions"	5	3	5	2	5	3	4	5	4	3	5	2	1	2	1	50

C.III. (Department of Veterans' Affairs)	Flexibility in Level of Care Capability in Facility	Time to Implementation	Existing Program	Facility 1 x Cost	Existing Experience in Welfare Program	Existing Experience in Veteran Affairs	Existing Experience in Nursing Home Care	Existing Experience in Domiciliary Care	Existing Personnel Capability	Difficulty of Conversion	Site 1 x Cost Current	Political Impact (Other than VSO)	Political Impact (VSO)	Public Transportation	Vox Populi	Total
	PROGRAM			FACILITY	OPERATIONS						SITE	SECONDARY				
C'																
65. Same Bldg./Site - "As Is"	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15
66. New Bldg. - "Whole-Site"	5	3	1	2	2	4	1	1	1	1	4	1	5	4	5	40
67. New Bldg. - "Half-Site"	5	3	1	2	2	4	1	1	1	1	4	1	5	4	5	40
68. New Bldg. - "New Existing State Land"	5	3	1	2	2	4	1	1	1	1	3	1	5	3	2	35
69. New Bldg. - "New Land Acquisition"	5	1	1	2	2	4	1	1	1	1	1	1	5	3	2	31
70. Another Existing Bldg./Site - (i.e., Anoka, etc.) - "As Is"	3	4	1	4	2	4	1	1	1	1	5	1	5	2	1	36
71. Another Existing Bldg./Site - "Modernize"	4	4	1	3	2	4	1	1	1	1	5	1	5	2	1	36
72. Another Existing Bldg./Site - "Additions"	5	3	1	2	2	4	1	1	1	1	5	1	5	2	1	35
D'																
D.I. 73. Public Welfare		5	5	5	5	3			5	5	5	5	1		2	46
D.II. 74. Veterans' Affairs		4	5	5	3	5			5	3	5	3	4		2	44
D.III.75. Veterans' Service Organizations		3	4	5	2	5			5	3	5	4	5		2	43

OVERALL ALTERNATIVES

In this section, we shall point out the alternative plans-of-action receiving the highest weighted values in each of the major programs. It must be remembered that the results of the overall evaluation methodology was based on the consideration of many factors, including the existing socio-economic-political environment in evidence within the State as determined during the course of this study.

Controlling Agent

Without exception the Department of Public Welfare consistently scored higher than the other Home controlling agents.* In sequence, according to points received, they were:

Department of Public Welfare

Veterans' Home Board of Trustees

Department of Veterans Affairs

Facility Site

The alternative concerning the Home facility and its location, according to the total numerical value received, was limited to the following:

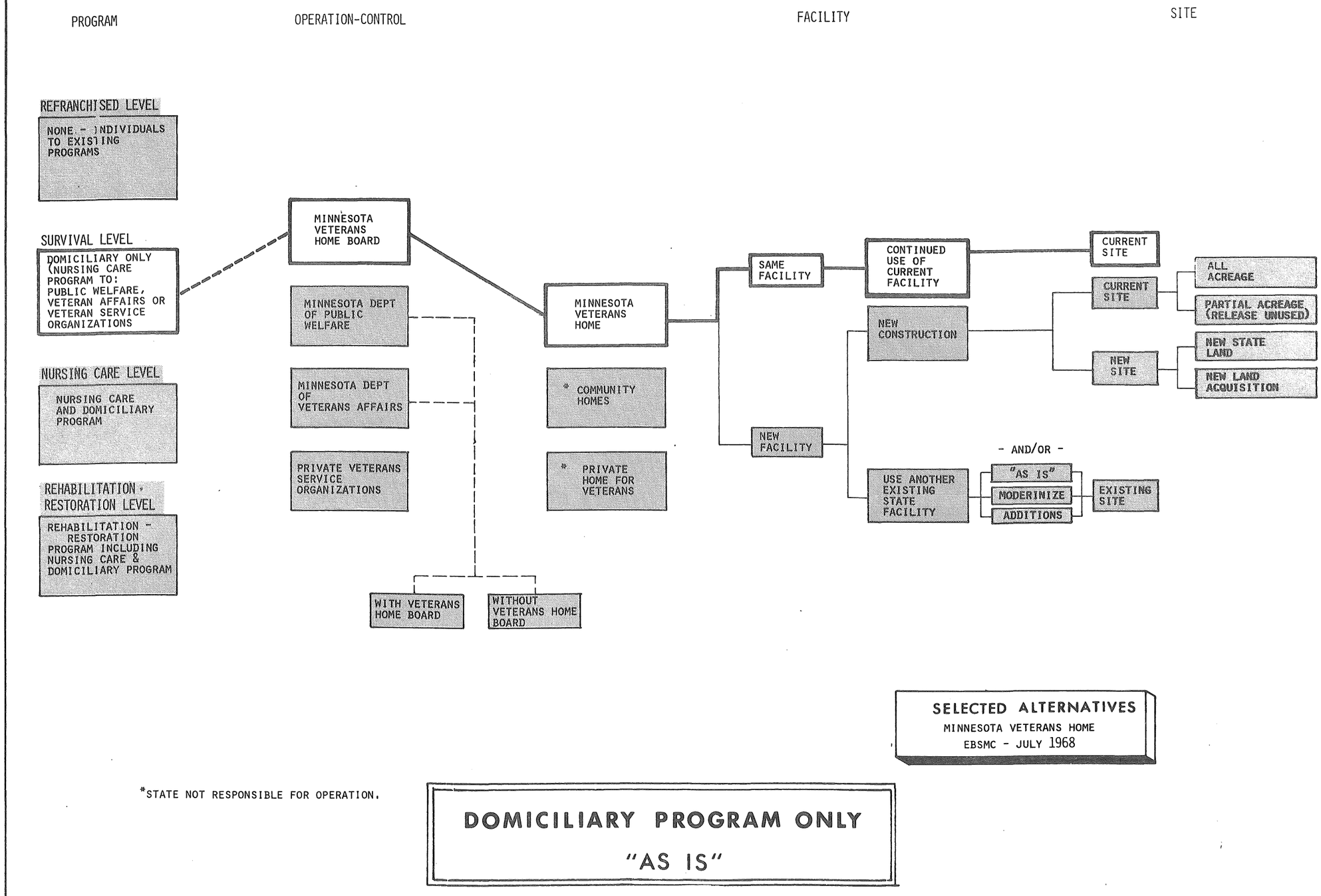
1. Utilize "another existing building and site" within the State in an "As is" condition;
2. the same as above, except construct or provide "additions" to the existing structure;

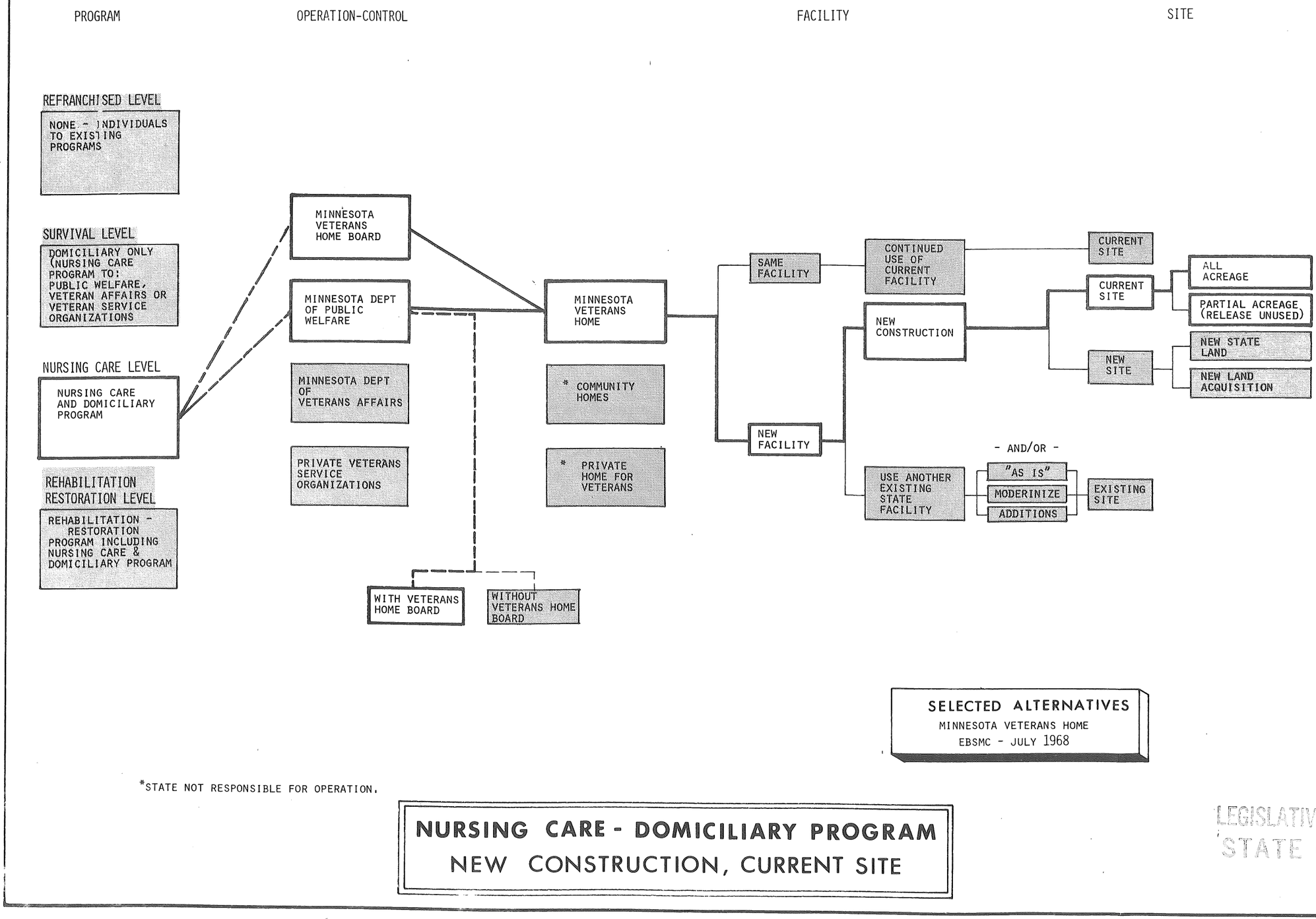
* It should be noted other departments of State Government were considered, i.e., Public Health and Administration. Because each functions in areas inconsistent with requirements of directly controlling institutional facilities, they were disregarded for the purpose of this study.

3. the same as number 1, but "modernize";
4. construct a "new facility" on all of the existing site;
5. the same as number 4, but utilize only half of the existing site.

Our inspection of selected facilities within the State failed to provide any "as is" buildings suitable for the future implementation of a suitable program of dignified care for the aging veteran. Therefore, this alternative plan of action was discarded until such time an "as is" facility can be located and examined in line with the established selection criteria presented earlier in this study.

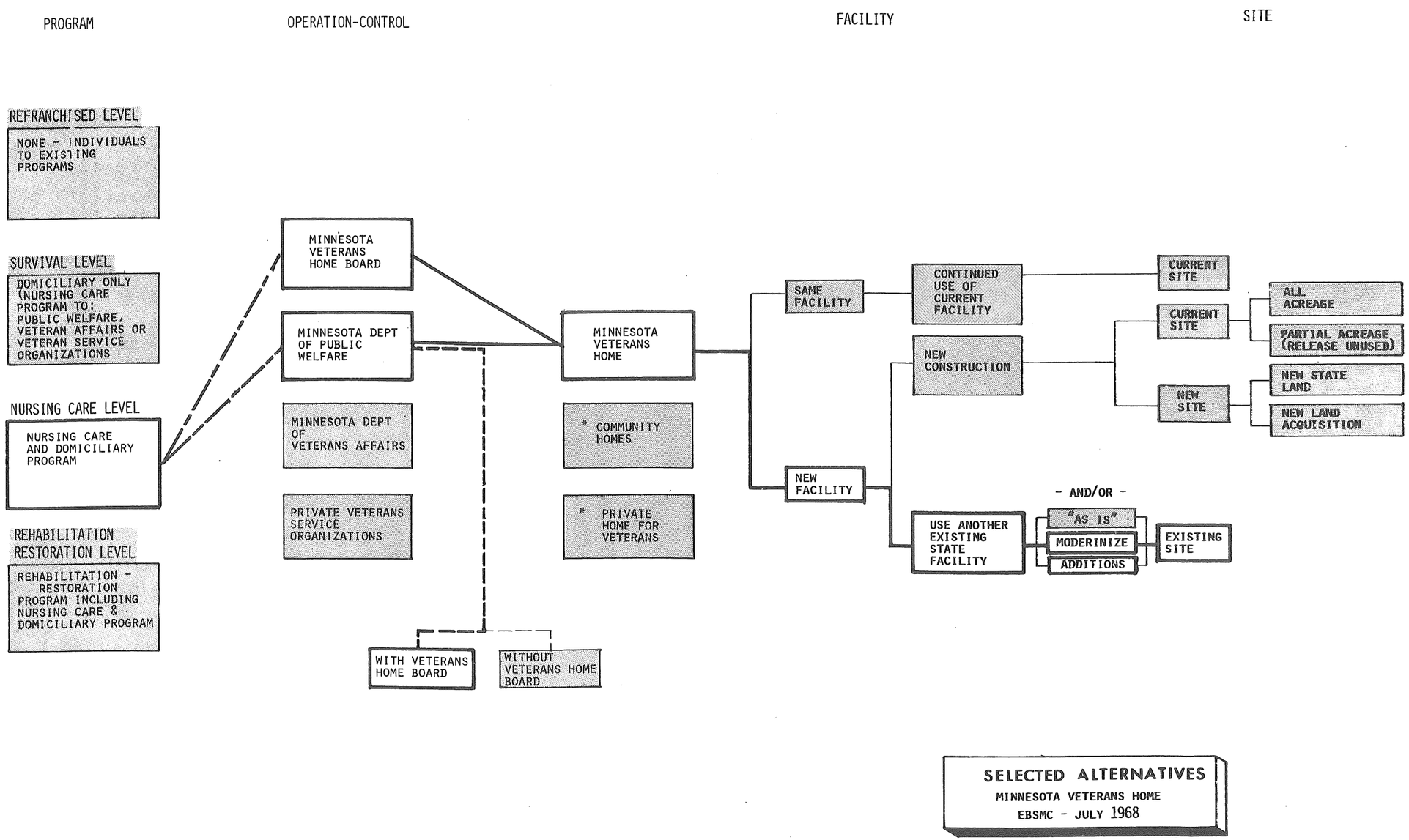
It would appear the construction of a new facility on the same "whole" or "half" site would be the major alternative of importance to the State.


PROGRAM
OPERATION-CONTROL
FACILITY
SITE
REFRANCHISED LEVEL
NONE - INDIVIDUALS TO EXISTING PROGRAMS
SURVIVAL LEVEL
DOMICILIARY ONLY (NURSING CARE PROGRAM TO: PUBLIC WELFARE, VETERAN AFFAIRS OR VETERAN SERVICE ORGANIZATIONS
NURSING CARE LEVEL
NURSING CARE AND DOMICILIARY PROGRAM
REHABILITATION - RESTORATION LEVEL
REHABILITATION - RESTORATION PROGRAM INCLUDING NURSING CARE & DOMICILIARY PROGRAM
MINNESOTA VETERANS HOME BOARD
MINNESOTA DEPT OF PUBLIC WELFARE
MINNESOTA DEPT OF VETERANS AFFAIRS
PRIVATE VETERANS SERVICE ORGANIZATIONS
WITH VETERANS HOME BOARD
WITHOUT VETERANS HOME BOARD
MINNESOTA VETERANS HOME
* COMMUNITY HOMES
* PRIVATE HOME FOR VETERANS
SAME FACILITY
CONTINUED USE OF CURRENT FACILITY
NEW CONSTRUCTION
NEW FACILITY
USE ANOTHER EXISTING STATE FACILITY
- AND/OR -
"AS IS"
MODERINIZE
ADDITIONS
EXISTING SITE
CURRENT SITE
CURRENT SITE
ALL ACREAGE
PARTIAL ACREAGE (RELEASE UNUSED)
NEW SITE
NEW STATE LAND
NEW LAND ACQUISITION
SELECTED ALTERNATIVES
MINNESOTA VETERANS HOME
EBSMC - JULY 1968
*STATE NOT RESPONSIBLE FOR OPERATION.
DOMICILIARY PROGRAM ONLY
"AS IS"



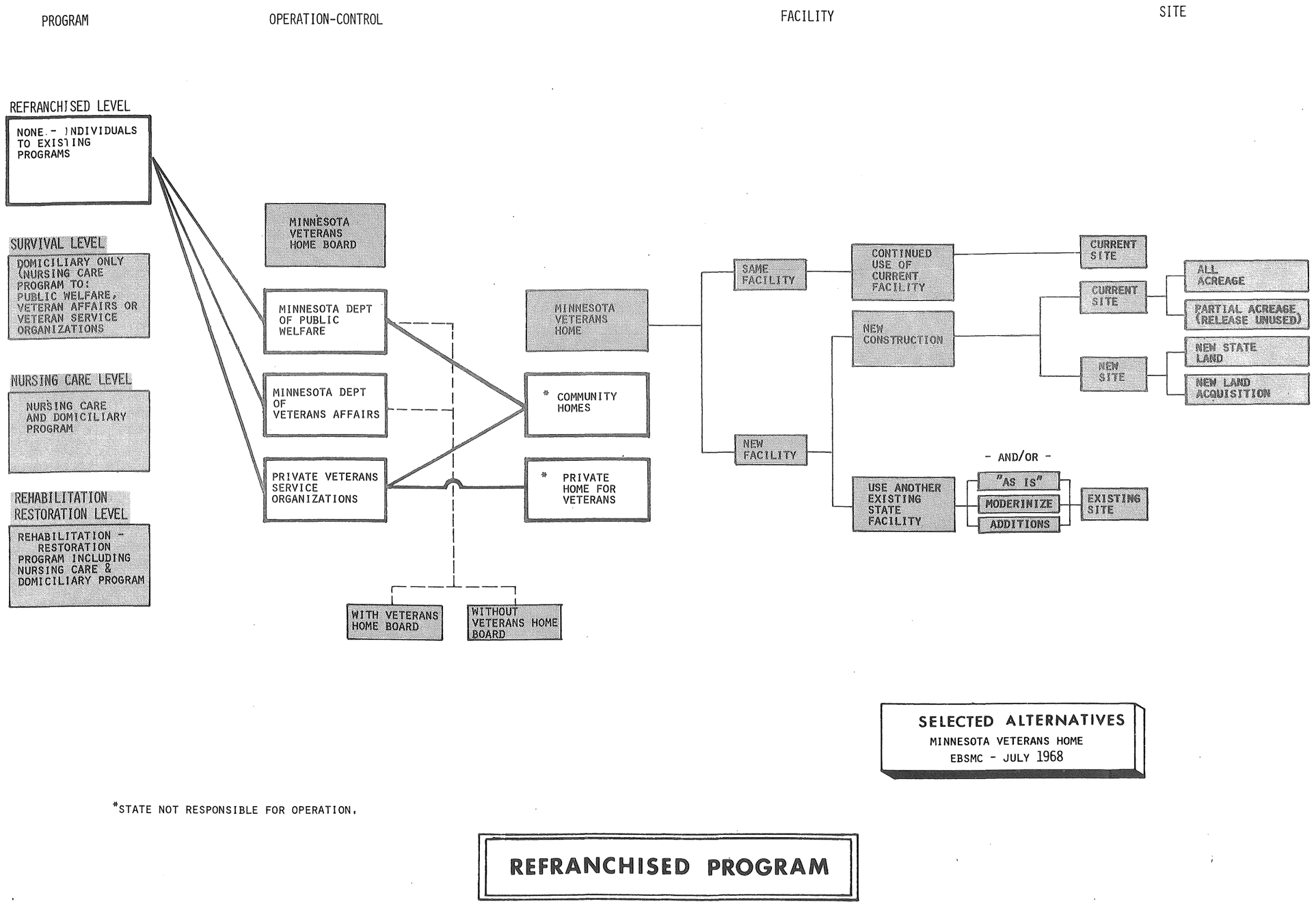
*STATE NOT RESPONSIBLE FOR OPERATION.

NURSING CARE - DOMICILIARY PROGRAM
NEW CONSTRUCTION, CURRENT SITE



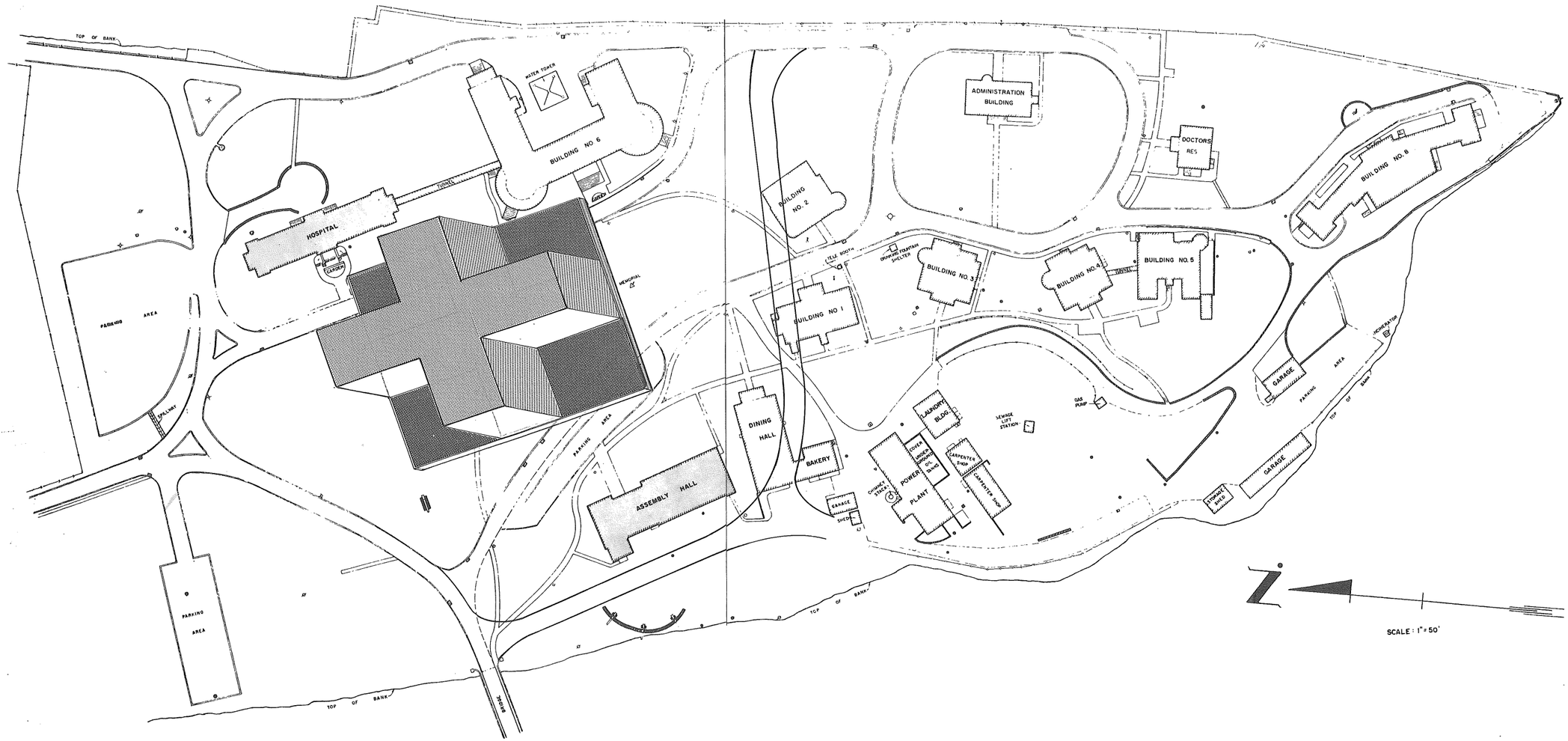
*STATE NOT RESPONSIBLE FOR OPERATION.

NURSING CARE - DOMICILIARY PROGRAM
ANOTHER EXISTING STATE FACILITY & SITE



*STATE NOT RESPONSIBLE FOR OPERATION.

REFRANCHISED PROGRAM



-LEGEND-

- CURBING
- SIDEWALK
- CYCLONE FENCE
- GUARD POST FENCE
- IRON RAIL FENCE
- STEPS
- RETAINING WALL
- CANNON
- CATCH BASINS
- GATE VALVE
- POWER POLE
- LIGHT POLE
- HYDRANT
- FLAG POLE
- VENT SHAFT FOR TUNNEL
- MANHOLES

DESIGN 1:

SINGLE HIGH-RISE WITH SUPPORT FACILITIES BASE (128 members per level).

MINNESOTA SOLDIERS HOME

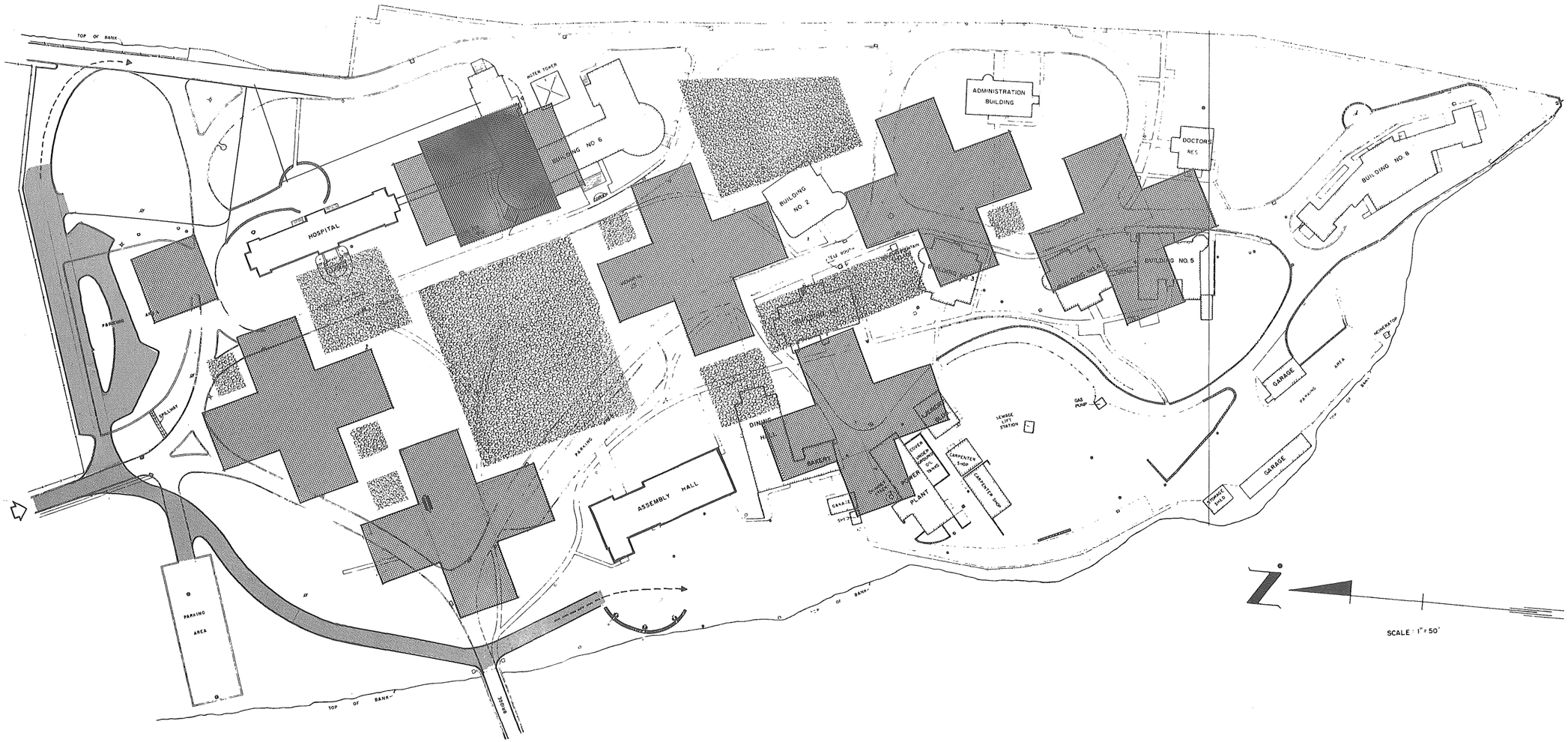
PLOT PLAN

SCHOELL & MADSON — MINNEAPOLIS

DEPT. OF ADMINISTRATION — STATE OF MINN.
ROOM 120 STATE CAPITOL BUILDING — ST PAUL, MINN.
ARCHITECTURAL & ENGINEERING DIVISION

A.J. NELSON STATE ARCHITECT

DATE	APPROVED BY _____ COMMANDANT, MINN. SOLDIERS HOME	SHEET NO 1 OF 5
REVISED	APPROVED BY _____ AGENCY HEAD	STATE PROJECT NO. 3128
DRAWN BY	APPROVED BY COMMISSIONER OF ADMINISTRATION - AN AUTHORIZED SIGNATURE	
CHECKED BY		



-LEGEND-

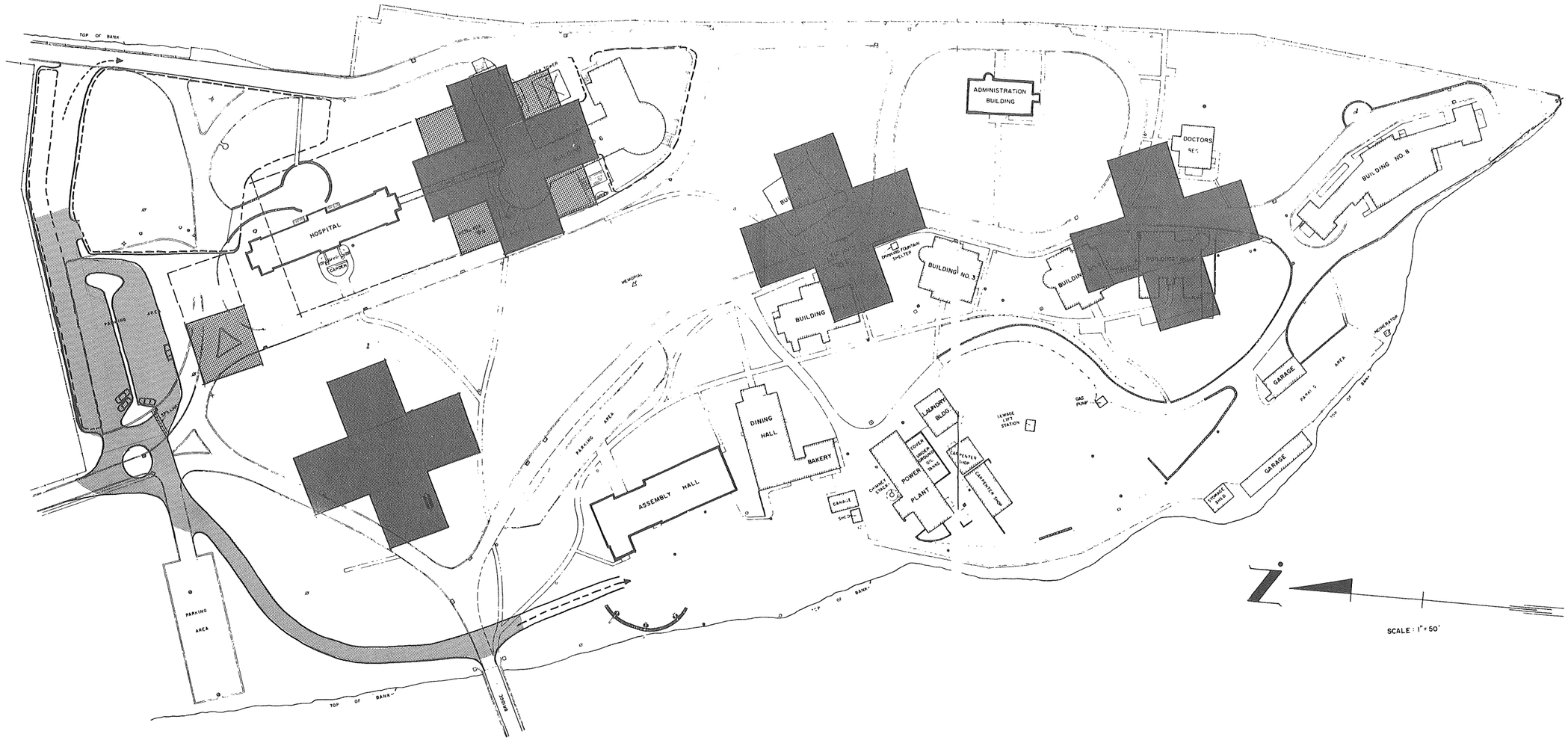
- CURBING
- SIDEWALK
- CYCLONE FENCE
- GUARD POST FENCE
- IRON RAIL FENCE
- STEPS
- RETAINING WALL
- CANNON
- CATCH BASINS
- GATE VALVE
- POWER POLE
- LIGHT POLE
- HYDRANT
- FLAG POLE
- VENT SHAFT FOR TUNNEL
- MANHOLES

DESIGN 2:

MULTIPLE OR SINGLE LEVEL
WITH SEPARATE SUPPORT FACILITIES
(128 members per level).

MINNESOTA SOLDIERS HOME
PLOT PLAN
SCHOELL & MADSON MINNEAPOLIS
DEPT. OF ADMINISTRATION STATE OF MINN.
ROOM 120 STATE CAPITOL BUILDING ST PAUL, MINN
ARCHITECTURAL & ENGINEERING DIVISION
A.J. NELSON STATE ARCHITECT

DATE	APPROVED BY _____ COMMANDANT, MINN SOLDIERS HOME	SHEET NO 1
REVISED		OF 5
DRAWN BY	APPROVED BY _____ AGENCY HEAD	STATE PROJECT NO. 3128
CHECKED BY	APPROVED BY _____ COMMISSIONER OF ADMINISTRATION OR AUTHORIZED SIGNATURE	



-LEGEND-

- CURBING
- SIDEWALK
- CYCLONE FENCE
- GUARD POST FENCE
- IRON RAIL FENCE
- STEPS
- RETAINING WALL
- CANNON
- CATCH BASINS
- GATE VALVE
- POWER POLE
- LIGHT POLE
- HYDRANT
- FLAG POLE
- VENT SHAFT FOR TUNNEL
- MANHOLES

DESIGN 3:

MULTIPLE OR SINGLE LEVEL WITH SEPARATE SUPPORT FACILITIES (128 members per level).

MINNESOTA SOLDIERS HOME

PLOT PLAN

SCHOELL & MADSON — MINNEAPOLIS

DEPT. OF ADMINISTRATION — STATE OF MINN.
ROOM 120 STATE CAPITOL BUILDING — ST. PAUL, MINN.
ARCHITECTURAL & ENGINEERING DIVISION

A.J. NELSON STATE ARCHITECT

DATE		SHEET NO. 1
REVISED	APPROVED BY COMMANDANT, MINN. SOLDIERS HOME	OF 5
DRAWN BY	APPROVED BY AGENCY HEAD	STATE PROJECT NO. 328
CHECKED BY	APPROVED BY COMMISSIONER OF ADMINISTRATION OR AUTHORIZED SIGNATURE	

-LEGEND-

- CURBING
- SIDEWALK
- CYCLONE FENCE
- GUARD POST FENCE
- IRON RAIL FENCE
- STEPS
- RETAINING WALL
- CANNON
- CATCH BASINS
- GATE VALVE
- POWER POLE
- LIGHT POLE
- HYDRANT
- FLAG POLE
- VENT SHAFT FOR TUNNEL
- MANHOLES

DESIGN 4:

CLUSTER SERIES WITH SEPARATE SUPPORT FACILITIES (32 member per unit capacity).

MINNESOTA SOLDIERS HOME
PLOT PLAN
SCHOELL & MADSON MINNEAPOLIS
DEPT. OF ADMINISTRATION STATE OF MINN.
ROOM 120 STATE CAPITOL BUILDING ST. PAUL, MINN
ARCHITECTURAL & ENGINEERING DIVISION
A.J. NELSON STATE ARCHITECT

DATE	APPROVED BY COMMANDANT, MINN SOLDIERS HOME	SHEET NO 1 OF 5
REVISED	APPROVED BY AGENCY HEAD	
DRAWN BY		STATE PROJECT NO. 328
CHECKED BY	APPROVED BY COMMISSIONER OF ADMINISTRATION AN AUTHORIZED SIGNATURE	

PROJECTED COSTS OF CONSTRUCTION

The following estimations for the construction of a 500-bed facility for the year 1970 must be determined by projecting the 1963 costs of $20 per square foot* for a related facility's construction in Minnesota. Increases in construction costs must be evaluated at the increased rate of five percent per year (on a curve). Today this approximates $26 per square foot per member.

Construction cost differentials between a low-rise and high-rise facility is $5.00 per square foot per member in a nursing home and $3.75 per member in a domiciliary home.

Final cost estimations are determined by percentages of types of care to be offered by the establishment, i.e., 30% domiciliary, 60% nursing home care, and 10% rehabilitative.

State-of-the-Art determinants regarding space allocations per square feet per member is 500 square feet.

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*Source: Department of Administration, State Architect. (See Attached Chart).

COST ESTIMATIONS: New Facilities (Complete Nursing Home Example)*

500 Members x 500 Sq. Ft. per Member = 250,000 Sq. Ft.

	Low Rise	High Rise
	250,000 Sq. Ft.	250,000 Sq. Ft.
Construction:	x 26 ($ Per Sq. Ft.)	x 31 ($ Per Sq. Ft.)
	$6,500,000	$7,750,000
Elevators, Group I Equip. (only) Architect Fees & Costs (approx.)	200,000	750,000
	$6,700,000	$8,500,000

To Compute Future Costs: The needs of 1980 will show an estimated increase of 136 members, bringing the total to 636 members and requiring an additional 68,000 square feet of living space per member, according to existing criteria. Provided a continued five percent per year increase in construction costs is in effect, the low-rise facility would cost approximately $10 million for the year 1980. The high-rise type of facility would approximate $13.3 million.

Cost Estimations: Remodeling Existing Facilities

State-of-the-Art construction expenses derived from the national average approximates a 15-20 percent decrease of costs over that of new construction.

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*The costs of elevators, Groups II and III equipment, and first year operations are not included in the overall estimations.

Provided existing structures are usable (after gutting) the State would realize a 15-20 percent decrease in facilities replacement expenditures. With the old structures, however, continued maintenance of the facilities would require additional upkeep costs as compared to new structures. Additionally, limitations as to the carrying out of the optimum program would be in evidence in relation to the facility specifically designed according to a predetermined plan of action.

TYPE OF USE	LOCATION	AWARD DATE	NUMBER OR FLOORS	%AGE GENERAL CONSTRUCTION CONTRACT PORTION	PLANT	HEATING	VENTILATION	ELECTRICAL	DIRECT LINE TOTAL COST (APPROX.)
Domiciliary (Dormitory)	Faribault	1963		63.4	.054	.05	.039	.084	$20.00
Administration Wing	Fergus Falls	1963	2	75.4	/-----15.9--------/			.082	20.39
School and Rehabilitation Therapies	Brainerd	1964	(Count) 1	70.9					17.46
Continued Treatment #2	St. Peter	1963	3	80.4					15.33
#3	St. Peter	1964	3	77.8					15.81
Laundry	Hastings	1963	1-2	46.3					25.17
Heating Plant	St. Peter	1965	2	34.0	/-----60.3--------/			.057	81.47
Continued Treatment # 3	Rochester	1960							15.70

Source: Department of Administration; State Architect

Absorption of Facilities Capability*

A. Single High Rise** - Because of the favorable conditions of adjacency to Minnehaha Park and Mississippi River, restrictions to high rise facilities should not be prohibitive as to interference with others. Outlook from the various levels would be unrestricted and attractive. It is possible to provide a density commensurate with the expanding needs of Veterans to the point of approximately 2,000 domiciliary and nursing beds in terms of two large towers and corresponding support bases. Future additions could be vertical. It is expected that sites for parking, to support visitors and staff, would be adequate. Potential design of facilities such as a Nursing Home, Domiciliary and/or perhaps a Restorative Center, could absorb the necessary parking requirements.

B. Multiple (Combination Low Rise) or Single Level (Single Level to 3 or 4 Levels) - The site could handle, under these combinations, approximately 750 - 1,000 beds of the same care types, depending which low-rise concept is implemented.

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*Absorption capacity was determined on a maximum basis of an actual space layout of all single rooms, common toilet facilities, support areas, 8 bed-clusters of social groupsing with 4 units or 32 beds larger social groupings. High rise was considered on a basis of 128 beds per level. This allows the flexibility required for sex, age, social and medical interest,etc. Each unit of area per bed was taken at a maximum of 375 square feet per member from the layout. This area per member figure, includes only the domiciliary and nursing home area. Additional area was added for support facilities such as kitchen, recreation, storage, chemical areas, etc. These support areas are suggested to be located in a central or concentrated higher rise center with the more critical nursing beds. All facilities would be Type I or II, construction for estimating purposes and based on the most recent construction experience of the State (1963) for the building type with adjustments for high rise construction and cost increase due to time lapse (1970).

**See attached example designs 1 through 4 for composite layouts on the present site.

Costs

The facility costs are based upon:

Foundation:	Reinforced concrete
Frame:	Steel frame with concrete rib slabs
Roof:	Built up roofing
Walls:	Exterior brick bearing walls, glazed tile
Ceilings:	Sand finish, accoustical tile
Floors:	Terrazzo floor and base, quarry and ceramic tile
Windows:	Aluminum
Heating:	Radiant Slab or warm air or fire tube. High pressure steam system (12 air changes/hour in living areas; 20 air changes in shower and toilets, etc.)
Elevators:	Additional (Not included in single level structures).

Construction cost per square foot, exclusive or architects' fees, legal fees, etc., is $20.00 plus time lapse increase @ $6.00/sq. ft. equals $26.00. For High Rise buildings over 3 levels add $5.00/sq. ft. equals $29.00 (+ elevators).

Area unit figures at:

a. Nursing Care Areas @ 500/sq. ft./member (includes support).

b. Domiciliary Areas @ 375/sq. ft./member (includes support).

CHAPTER VII. PROVISIONS OF HEALTH CARE FOR THE VETERAN

A. THE AVAILABILITY TO THE VETERAN OF NURSING HOME CARE IN MINNESOTA

One major aspect of the intent of this study is to ascertain whether or not nursing home care should be provided at the Minnesota State Veterans' Home. In considering this proposition, the question may arise as to whether "veterans' benefits" would be improved if they had to go to a private facility for care with increased payment by the veteran, State, county, (with appropriate reimbursement from the Federal and State government).

At the present time, the Veterans Administration in Washington, D.C. is neither planning to extend the currently authorized time span of up to six months of care (for which they make payments on behalf of the veterans in community nursing homes), nor are they presently planning to recommend legislation that would authorize veterans to enter a Veterans Administration nursing home bed directly from civilian life (as opposed to the present policy of requiring veteran admittance to and discharge from a Veterans Administration hospital prior to entering a Veterans Administration nursing care facility).

If "veteran benefits" are considered from the viewpoint of the State, the answer is both yes and no. The Veterans Administration will pay the State up to $3.50 per day*, or approximately $105 per month or $1,260 per year for each veteran receiving nursing home care or up to $2.50 per day for domiciliary care for as long as he needs such care (whether the time be measured in days, weeks, months, years, or for the duration of the veteran's life). However, the $3.50 per diem payments are made only if the veteran is receiving such care in a state-operated veteran home approved by the Veterans Administration as is the situation in Minnesota.

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*Based upon 50% of actual cost up to $7.00 to a state in a state-operated Veterans' Home.

If the veteran requires nursing care and receives it outside the Minnesota Veterans' Home, then, as already mentioned, the Veterans Administration will pay up to, but not more than six months of care to a community nursing home at whatever the average charges to the public are established by the community facility. In this situation, the Veterans Administration assumes the cost of the veteran's care and the state does not.

Upon release from the community facility the veteran, if qualified and still in need of nursing care, may enter a medically approved nursing home for another 100 days under Medicare Law, again, at no expense to the State. If he needs additional care, after using up his 100 days under a particular spell of illness, as defined by the Department of Health, Education and Welfare, he may be qualified for Medicaid at the expense of the state (as previously discussed), or he may be placed in a Veterans Administration nursing home bed, (if it is available) after Veterans Administration Hospital discharge, for as long as he needs care at the expense of the Veterans Administration. In the latter situation, the State again has no expense.

A third viewpoint in considering veteran benefits are the kind of services he may receive in a nursing home outside the Minnesota Veterans' Home. In a private facility that is approved by Medicare, for example, benefits would be better than at the Minnesota Veterans' Home. The reason for this judgment is that Medicare approved facilities throughout the country must adhere to strict Federal Government standards which the Minnesota Veterans' Home does not and cannot meet at the present time. For example, some of the Medicare criteria which the Minnesota Veterans' Home does not meet, can

be discerned from the Department of Health, Education and Welfare's rejection of the Veterans' Homes' application for Medicare approval.

According to the Department of Health, Education and Welfare, the Minnesota Veterans' Home was deficient in regard to the following criteria:

1. Disaster Plan - The facility did not have a written procedure to be followed in case of fire or other disaster.
2. Patient Care Policies - It was found that the facility was not in substantial compliance with a Medicare regulation which states that there should be policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses.
3. Administrative Management - It was found that there was no evidence of written personnel policies, practices and procedures pursuant to the Medicare Law requirements. It was found that the facility was not in compliance with a regulation which states that there should be appropriate written policies and procedures relating to notification of responsible persons in the event of significant change in patient status, patient charges, billings and other related administrative matters.
4. Utilization Review - The Veterans' Home did not submit a utilization review plan to the Department of Health, Education and Welfare, and therefore was not in compliance

with the Medicare Law. Medicare regulations state that the extended care facility must have in effect a plan for utilization review which applies at least to the services furnished by the facility to individuals entitled to benefits under the law. It states that an acceptable utilization review plan should provide for: (1) the review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) a review of each case of continuous extended duration.

5. Pharmacy or Drug Rooms - The Veterans' Home was also deficient in regard to certain aspects of Medicare regulations which pertain to pharmacy. It was found that the facility was not in compliance with regulations that state all medications should be administered by licensed medical or nursing personnel in accordance with the medical and nurse practice acts of each state. Each dose administered should be properly recorded in the clinical record. The Home was also deficient in regard to the regulation that the extended care facility must comply with all Federal and State laws relating to the procurement, storage, dispensing, administration and disposal of narcotics, hypnotics, amphetamines, certain psychosomatic medications and other drugs.

6. Nursing Service - The Home did not have written nursing plans pursuant to the Medicare Law.

7. Patient Transfer - The Home did not submit a patient transfer agreement to the Department of Health, Education and Welfare. The transfer regulation states that the extended care facility must have in effect a transfer agreement (meeting the requirements of Section 1861 (l) of the Social Security Act) with one or more hospitals which have entered into agreements with the Secretary to participate in the program.

All of these Medicare requirements, as well as others developed by the Department of Health, Education and Welfare, contribute to the patient's well being, whether he be veteran or civilian, by providing him with as high a quality of medical care as the individual requires. In addition, there are sufficient Medicare approved beds in Hennepin County as well as in other areas of Minnesota, to absorb the 102 individuals currently stated by the Home's physician as requiring nursing care above and beyond domiciliary care of the Minnesota Veterans' Home, as noted in tables in this report and which pertain to the distribution of nursing home facilities in the state.

1. DISTRIBUTION BY COUNTY OF MINNESOTA BOARDING HOMES
ACCORDING TO OCCUPANCY RATES AS OF MARCH 15, 1967

MINNESOTA COUNTIES 1/	Total Number of BCH 2/	Total BCH Beds	OCCUPANCY RATE PERCENTAGE								
			50% Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Anoka	1	12	-	1	-	-	-	-	-	-	-
Benton	1	11	-	-	-	-	-	1	-	-	-
Big Stone	2	30	-	1	-	-	-	1	-	-	-
Blue Earth	1	21	-	-	-	-	-	-	-	1	-
Chisago	2	71	-	-	-	-	-	1	-	1	-
Cottonwood	1	35	-	-	-	-	-	-	-	1	-
Crow Wing	2	46	-	-	-	1	-	-	-	1	-
Dakota	2	110	1	-	-	-	-	-	-	-	1
Dodge	3	30	-	-	-	1	-	-	1	-	1
Douglas	3	96	-	-	-	-	-	2	-	-	1
Faribault	2	39	-	1	-	-	-	-	-	-	1
Fillmore	3	42	-	-	-	-	-	-	-	2	1
Freeborn	4	81	-	1	-	-	-	1	-	1	1
Goodhue	5	76	1	-	-	1	-	1	-	1	1
Hennepin - Minneapolis	28	1,756	-	1	3	3	5	1	3	8	4
Hennepin - Rural & Suburban	3	252	-	-	-	2	-	-	-	-	1
Houston	3	40	-	-	1	1	-	1	-	-	-
Isanti	3	36	-	-	-	-	-	1	2	-	-
Itasca	1	26	1	-	-	-	-	-	-	-	-
Jackson	1	7	-	-	-	-	1	-	-	-	-
Kandiyohi	6	197	1	1	-	1	1	-	1	1	-
Kittson	1	41	-	-	-	-	-	1	-	-	-
Lac Qui Parle	1	85	-	-	-	-	-	-	1	-	-
LeSeur	1	17	-	-	-	-	1	-	-	-	-
Marshall	1	25	-	-	-	-	-	-	-	1	-
Martin	3	87	-	-	1	-	-	-	1	1	-
Meeker	2	70	-	-	-	-	-	-	1	-	1
Mille Lacs	2	10	-	-	-	-	-	-	-	1	1
Mower	6	142	1	-	-	-	-	1	1	-	3
Nobles	2	16	-	-	-	-	-	-	-	-	2
Norman	1	40	-	-	-	-	-	-	1	-	-
Olmsted	2	66	-	-	-	-	-	-	1	-	1

Distribution by County of Minnesota Boarding Homes According to Occupancy Rates as of March 15, 1967 (Cont'd.)

MINNESOTA COUNTIES 1/	Total Number of BCH 2/	Total BCH Beds	OCCUPANCY RATE PERCENTAGE								
			50% Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Otter Tail	5	83	-	-	-	-	1	1	-	2	1
Pennington	1	14	-	-	-	-	-	-	-	1	-
Pine	1	32	-	-	-	-	-	-	1	-	-
Polk	1	13	1	-	-	-	-	-	-	-	-
Pope	2	44	-	-	-	1	-	-	-	-	1
Ramsey - St. Paul	13	756	-	-	-	-	1	3	3	4	2
Ramsey - Rural & Suburban	2	92	-	-	-	1	-	-	-	-	1
Renville	1	11	-	-	-	1	-	-	-	-	-
Rice	4	102	-	-	1	-	1	-	-	2	-
Roseau	2	156	-	1	-	-	-	-	-	-	1
St. Louis	2	71	-	-	-	-	-	-	-	1	1
Scott	1	9	-	-	-	-	-	-	-	-	1
Stearns	7	161	-	-	1	-	-	1	1	-	4
Steele	1	28	-	-	-	-	-	-	-	1	-
Stevens	2	44	-	-	-	1	-	-	1	-	-
Swift	1	13	-	-	-	-	-	-	1	-	-
Todd	2	29	-	-	-	1	1	-	-	-	-
Wabash	2	21	-	-	1	-	-	1	-	-	-
Washington	2	57	-	-	-	-	-	-	-	1	1
Wilkin	1	51	-	-	-	-	-	-	-	-	1
Winona	7	205	1	-	-	2	-	1	-	2	1
Wright	2	38	-	-	-	1	-	1	-	-	-
Total	161	5,643	7	7	8	18	12	20	20	34	35

Note: BCH means Boarding Care Home.
"-" means zero units

1/ Only those counties are listed for which boarding care home are reported.
2/ Includes only those units and their beds for which an occupancy rate is available.

Sources: Minnesota. Minnesota Hospitals, 19th Annual Revision. State Department of Public Health. Division of Hospital Services, Minneapolis. 1967-68

2. DISTRIBUTION BY COUNTY OF MINNESOTA HOSPITAL NURSING CARE UNITS ACCORDING TO OCCUPANCY RATES, AS OF MARCH 15, 1967 1/

MINNESOTA COUNTIES 1/	Number of 2/ Hosp. Nursing Care Units	Total Beds NC	Total Beds Medicare 3/	OCCUPANCY RATE PERCENTAGE 50% or Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Aitkin	1	48	48	-	-	-	-	-	-	-	-	1
Beltrami	1	60	60	-	1	-	-	-	-	-	-	-
Brown	2	73	0	-	-	-	-	-	1	-	-	1
Carlton	2	74	74	-	-	-	-	-	-	-	2	-
Cook	1	24	24	-	-	-	-	-	-	-	-	1
Cottonwood	1	23	23	-	-	-	-	1	-	-	-	-
Dakota	1	60	60	1	-	-	-	-	-	-	-	-
Goodhue	1	22	22	-	-	-	-	-	1	-	-	-
Grant	1	24	-	-	-	-	-	-	-	-	1	-
Hennepin - Minneapolis	3	164	164	1	-	-	2	-	-	-	-	-
Hennepin - Rural & Suburban	1	325	-	-	-	-	-	-	-	-	1	-
Houston	2	82	66	-	-	-	-	-	-	-	-	2
Koochiching	1	27	27	-	-	-	-	-	-	-	-	1
LeSueur	1	11	11	-	-	-	-	-	-	-	-	1
Lincoln	1	31	-	-	-	-	-	-	-	-	-	1
Lyon	1	76	76	-	-	-	-	-	-	-	-	1
McLeod	1	44	-	-	-	-	-	-	-	-	-	1
Mille Lacs	1	40	-	-	-	-	-	-	-	1	-	-
Morrison	1	75	75	-	-	-	-	-	-	-	-	1
Nicollet	1	24	-	-	-	-	-	-	-	-	-	1
Norman	1	51	54	-	-	-	-	-	-	-	-	1
Otter Tail	2	60	60	-	-	-	-	-	-	-	1	1
Pennington	1	25	25	1	-	-	-	-	-	-	-	-
Pipestone	1	43	43	-	-	-	-	-	-	1	-	-
Polk	1	20	-	-	1	-	-	-	-	-	-	-
Ramsey - St. Paul	2	186	186	1	-	-	-	-	-	-	1	-
Rice	2	125	40	-	-	-	-	-	-	1	1	-
Roseau	3	79	20	-	-	-	-	-	-	-	2	1
St. Louis	7	459	235	-	-	-	-	-	1	2	2	2
Scott	1	20	-	-	-	-	-	-	-	1	-	-
Stearns	2	83	-	-	-	-	-	1	-	-	1	-
Swift	1	25	25	-	-	-	-	-	-	-	1	-

Distribution by County of Minnesota Hospital Nursing Care Units According to Occupancy Rates, as of March 15, 1967 1/ (Cont'd.)

MINNESOTA COUNTIES 1/	Number of Hosp. Nursing Care Units 2/	Total Beds NC	Total Beds Medicare 3/	OCCUPANCY RATE PERCENTAGE 50% or Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Todd	2	85	-	-	-	-	2	-	-	-	-	-
Wabasha	1	45	45	-	-	-	-	-	1	-	-	-
Winona	1	100	100	1	-	-	-	-	-	-	-	-
Yellow Medicine	2	110	110	-	-	-	-	-	-	1	1	-
Total	55	2,823	1,673	5	2	-	4	2	4	7	14	17

Note: NC means Nursing Care Unit
"-" means zero units

1/ Only those counties are listed for which nursing care units and their occupancy rates were available.
2/ Includes only those units and their beds for which an occupancy rate was available.
3/ Total number of beds which were Medicare approved by Department of Health, Education, and Welfare as of October 1967.

Sources: Minnesota. Minnesota Hospitals, 19th Annual Revision. State Department of Public Health. Division of Hospital Services, Minneapolis 1967-1968
Department of Health, Education, and Welfare. Directory of Providers - Extended Care Facilities. Social Security Administration. Washington, D.C. October 1967.

3. DISTRIBUTION BY COUNTY OF MINNESOTA NURSING HOMES ACCORDING TO OCCUPANCY RATES AS OF MARCH 15, 1967 [1]

MINNESOTA COUNTIES [2]	Number of Nursing Homes [3]	Total Beds NH	Total Beds Medicare [4]	OCCUPANCY RATE PERCENTAGE 50% or Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Aitkin	1	98	-	-	-	-	-	-	-	-	1	-
Anoka	5	317	66	-	-	1	-	-	-	-	3	1
Becker	2	150	104	-	-	-	-	-	-	1	-	1
Beltrami	3	135	-	-	-	-	-	1	2	-	-	-
Benton	2	127	102	-	-	-	-	-	-	-	1	1
Big Stone	2	71	-	-	-	-	-	1	-	-	1	-
Blue Earth	6	390	45	-	-	1	1	1	-	1	1	1
Brown	3	176	134	-	-	-	-	-	1	2	-	-
Carlton	1	56	56	-	-	-	-	-	-	1	-	-
Carver	1	37	-	-	-	-	-	-	-	1	-	-
Cass	3	571	-	-	-	-	-	-	1	-	-	2
Chippewa	2	107	-	1	-	-	-	-	-	-	1	-
Chisago	2	150	-	-	-	-	-	-	-	-	1	1
Clay	4	297	78	-	-	-	1	-	1	1	1	-
Clearwater	1	97	-	-	-	-	-	-	-	1	-	-
Cottonwood	4	181	-	-	1	-	-	-	2	1	-	-
Crow Wing	3	154	-	-	-	-	-	-	1	-	-	2
Dakota	2	147	-	-	-	-	-	1	-	-	1	-
Dodge	2	72	-	-	-	-	-	-	1	-	1	-
Douglas	3	96	121	-	-	-	-	-	2	-	-	1
Faribault	3	131	-	-	-	-	-	-	1	-	2	-
Fillmore	3	194	135	-	-	-	-	1	-	1	-	1
Freeborn	4	203	60	-	-	-	-	-	1	1	1	1
Goodhue	6	322	128	-	-	-	-	-	-	2	3	1
Grant	2	105	-	-	-	-	-	-	-	1	-	1
Hennepin - Minneapolis	45	3,321	2,020	-	-	2	2	5	3	13	17	3
Hennepin - Rural & Suburban	24	2,407	-	1	-	-	2	2	1	7	8	3
Hubbard	1	97	-	-	-	-	-	-	-	-	1	-
Isanti	2	134	94	-	-	-	-	-	-	1	-	1
Itasca	2	129	62	-	-	-	-	-	-	-	-	2

Distribution by County of Minnesota Nursing Homes According to Occupancy Rates as of March 15, 1957 [1/] (Cont'd.)

MINNESOTA COUNTIES [2/]	Number of Nursing Homes [3/]	Total Beds NH	Total Beds Medicare [4/]	OCCUPANCY RATE PERCENTAGE 50% or Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
Jackson	1	75	-	-	-	-	-	-	-	-	1	-
Kanabec	1	24	-	-	-	-	-	-	-	-	-	1
Kandiyohi	4	318	318	1	-	-	-	-	-	1	2	-
Koochiching	2	118	-	-	-	-	-	-	-	-	2	-
Lac Qui Parle	2	56	-	-	-	-	-	-	-	-	-	2
Lake	1	42	-	-	-	-	-	-	-	-	-	1
Lake Of The Woods	1	51	-	-	-	-	-	-	-	-	1	-
LeSueur	2	80	-	-	-	1	-	-	-	1	-	-
Lincoln	1	29	29	-	-	-	-	-	-	-	-	1
Lyon	2	103	51	1	-	-	1	-	-	-	-	-
Mahnomen	1	24	-	-	-	-	-	-	-	1	-	-
Marshall	2	53	-	-	-	-	-	-	-	1	1	-
Martin	4	124	41	-	-	-	-	-	1	2	1	-
McLeod	4	235	65	-	-	-	1	-	1	1	1	-
Meeker	4	181	-	-	-	-	-	-	1	2	1	-
Mille Lacs	3	151	-	-	-	-	-	-	-	1	1	1
Morrison	2	162	-	-	-	-	-	-	-	-	1	1
Mower	5	301	159	-	-	-	-	-	-	2	3	-
Murray	2	120	-	1	-	-	-	-	-	-	1	-
Nicollet	1	40	-	-	-	-	-	-	1	-	-	-
Nobles	4	148	-	-	-	-	-	-	3	-	1	-
Norman	2	97	-	-	1	-	1	-	-	-	-	-
Olmsted	6	236	-	-	-	-	-	-	1	1	3	1
Otter Tail	7	392	70	-	-	-	-	-	-	2	3	2
Pennington	1	49	-	-	-	-	-	-	-	-	-	1
Pine	2	114	-	-	-	-	-	-	-	-	2	-
Pipestone	1	33	-	-	-	-	-	-	-	1	-	-
Polk	8	446	208	-	-	-	-	-	1	4	1	2
Pope	3	160	-	-	-	1	-	-	-	1	1	-
Ramsey - St. Paul	18	1,717	1,467	-	-	1	-	1	2	3	8	3
Ramsey - Rural & Suburban	10	690	-	1	-	1	1	-	1	2	3	1
Red Lake	1	75	-	-	-	-	-	-	-	-	1	-
Redwood	6	283	-	-	-	2	-	-	-	-	1	3
Renville	5	269	64	-	1	-	-	-	2	2	-	-
Rice	5	273	241	-	-	-	-	1	1	1	1	1
Rock	2	118	-	-	-	-	1	-	-	1	-	-

Distribution by County of Minnesota Nursing Homes According to Occupancy Rates as of March 15, 1957 [1] (Cont'd.)

MINNESOTA COUNTIES [2]	Number of Nursing Homes [3]	Total Beds		OCCUPANCY RATE PERCENTAGE								
		NH	Medicare [4]	50% or Less	51 - 60	61 - 70	71 - 80	81 - 85	86 - 90	91 - 95	96 - 99	100% or More
St. Louis	13	939	286	1	-	-	-	-	1	2	6	3
Scott	3	232	-	-	-	-	-	-	1	2	-	-
Sherburne	4	207	60	-	-	1	-	-	1	1	-	1
Sibley	3	140	-	-	-	1	-	-	-	1	1	-
Stearns	8	371	137	-	-	-	-	-	1	2	4	1
Steele	2	153	-	-	-	-	-	-	-	-	-	2
Stevens	1	70	-	-	-	-	-	-	1	-	-	-
Swift	2	62	-	-	-	-	-	-	-	-	2	-
Todd	2	71	60	-	-	-	-	-	-	1	1	-
Traverse	1	60	-	-	-	-	-	-	-	-	1	-
Wabasha	3	104	-	-	-	-	-	-	1	1	1	-
Wadena	2	121	-	-	-	-	-	-	-	-	1	1
Waseca	2	105	63	-	-	1	-	-	-	1	-	-
Washington	5	248	-	-	1	-	-	-	-	-	2	2
Watonwan	2	137	-	-	-	-	-	-	-	-	2	-
Wilkin	1	81	81	-	-	-	-	-	-	1	-	-
Winona	4	188	245	1	-	1	-	-	-	-	2	-
Wright	6	279	-	-	-	-	-	-	-	2	1	3
Yellow Medicine	1	44	-	-	-	-	-	-	-	-	-	1
Total	335	21,471	6,850	8	4	14	11	14	38	79	109	58

Note: NH means Nursing Home
"-" means zero units

1/ Excludes hospital nursing care units and boarding care homes.
2/ Only those counties are listed for which nursing care units and their occupancy rates were available.
3/ Includes only those units and their beds for which an occupancy rate was available.
4/ Total number of beds which were Medicare approved by the Department of Health, Education, and Welfare - as of October,1967.

Sources: Minnesota. Minnesota Hospitals, 19th Annual Revision. State Department of Public Health, Division of Hospital Services. Minneapolis. 1967-68.

Department of Health, Education, and Welfare. Directory of Providers - Extended Care Facilities. Social Security Administration, Washington, D.C. October 1967.

THE PROVISIONS OF HEALTH CARE FOR VETERANS IN THE UNITED STATES

Minnesota is one of 28 States which maintains and operates a State Veterans' Home. In order that it might be knowledgeable about the activities of other states in this field, the results of a survey concerning the characteristics of State Veterans' Homes are attached. This survey compares Minnesota's policies of veterans' income collection, requirements of veterans' assets, facility charges made to the veterans, etc., with those in other states. In addition, the attached tables detail the costs of providing domiciliary and nursing home care in State Veteran Homes, including that of Minnesota.

As far as the activities of the Federal Government are concerned in providing care for veterans, the U. S. Veterans Administration is the principal agency which provides care for the veteran groups specifically, as opposed to those Federal Government agencies which provide health care for veterans, as citizens, rather than for reasons of being current or past members of our armed services. At the present time the U. S. Veterans Administration operates 165 hospitals; 16 domiciliaries; assists states in the construction of and payment for veteran care in a State Veterans' Home; operates 4000 nursing home beds throughout the United States; and contracts with community nursing homes to provide nursing care for veterans of up to six months duration. Attached are tables which show the distribution of Veteran Administration hospitals, domiciliary, and nursing care listed by State; the agreements and number of beds involved between the United States Veteran Administration and private nursing homes, distribution of Veteran Administration operated nursing home beds by State; per diem cost of care at ten selected Veterans Administration nursing

homes and at all VA nursing homes, including those in Minnesota; estimated cost of approved State nursing home bed projects, and a comparison of the average per diem rates paid for community nursing home care and rates of Veterans Administration in VA Hospital Service areas.

The tables which are presented are intended as illustrations of the variety and scope of Veterans Administration health services throughout the United States. Wherever the statistics are applicable to Minnesota, the position of the State in regard to the remainder of the country can be seen in their proper perspective. It is the purpose of these tables to be so illustrative.

CRITERIA FOR ADMISSION OF VETERANS TO STATE HOMES (FOR NURSING AND MEMBER CARE) AS OF JULY 3, 1967

Location of State home	How much of the veteran's income does the home collect? Yes/No	Criteria	What are the State homes' requirements with respect to veteran's assets, such as bank account, bonds, and cash?	What are the State homes' requirements with respect to veteran's property, such as home, automobile, etc.?	Are veterans, when admitted, required to make assignment of life insurance to the State home?	In responding to cols. A, B, C, and D, indicate disposition in event of veteran's death in the State home.	What charges other than those covered in cols. A, B, C, and D are made to the veteran or his family or representative by the State home?	Is the State home affiliated with a medical school?
		(A)	(B)	(C)	(D)	(E)	(F)	(G)
Atlanta, Ga.	No		Not asked this question	None	No	None	Glasses, $25; Dental, charge for material.	No.
Boise, Idaho	Yes	Above $65 to maximum of $40 per month. Income over $105 per month not disturbed.	Not considered in determining eligibility or monthly rate of charge.	do	No	To next of kin. If no kin or claim within 5 years to State treasurer.	None	No.
Chelsea, Mass.	Yes	Aid and attendance pension allowance.	If assets exceed following veteran encouraged to seek other service: Domiciliary $5,500; acute hospital (total) $5,000; chronic hospital care $10,000.	If real property exceeds cash values cited in col. B, encouraged to seek other service.	No	As willed by patient	3d party coverage for care, etc., on assignment by patient.	Negotiating.
Holyoke, Mass.	Yes	do	None	None	No	do	3d party coverage for care on assignment by patient.	No.
Buffalo, Wyo.	Yes	Not to exceed $999, but in all cases veteran retains $50 per month.	Financial statement required of all veterans who are admitted to home.	If no income and has assets, encouraged to convert assets to cash to make monthly payments.	No	According to will or to next of kin under applicable State laws.	None	No.
Quincy, Ill.	Yes	Graduated scale from $5 to $150 per month.	None	None	No	None unless liquid assets exceed $5,000, then minimum of $150 month for period he paid less.	do	Yes.
Sandusky, Ohio	No		Eligibility established according to p. 2 of VA form 10-10 query.	do	No	As willed by patient. Valuables and money by probate court.	do	No.
Grand Rapids, Mich.	Yes	Over $50 to maximum of $126 per month.	Assets fixed and considered as to sufficient for support. Assistance to home made and retained unless claimed by next of kin.	Real estate and car fixed, however, no adjustment of such pay, only if gained.	No	Accepted at time of admission and retained by home unless claimed by next of kin.	None	No.
Home Lake, Colo.	Yes	$30 a month maximum from other income. None from compensation and pension income.	None	None	No	If no heirs to personal property buried in 6 months, property sold for benefit State general fund.	None except for non-veteran.	No.
Marshalltown, Iowa	Yes	If personal est. is $1,500 or more and no dependents, he pays total support. If $500 or less, charges as follows: 1st $20—none; $20–40 percent; 57%–75 percent.	None	Home is counted as asset only if it is rented. Car not allowed on grounds.	No	Not required to sign over home. All assets, after burial expenses go to next of kin.	Veteran buys his own clothes and personal items.	No.
Menlo Park, Vineland, N.J.	No		Veteran must be needy, has insufficient income or assets to maintain himself.	Without dependents is not permitted to have property or car. Married veteran can have home and/or car if used by wife.	No	None	None	No.
Lisbon, N. Dak.	No		No special provisions. Individual cases reviewed.	No restrictions	No	If no heirs or will, becomes property of board of trustees.	do	No.
Columbia Falls, Mont.	Yes	Approximately 20 percent	Non	None	No	If no heirs or will to State	do	No.
Lafayette, Ind.	Yes	$45 per month. Less if income not adequate. 1st $30 of compensation and pension exempt, 80 percent of balance collected.	Not admitted if liquid assets $3,000 or more; this waived if special care required, upon advice of advisory committee.	Permitted to retain property, such as home, car, etc.	No	Claim for cost of maintenance made by State. If dependent parent or wife or child, no claim.	do	No.
Grand Island, Nebr.	Yes	Maximum—$125 per month. Women must pay $14 minimum. $10 allowed for personal needs by State law.	Must be dependent wholly or partially on charity. Income in excess of $10—reasonable amount charged for maintenance.	See col. B	No	Personal effects and valuables as willed. Property disposed of per State laws.	do	No.
Tilton, N. H.	Yes	Income from all sources in excess of $115 per month.	Not admitted if real or personal property exceeds $1,500, or if receiving unemployment compensation.	$1,500 limitation covers property, cash, bonds, etc. Cannot own or operate car.	No	As designated on State home application.	Cost of prescriptions	No.
Minneapolis, Minn.	Yes	1st $30 exempt; 2d of $65; $10 of $50, $20 of $70; over $100, $45 plus 90 percent collected.	Veteran ineligible if total of all assets and property owned exceeds $2,000.	See col. B	No	Will is made upon admission. No claim by home.	None	No.
Norman, Okla.	Yes	If veteran has dependent, no charge regardless of income. If no dependent, no charge if income $81 or less per month.	None	None	No	Claim against estate for difference between per diem cost and what veteran paid.	do	No.
Ardmore and Sulphur, Okla.	Yes	In excess of $4, charge varies from 1.2 percent to maximum of 50 percent depending on income per month.	do	do	No	May make claim to cover difference between per diem cost and amount paid.	do	No.
Rocky Hill, Conn.	No		Home acts as credit firm for bonds, bank books and cash. No investigation by home of resources.	do	No	Claim against estate billing home cost less Federal aid and medicare received.	do	No.
Erie, Pa.	No		If total assets exceed $10,000, veteran not admitted.	See B; no dependents and income excess of $225 per month not admitted.	No	All assets held 1 year. If no claim placed in welfare fund.	do	No.
Bristol, R.I.	No	No presently, but planning to collect percentage in excess of $15 monthly.	Remain in veterans name but deposits and expenditures supervised by home.	No restrictions on property; cannot retain car.	No	Advised to make will. Assets become property of State.	do	No.

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May 20, 1968 CONGRESSIONAL RECORD — HOUSE H3977

CRITERIA FOR ADMISSION OF VETERANS TO STATE HOMES (FOR NURSING AND MEMBER CARE) AS OF JULY 3, 1967—Continued

Location of State home	How much of the veteran's income does the home collect? Yes No	Criteria (A)	What are the State homes' requirements with respect to veteran's assets, such as bank account, bonds, and cash? (B)	What are the State homes' requirements with respect to veteran's property, such as home, automobile, etc.? (C)	Are veterans, when admitted, required to make assignment of life insurance to the State home? (D)	In responding to cols. A, B, C, and D, indicate disposition in event of veteran's death in the State home. (E)	What charges other than those covered in cols. A, B, C, and D are made to the veteran or his family or representative by the State home? (F)	Is the State home affiliated with a medical school? (G)
Napa County, Calif.	No		Liquid assets should not exceed $[illegible]. Needs of dependents are considered.	Real assets not in excess of $[illegible] [illegible] of dependents considered. Must [illegible] to defray cost of care elsewhere.	No	Per will if made 1 year prior to admission. If intestate, after 5 years assets to post fund unless claimed by kin.	None except for dentures if veteran can afford to pay for them.	No.
Retsil, Wash.	No		$1,000 limitation of total assets as property, car, cash, bonds, etc.	See B	No	To next of kin. If no heirs after 2 years to State.	Charge of 50 cents a week for personal laundry.	No.
Orting, Wash.	No		do	do	No	do	None	No.
Hot Springs, S. Dak.	Yes	Nothing to $[illegible], $5 from $50 to $[illegible], $10 to $[illegible], $17.50 to $79, maximum $75 on $150 or more a month.	Not able to earn living, less than $1,800 income, unable to support self and dependents.	Property not a factor, may own and use cars.	No	If no will or legal dependents, home is sole heir.	If more than $3,000 cash accumulated while at home must pay maximum monthly cost until cash assets reduced to $3,000.	No.
St. James, Mo.	Yes	From $2 to $[illegible] [illegible] scale of 17 to 45.5 percent. Over $[illegible] per month, 50 percent.	3 percent in excess of $750 cash added to monthly income.	3 percent of real estate over $[illegible] added to monthly income.	No	As willed or to next of kin.	None	No.
Oxford, N.Y.	Yes	All income in excess of $[illegible] per month.	Required to place assets in joint ownership with home.	[illegible]	Yes	Assets in excess of amounts claimed by home to State.	do	No.
Bennington, Vt.	Yes	All over $[illegible] if single and no dependents; otherwise none.	Must give evidence of no adequate means of support. [illegible] property are considered.	See B	No	To next of kin or heir if will exists, otherwise to State.	do	No.
Fort Lodge, [illegible]	Yes	[illegible] $30 reduced to $15 a month.	[illegible] living expenses.	If [illegible] value of real [illegible] for [illegible] property. Late model car might be considered.	No	According to State laws	do	No.
King, Wis.	Yes	1st $20 exempt; $30–40 percent, $50–60 percent, $70–75 percent; over $75–100 percent. If pension payments suspended due to excess assets, per diem cost may be charged to estate.	All assets in excess of $1,000 must be turned over to home.	See B	No	If no legal dependents, to the State.	do	No.

Source: Veterans Administration. "Department of Medicine and Surgery Circular" 1-67-157 Washington, D.C. July 3, 1967.

VA FEDERAL AID PAYMENTS MADE FOR MEMBER AND NURSING CARE PROVIDED BY STATE VETERANS HOMES
FISCAL YEAR 1967

LOCATION OF STATE HOMES		DAYS OF CARE DURING FISCAL YEAR 1967 d/	AVERAGE DAILY MEMBER AND NURSING CENSUS FISCAL YEAR 1967 c/	COSTS - SHARED BY VETERANS ADMINISTRATION AND STATE VETERANS HOMES					
				PER DIEM COST d/	TOTAL COST d/	DISTRIBUTED COST e/			
						BY VA	BY STATE	PERCENT	
								BY VA	BY STATE
MEMBER CARE									
TOTAL		2,806,204	7,687	$ 8.92	$25,046,783 h/	$ 6,900,598	$ 18,146,185	27.6	72.4
CALIF.	NAPA	510,390	1,398	11.12	5,675,537	1,275,933	4,399,604	22.5	77.5
COLO	HOMELAKE	30,937	85	7.71	238,524	77,700	160,824	32.6	67.4
CONN	ROCKY HILL	f/ 237,817	652	9.92	2,359,145	605,810	1,753,335	25.7	74.3
GA	MILLEDGEVILLE	127,388	349	6.03	768,150	318,542	449,608	41.5	58.5
IDAHO.	BOISE	35,552	97	3.79	134,742	66,519	68,223	49.4	50.6
ILL.	QUINCY	131,767	361	6.39	841,991	329,418	512,573	39.1	60.9
IND.	LAFAYETTE	52,963	145	6.50	344,260	133,909	210,351	38.9	61.1
IOWA	MARSHALLTOWN	140,285	384	8.58	1,203,645	350,678	852,967	29.1	70.9
KANS	FORT DODGE	32,998	90	4.04	133,312	66,472	66,840	49.9	50.1
MASS	CHELSEA	138,309	379	20.30	2,807,673	345,634	2,462,039	12.3	87.7
	HOLYOKE	60,746	166	24.60	1,494,352	143,873	1,350,479	9.6	90.4
MICH	GRAND RAPIDS	115,977	318	8.53	989,284	292,245	697,039	29.5	70.5
MINN	MINNEAPOLIS	116,232	318	5.68	660,198	290,785	369,413	44.0	56.0
MO	ST. JAMES	18,867	52	6.00	113,202	47,217	65,985	41.7	58.3
MONT	COLUMBIA FALLS	17,188	47	6.95	119,457	42,961	76,496	36.0	64.0
NEBR	GRAND ISLAND	85,456	234	7.74	661,429	213,638	447,791	32.3	67.7
N. H	TILTON	13,263	36	6.67	88,464	33,162	55,302	37.5	62.5
N. J	MENLO PARK	40,101	110	6.82	273,489	99,765	173,724	36.5	63.5
	VINELAND	53,619	147	8.35	447,719	134,047	313,672	29.9	70.1
N. Y	OXFORD	7,894	22	9.03	71,283	21,272	50,011	29.8	70.2
N. DAK	LISBON	34,662	95	4.11	142,461	71,244	71,217	50.0	50.0
OHIO	ERIE COUNTY	g/ 207,844	568	4.33	899,964	449,982	449,982	50.0	50.0
OKLA	ARDMORE	70,513	193	4.92	346,924	172,102	174,822	49.6	50.4
	NORMAN	81,115	222	5.62	455,866	204,336	251,530	44.8	55.2
	SULPHUR	43,021	118	9.57	411,711	108,985	302,726	26.5	73.5
PA	ERIE	63,151	173	7.17	452,793	157,407	295,386	34.8	65.2
R. I	BRISTOL	44,425	122	6.82	302,979	111,427	191,552	36.8	63.2
S. DAK	HOT SPRINGS	36,102	99	7.83	282,679	90,255	192,424	31.9	68.1
VT	BENNINGTON	21,123	58	9.12	192,642	52,807	139,835	27.4	72.6
WASH	ORTING	40,562	111	8.11	328,958	101,405	227,553	30.8	69.2
	RETSIL	62,442	171	6.68	417,113	156,105	261,008	37.4	62.6
WIS.	KING	125,902	345	10.50	1,321,971	314,755	1,007,216	23.8	76.2
WYO.	BUFFALO	8,018	22	8.09	64,866	20,208	44,658	31.2	68.8
NURSING CARE									
TOTAL		519,560	1,426	$11.38	$ 5,914,654	$1,819,475	$ 4,095,179	30.8	69.2
CALIF.	NAPA	48,916	134	8.94	437,309	171,117	266,192	39.1	60.9
ILL.	QUINCY	72,615	199	10.25	744,304	254,153	490,151	34.1	65.9
IND.	LAFAYETTE	29,023	80	7.87	228,411	101,782	126,629	44.6	55.4
MASS	CHELSEA	64,168	176	21.09	1,353,303	224,585	1,128,718	16.6	83.4
MICH	GRAND RAPIDS	140,362	385	9.79	1,374,144	494,687	879,457	36.0	64.0
MO	ST. JAMES	11,984	33	9.23	110,612	42,347	68,265	38.3	61.7
N. H	TILTON	2,723	7	15.62	42,533	9,542	32,991	22.4	77.6
N. J	MENLO PARK	20,327	56	11.70	237,826	71,144	166,682	29.9	70.1
N. Y	OXFORD	1,680	5	16.47	27,670	4,322	23,348	15.6	84.4
OKLA	ARDMORE a/	2,236	6	8.97	20,057	7,826	12,231	39.0	61.0
	SULPHUR	23,387	64	10.99	257,023	81,855	175,168	31.8	68.2
R. I	BRISTOL	47,437	130	11.75	557,385	166,033	391,352	29.8	70.2
S. DAK	HOT SPRINGS	12,400	34	8.66	107,384	43,050	64,334	40.1	59.9
VT	BENNINGTON b/	558	2	18.03	10,061	1,953	8,108	19.4	80.6
WASH	ORTING	17,082	47	10.58	180,728	59,787	120,941	33.1	66.9
	RETSIL	24,662	68	9.16	225,904	85,292	140,612	37.8	62.2

a/ Program initiated at station during May 1967.
b/ Program initiated at station during June 1967.
c/ Based on total days of care during year divided by the number of calendar days in fiscal year.
d/ Per diem cost is based on the total cost divided by the total days of care during fiscal year.
e/ Data are an approximation of cost based as follows; (1) for the VA, the amount shown is the payment reported on DM&S Cost Report A-2; (2) for the State, the amount is the difference of total cost minus VA payment.
f/ Does not include adjustment of 4357 additional days of care owing to "medicare".
g/ Includes 425 patient days of care adjusted subsequent to release of official data and are not included in overall total.
h/ Data are $7511 less than originally reported due to corrections made retroactively by 3 stations.

SOURCE: VA Form 10-5588, RCS 10-167 series and RCS MPO-12B.

APPROVED: Harry Warren
Chief, State Home Services Division
Veterans Administration

Controller, Veterans Administration
Reports & Statistics Service - 042B21
November 13, 1967

EBS MANAGEMENT CONSULTANTS
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NURSING HOME CARE FACILITIES
STATE SOLDIERS' HOME

1. Under Title 38, USC 641, the following State Homes have been approved by VA Office of Jurisdiction to provide nursing home care:

STATE HOME	No. of Beds	STATE HOME	No. of Beds
California - Napa County	428	New York - Oxford	7
Colorado - Homelake	20	Oklahoma - Ardmore	38
Illinois - Quincy	357	- Sulphur	88
Indiana - Lafayette	152	Pennsylvania - Erie	64
Kansas - Fort Dodge	22	Rhode Island - Bristol	138
Massachusetts - Chelsea	241	S. Dakota - Hot Springs	42
Michigan - Grand Rapids	469	Vermont - Bennington	22
Missouri - St. James	93	Washington - Orting	50
New Hampshire - Tilton	20	- Retsil	80
New Jersey - Menlo Park	88	Wisconsin - King	248
			2,667

(Cumulative ADNL through May was 1,786)

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2. Construction Projects Completed:

State	Beds	VA Cost (000's)	Total Cost (000's)
Vermont, Bennington	22	123	252

3. Construction Projects Approved: Nine states have been given tentative approval for ten construction grants under Title 38 USC 5031-5037.

State	No. of Beds	VA Participation (Thousands, Est.)	Total Project (Thousands, Est.)
*Georgia, Augusta	192	$ 982	$ 2,065
Illinois, Quincy	200	1,619	3,239
*Iowa, Marshalltown	80	532	1,070
Kansas, Ft. Dodge	88	400	800

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State	No. of Beds	VA Participation (Thousands, Est.)	Total Project (Thousands, Est.)
*Nebraska, Grand Island	100	$ 744	$ 2,012
New Jersey, Menlo Park	100	1,030	2,073
*New Jersey, Vineland (#1)	100	592	1,297
New Jersey, Vineland (#2)	100	858	2,305
Oklahoma, Norman	50	209	418
*Rhode Island, Bristol	30	364	753
*Wisconsin, King #1	200	1,181	2,881
*Wisconsin, King #2	200	1,545	3,344
	1,440	$10,056	$22,257

*Under contract

4. Formal applications for the following states listed in order received are being processed:

State	No. of Beds	VA Participation (Thousands, Est.)	Total Project (Thousands, Est.)
Massachusetts, Holyoke	157	$ 1,200	$ 4,220
Montana, Columbia Falls	13	45	545
**New Jersey, Menlo Park (#2)	100	892	1,783
**New Hampshire, Tilton	50	290	580
Vermont, Bennington (#2)	40	561	1,124
	360	$ 2,988	$ 8,252

**NOTE: States advised that, subject to availability of Federal funds, VA will participate at 50% of project costs.

5. The following 13 states have contacted the VA and expressed an interest in securing financial assistance under Title 38 USC 5031-5037:

State	No. of Beds	
California	170	Remodeling
Colorado	40	Under consideration
Georgia	220	(2nd proj.) Remodeling planning stage
Indiana	168	Planning stage
Iowa	120	(2nd proj.) Under consideration
Michigan	260	State appropriations
Missouri	60	State appropriations
Nebraska	100	Under consideration
New Jersey	100	(5th proj.) Under consideration
Pennsylvania	100	Under consideration
South Dakota	86	Planning stage
Washington - Retsil	60	Under consideration
Wyoming	20	Under consideration
	1,604	

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PROJECTION:

Average VA share per bed of projects approved to date - $6,858

Potential additional beds - 1,604

Potential additional VA participation - $11,000,000

Source: Veterans Administration. Nursing Home Care Facilities - State Soldiers' Home. Department of Medicine and Surgery. Washington, D.C. June 28, 1968.

APPENDIX A

VA Regulation 6171

STATE HOME FACILITIES FOR FURNISHING NURSING HOME CARE

The maximum number of beds, as required by 38 U.S.C. 5034 (1), to provide adequate nursing home care to war veterans residing in each State is established as follows:

State	War Veteran Population*	No. of Beds
Alabama	330,000	495
Alaska	23,000	35
Arizona	187,000	281
Arkansas	180,000	270
California	2,427,000	3,641
Colorado	235,000	353
Connecticut	364,000	546
Delaware	60,000	90
District of Columbia	100,000	150
Florida	761,000	1,142
Georgia	392,000	588
Hawaii	50,000	75
Idaho	77,000	116
Illinois	1,310,000	1,965
Indiana	569,000	854
Iowa	313,000	470
Kansas	250,000	375
Kentucky	315,000	473
Louisiana	346,000	519
Maine	114,000	171
Maryland	428,000	642
Massachusetts	699,000	1,049
Michigan	948,000	1,422
Minnesota	417,000	626
Mississippi	184,000	276
Missouri	532,000	798
Montana	82,000	123
Nebraska	152,000	228
Nevada	53,000	80
New Hampshire	84,000	126
New Jersey	885,000	1,328
New Mexico	111,000	167
New York	2,175,000	3,263
North Carolina	442,000	663
North Dakota	56,000	84
Ohio	1,253,000	1,880

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Appendix A

VA Regulations
Medical--Trans. Sheet 69

State	War Veteran Population*	No. of Beds
Oklahoma	278,000	417
Oregon	250,000	375
Pennsylvania	1,479,000	2,219
Rhode Island	112,000	168
South Carolina	216,000	324
South Dakota	71,000	107
Tennessee	394,000	591
Texas	1,129,000	1,694
Utah	105,000	158
Vermont	43,000	65
Virginia	453,000	680
Washington	380,000	570
West Virginia	205,000	308
Wisconsin	464,000	696
Wyoming	45,000	68
Puerto Rico (Commonwealth)	99,000	149]

*Data as of June 30, [1967.] Source: [Reports and Statistics Service,] Office of the VA Controller. (Based on last available Bureau of the Census data.) (Feb. 27, 1968)

COST FOR MEMBER AND NURSING HOME CARE IN STATE HOMES

Fiscal year	Total	Paid by State homes	Paid by VA
Member care:			
1967	$25,046,783	$18,145,185	$6,900,598
1966	25,091,125	17,953,147	7,437,978
1965	25,848,771	18,157,145	7,691,626
1964	24,975,345	17,396,642	7,578,703
1963	23,304,418	15,889,411	7,415,007
1962	22,442,261	15,041,858	7,400,403
Nursing home care:			
1967	5,914,654	4,095,179	1,819,475
1966	3,843,226	2,652,049	1,191,177
1965 [1]	616,348	430,708	185,640

[1] Program began Jan. 1, 1965.

COST FOR MEMBER AND NURSING HOME CARE IN STATE HOMES, BY STATE, JULY 1967 THROUGH MARCH 1968

State	Member care	Nursing home care
Total	$17,101,100	$5,674,199
Cost of State home [1]	11,970,770	3,971,891
Cost to VA	5,130,330	1,702,299
California	905,117	151,385
Colorado	57,692	
Connecticut	498,560	
Georgia	241,812	
Idaho	45,825	
Illinois	240,102	257,856
Indiana	96,923	83,670
Iowa	252,605	
Kansas	54,609	
Louisiana	25,597	
Massachusetts	351,959	155,487
Michigan	189,125	387,317
Minnesota	209,595	
Missouri	31,275	31,784
Montana	34,479	
Nebraska	175,715	
New Hampshire	25,590	12,073
New Jersey	176,938	65,899
New York	13,360	4,173
North Dakota	56,573	
Ohio	481,758	
Oklahoma	313,915	102,552
Pennsylvania	169,350	40,692
Rhode Island	81,233	126,598
South Dakota	63,320	32,722
Vermont	26,035	26,648
Washington	192,857	110,414
Wisconsin	162,973	119,371
Wyoming	20,285	

[1] Estimated. Based on the experience of the past several years the State home contributes 70 percent and the VA contributes 30 percent of the cost care of veterans in the State homes.

Source: Congressional Record. House of Representatives. May 20, 1968 p. 3978

PER DIEM COST OF CARE AT TEN SELECTED VA NURSING HOMES
June 11-17, 1967

Service Provided	All Ten	Alexandria, La.	Brockton, Mass.	Butler, Pa.	Dublin, Ga.	Fayetteville, N.C.	Houston, Tex.	Indianapolis, Ind.	Lebanon, Pa.	Sepulveda, Calif.	Sioux Falls, S.D.
Total Cost	$13.96	$12.89	$12.72	$14.52	$14.07	$16.06	$14.41	$13.75	$12.34	$15.61	$13.38
Physician	.23	.02	.16	.13	.28	.09	.47	.49	.18	.21	.23
Professional Nurse	3.07	2.39	3.14	2.97	3.62	3.90	2.76	3.03	2.58	3.38	2.90
Licensed Practical Nurse, Nurses Aide	4.28	3.50	4.32	4.31	5.06	4.54	3.56	3.71	5.80	3.44	4.53
Social Work	.25	.06	.24	.19	.23	.22	.44	.27	.04	.71	.08
Radiology	.06	.04	.03	----	.02	.01	.09	.05	.02	.31	.01
Laboratory	.09	----	----	.01	.19	.16	.07	.02	----	.41	.04
Pharmacy	.33	.59	.21	.40	.46	.23	.27	.21	.18	.31	.45
Physical Medicine	.87	1.14	.51	1.00	.68	1.14	.99	.88	.41	1.35	.65
Dietary	2.47	3.25	2.77	3.21	2.14	2.68	2.49	2.17	1.83	2.35	1.82
Chaplain	.06	.06	.06	.07	.02	.03	.11	.09	.02	.10	.06
Dentistry	.20	.16	.11	.08	.04	.05	.51	.34	.29	.38	----
Housekeeping	.53	.42	.36	.76	.41	.36	.42	.72	.37	.77	.68
Laundry	.28	.16	.11	.19	.16	.50	.19	.33	.16	.72	.29
Administration	.62	.57	.39	.43	.39	.82	1.34	.66	.31	.54	.79
Engineering	.49	.49	.22	.65	.37	1.16	.42	.49	.15	.22	.73
All Other	.15	.04	.09	.12	----	.17	.28	.29	----	.41	.12

NOTE: Columns may not add due to rounding

Source: U. S. Veterans Administration. The VA Nursing Home Program - An Examination Into Quality and Cost. Department of Medicine and Surgery. Washington, D.C. January 1968 p.76

PER DIEM COST OF CARE AT ALL VA NURSING HOMES IN OPERATION
June 11-17, 1967

	Total Cost	Physician	Professional Nurse	LPN/RA	Social Work	Radiology	Laboratory	Pharmacy	Physical Medicine	Dietary	Chaplain	Dentistry	Housekeeping	Laundry	Administration	Engineering	All Other
All Fifty-One	$14.722	$1.355	$2,536	$3.910	$ .224	$ .039	$ .087	$ .386	$ .826	$3.014	$ .104	$ .133	$ .597	$ .354	$ .991	$ .976	$ .190
Albany, New York	16.386	1.294	2.681	5.151	.622	--	.017	.134	1.218	2.714	.437	--	.958	.244	.731	.109	.076
Alexandria, Louisiana	12.894	.018	2.389	3.496	.063	.040	--	.589	1.142	3.245	.062	..164	.420	.163	.572	.494	.037
American Lake, Washington	18.705	.473	1.230	4.978	.223	.073	.943	.437	.692	5.362	.020	.324	.777	.660	1.437	1.056	.020
Aspinwall, Pennsylvania	15.821	.406	2.070	3.370	.258	.015	.149	.515	.160	4.007	.242	.149	.444	.347	1.382	1.957	.350
Bath, New York	13.898	.272	3.205	2.609	.064	.139	.183	.503	1.076	2.184	.127	.138	.451	.097	.213	2.587	.050
Battle Creek, Michigan	19.590	.373	1.710	9.067	.288	.125	--	1.781	1.009	3.054	.040	--	.757	.540	.545	.279	.022
Beckley, West Virginia	17.936	.389	3.342	8.468	.141	.030	.081	.466	.637	3.064	.041	.059	.400	--	.481	.340	--
Bonham, Texas	12.122	.226	4.166	3.155	.063	.014	.008	.358	.617	2.390	.127	.130	.322	.274	.081	.255	.036
Brockton, Massachusetts	12.702	.161	3.144	4.318	.240	.028	--	.210	.509	2.767	.055	.110	.363	.105	.385	.219	.088
Buffalo, New York	13.500	.828	4.298	2.990	.083	.020	.015	.264	.544	2.738	.151	.016	.479	.106	.724	.156	.188
Butler, Pennsylvania	14.498	.128	2.973	4.308	.187	--	.005	.399	.995	3.209	.067	.084	.756	.187	.426	.653	.121
Canandaigua, New York	6.032	.094	..304	.921	--	--	.015	.207	.453	2.298	.055	.058	.532	.274	.164	.386	.271
Cheyenne, Wyoming	13.048	.172	3.691	3.486	.418	.017	.015	.324	1.015	1.720	.032	.038	.527	.608	.502	.470	.013
Chicago, Illinois (W.S.)	19.205	.384	3.024	5.033	.666	.096	.054	.376	3.101	3.827	.063	.101	11039	.346	.337	.395	.363
Chillicothe, Ohio	11.504	.107	1.062	4.597	.222	.022	.022	.163	..937	2.302	.039	.147	.525	.315	.113	.810	.221
Cincinnati, Ohio	25.575	.909	3.010	3.829	.438	.091	.170	.416	.812	4.921	.240	.553	1.030	.288	2.823	5.397	.648
Columbia, South Carolina	22.393	.359	7.969	4.675	.664	.028	.079	.151	4.595	1.517	--	--	.816	.493	.880	.143	.024
Dayton, Ohio	13.637	.136	3.547	3.047	.096	.006	--	.250	.636	3.655	.377	--	.743	.140	.342	.662	--
Dearborn, Michigan	10.940	.062	1.894	3.505	.183	.041	---	.287	.652	2.534	.121	--	.587	.165	.403	.293	.213
Dublin, Georgia	14.064	.279	3.617	5.059	.227	.018	.187	.463	.679	2.141	.020	.040	.412	.164	.395	.365	--
Fargo, North Dakota	16.031	.555	3.670	3.887	.121	.009	.040	.662	.951	3.803	.026	.014	.590	.445	.662	.515	.081
Fayetteville, North Carolina	16.038	.089	3.900	4.541	.219	.009	.159	.226	1.135	2.676	.025	.050	.358	.495	.820	1.164	.172
Fort Lyon, Colorado	12.985	.182	1.338	3.419	.204	.150	.051	.233	1.025	2.434	.055	.067	.222	.285	2.362	.760	.198
Grand Junction, Colorado	15.296	.246	2.339	2.814	.089	--	.061	.400	.736	6.011	.086	.039	.693	.364	.682	.707	.029
Gulfport, Mississippi	12.913	.920	.926	4.361	.277	.019	1137	.325	.682	3.349	.050	.054	.506	.430	.709	.128	.040

(Note: See next page for footnote)

PER DIEM COST OF CARE AT ALL VA NURSING HOMES IN OPERATION
June 11-17, 1967

	Total Cost	Physician	Professional Nurse	LPN/NA	Social Work	Radiology	Laboratory	Pharmacy	Physical Medicine	Dietary	Chaplain	Dentistry	Housekeeping	Laundry	Administration	Engineering	All Other
Houston, Texas	14.380	.467	2.760	3.560	.437	.089	.070	.267	.989	2.486	.108	.512	.416	.187	1.341	.416	.275
Indianapolis, Indiana	13.744	.486	3.025	3.714	.273	.053	.023	.207	.877	2.174	.092	.338	.716	.328	.663	.486	.289
Kecoughtan, Virginia	15.141	.141	3.736	3.838	.803	.068	.033	.219	.444	2.830	.120	.184	.539	.430	.876	.565	.315
Kerrville, Texas	22.414	.739	3.888	4.075	.068	.033	.008	.578	27714	1.218	.149	--	.453	.677	4.441	27975	.398
Knoxville, Iowa	8.843	.203	.302	2.773	.049	.016	.021	.203	.773	2.202	.043	.200	1.106	.207	.450	.236	.059
Lebanon, Pennsylvania	12.322	.180	2.582	5.796	.038	.018	--	.176	.409	1.834	.023	.285	.370	.157	.309	.145	--
Livermore, California	21.788	.333	2.680	4.848	.126	.022	.203	.446	.195	1.801	.147	.416	.537	.255	8.952	.719	.108
Los Angeles, California	13.262	.481	1.615	1.872	.132	.011	.066	.320	.536	4.260	.081	.050	.823	.272	1.559	.952	.232
Manchester, New Hampshire	12.859	.130	3.549	2.810	.149	--	.046	.350	.971	2.957	.112	.063	.730	.341	..367	.082	.202
Montrose, New York	9.155	.415	.784	3.675	.070	.014	.052	.148	1.539	1.334	.284	.049	.089	.078	.191	.406	.027
Mountain Home, Tennessee	14.840	.119	3.862	4.886	.468	--	.026	.505	.926	1.910	.034	.114	.635	.156	.437	.714	.048
Poplar Bluff, Missouri	17.190	.164	1.683	3.514	.048	.056	.020	.235	.202	3.288	.065	.324	.731	2.100	2.418	1.695	.647
Reno, Nevada	13.161	.136	2.519	2.968	.156	.026	.013	.266	.877	3.688	.045	.104	1.130	.909	.045	.065	.214
Roseburg, Oregon	10.041	.662	.604	2.629	--	--	--	.416	.555	3.229	.114	--	.812	.641	.216	.090	.073
Salisbury, North Carolina	11.454	.054	1.692	3.498	.125	--	.059	.222	.607	2.146	.037	--	.377	.530	1.962	.138	.007
Salt Lake City, Utah	16.204	.153	3.516	4.701	.685	--	.104	.653	.974	3.214	.055	.185	.380	.295	.867	.422	--
San Fernando, California	14.730	.218	4.127	2.663	.452	.087	.067	.397	1.091	3.806	.111	.052	.504	.111	.560	.135	.329
Sepulveda, California	15.605	.208	3.376	3.444	.709	.307	.409	.307	1.353	2.346	.099	.383	.765	.720	.542	.224	.413
Sioux Falls, South Dakota	13.373	.233	2.895	4.526	.079	.014	.038	.448	.649	1.818	.056	--	.680	.292	.789	.734	.122
St. Cloud, Minnesota	16.916	.079	2.926	6.102	.122	.062	.016	.407	1.511	2.555	.122	.056	.643	1.435	.640	.535	.105
Togus, Maine	11.952	.112	2.363	4.756	.119	.055	--	.310	.757	1.908	.031	.062	.595	.227	.292	.289	.076
Tomah, Wisconsin	10.193	.315	1.980	4.379	--	--	--	.102	.300	1.501	.017	.047	.534	.589	.163	.251	.015
Waco, Texas	13.191	.731	1.952	5.215	.247	.028	.091	.250	.602	1.980	.088	.060	.416	.215	..461	.771	.084
Wadsworth, Kansas	15.601	.714	.971	4.470	.346	.263	.530	.632	1.340	3.460	.060	.159	.406	.238	.892	.698	.622
Wilmington, Delaware	14.893	.013	4.188	3.646	.085	.013	.085	.373	.445	3.942	.203	.072	.471	.335	.445	.547	.030
Wood, Wisconsin	15.253	.616	3.507	2.675	--	.031	.088	.361	1.284	2.660	.114	.084	.664	.155	.473	2.080	.461

Source: U. S. Veterans Administration. The VA Nursing Home Program - An Examination Into Quality And Cost. Department of Medicine and Surgery. Washington, D.C. January 1968 Appendix IV.

VA NURSING HOME CARE
ACTIVATION OF BEDS

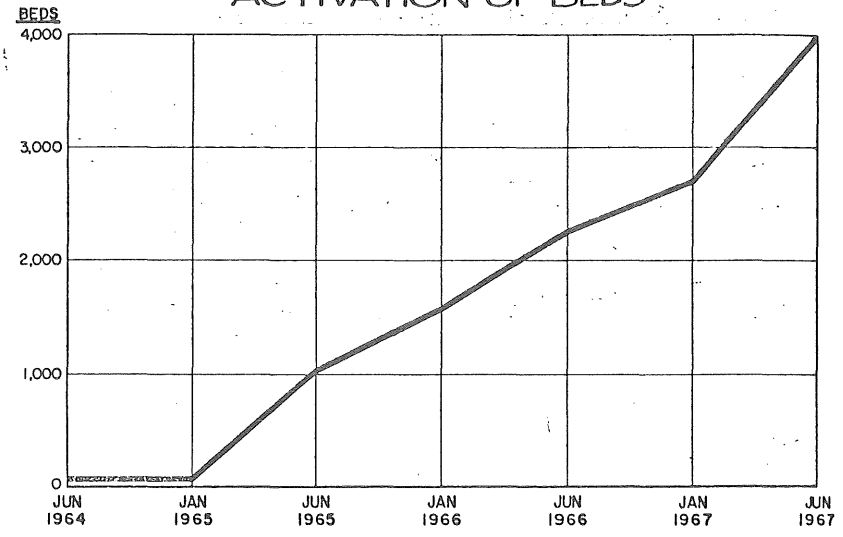

CHART VII

CURRENT DISTRIBUTION OF VA NURSING HOME FACILITIES
4000 BEDS

STATION	NO. BEDS	STATION	NO. BEDS	STATION	NO. BEDS
•ALEXANDRIA, LA.	95	•ALBANY, N.Y.	40	•KERRVILLE, TEX.	37
•AMERICAN LAKE, WASH.	76	•AUGUSTA, GA.	40	•KNOXVILLE, IOWA	50
•BATTLE CREEK, MICH.	65	•BATH, N.Y.	40	•LEBANON, PA.	37
•BRECKSVILLE, OHIO	50	•BECKLEY, W.VA.	42	•LEXINGTON, KY.	51
•CANANDAIGUA, N.Y.	47	•BILOXI, MISS.	71	•LIVERMORE, CAL.	36
•CASTLE POINT, N.Y.	100	•BONHAM, TEX.	38	•LOS ANGELES, CAL.	229
•CHILLICOTHE, OHIO	99	•BROCKTON, MASS.	51	•MARION, IND.	69
•CINCINNATI, OHIO	201	•BUFFALO, N.Y.	36	•MONTROSE, N.Y.	75
•FAYETTEVILLE, N.C.	39	•BUTLER, PA.	64	•LITTLE ROCK, ARK.	100
•GRAND JUNCTION, COL.	42	•CHEYENNE, WYO.	47	•PALO ALTO, CAL.	89
•INDIANAPOLIS, IND.	46	•CHICAGO, ILL.	40	•POPLAR BLUFF, MO.	49
•JEFFERSON BRKS, MO.	68	•COLUMBIA, S.C.	72	•RENO, NEV.	22
•JOHNSON CITY, TENN.	58	•DANVILLE, ILL	58	•ROSEBURG, ORE.	35
•MANCHESTER, N.H.	38	•DAYTON, OHIO	84	•SALISBURY, N.C.	100
•MURFREESBORO, TENN.	51	•DEARBORN, MICH.	36	•SEPULVEDA, CAL.	45
•PITTSBURGH, PA.	208	•DUBLIN, GA.	56	•ST. CLOUD, MINN.	44
•SALT LAKE CITY, UTAH	46	•FARGO, N.D.	50	•TOGUS, ME.	60
•SAN FERNANDO, CAL.	36	•FT. LYON, COL.	37	•TOMAH, WIS.	53
•SIOUX FALLS, S.D.	75	•HAMPTON, VA.	41	•TUSKEGEE, ALA.	68
•WADSWORTH, KAN.	45	•HOUSTON, TEX.	78	•WACO, TEX.	100
•WILMINGTON, DEL.	39			•WOOD, WIS.	106

CHART VIII

Source: U. S. Congress. House of Representatives. VA Nursing HOme Care Programs. Subcommittee on Intermediate Care of the Committee on Veterans Affairs. Washington, D.C. June, July, and August Hearings. p. 1536.

EBS MANAGEMENT CONSULTANTS
INCORPORATED

AGREEMENTS AND BEDS IN VETERANS ADMINISTRATION
APPROVED COMMUNITY NURSING HOMES
ON MARCH 31, 1967

STATE	NUMBER OF AGREEMENTS WITH COMMUNITY NURSING HOMES	BED CAPACITY OF NURSING HOMES
Alabama	55	3,475
Arizona	29	2,009
Arkansas	54	4,310
California	213	16,477
Colorado	30	2,606
Connecticut	23	2,000
Delaware	7	343
Florida	111	6,963
Georgia	29	2,485
Idaho	19	1,362
Illinois	111	9,856
Indiana	40	2,575
Iowa	62	3,782
Kansas	38	2,280
Kentucky	36	2,227
Louisiana	29	1,982
Maine	21	776
Maryland	27	1,935
Massachusetts	113	8,126
Michigan	21	1,784
Minnesota	141	10.066
Mississippi	8	505
Missouri	42	3,552
Montana	4	272
Nebraska	40	2,696
Nevada	1	63
New Hampshire	11	470

EBS MANAGEMENT CONSULTANTS
INCORPORATED

STATE	NUMBER OF AGREEMENTS WITH COMMUNITY NURSING HOMES	BED CAPACITY OF NURSING HOMES
New Jersey	35	3,011
New Mexico	7	382
New York	90	4,445
North Carolina	20	1,381
North Dakota	19	1,275
Ohio	104	6,888
Oklahoma	68	4,103
Oregon	58	3,678
Pennsylvania	79	4,629
Rhode Island	15	537
South Carolina	21	1,372
South Dakota	9	650
Tennessee	62	3,035
Texas	170	11,769
Utah	4	346
Vermont	5	103
Virginia	22	1,999
Washington	59	5,686
West Virginia	21	1,077
Wisconsin	125	7,894
Wyoming	7	509
TOTAL	2,315	159,746

Source: U.S. Congress, House of Representatives, Veterans Administration Nursing Home Care Programs. Subcommittee on Intermediate Care of the Committee on Veterans' Affairs. Washington, D.C. June, July and August 1967 Hearings.

AVERAGE PER DIEM RATES PAID FOR COMMUNITY NURSING HOME CARE BY MEDICARE (AS REPORTED BY VA SOCIAL WORKERS) AND BY THE VETERANS ADMINISTRATION IN VA HOSPITAL SERVICE AREAS
Fiscal Year 1967

State	Medicare	VA	State	Medicare	VA
Alabama	$14.00	$10.56	Nebraska	$16.00	$10.37
Arizona	14.85	10.60	Nevada	18.20	*
Arkansas	10.00	10.28	New Hampshire	13.00	10.53
California	17.75	10.57	New Jersey	16.66	10.62
Colorado	14.00	10.52	New Mexico	9.64	10.34
Connecticut	17.00	10.73	New York	15.30	10.18
Delaware	13.50	10.47	North Carolina	10.00	10.66
District of Columbia	16.50	10.74	North Dakota	14.70	10.45
Florida	15.00	10.57	Ohio	16.02	10.83
Georgia	12.33	9.94	Oklahoma	12.00	9.34
Idaho	14.00	10.38	Oregon	14.96	9.84
Illinois	17.00	10.76	Pennsylvania	15.42	10.61
Indiana	15.00	10.93	Puerto Rico	13.50	10.43
Iowa	15.50	10.50	Rhode Island	13.33	10.63
Kansas	10.40	10.60	South Carolina	10.41	11.50
Kentucky	12.50	10.40	South Dakota	13.33	9.60
Louisiana	11.95	10.46	Tennessee	12.50	10.62
Maine	12.00	10.59	Texas	16.50	10.24
Maryland	15.16	10.58	Utah	17.00	7.53
Massachusetts	16.00	10.35	Vermont	15.00	*
Michigan	16.00	10.66	Virginia	14.50	10.53
Minnesota	14.00	10.08	Washington	15.00	10.49
Mississippi	13.33	10.18	West Virginia	11.00	8.81
Missouri	17.67	10.48	Wisconsin	14.33	10.63
Montana	15.50	10.58	Wyoming	8.75	10.26

*No community program in operation at time of survey.

Note: The following measures pertain:

	Medicare	VA
1st Quartile	$12.50	$10.30
Median	14.60	10.45
3rd Quartile	16.00	10.61

Source: Data based on U.S. Veterans Administration's Department of Medicine and Surgery Circular 10-7-64, Dated April 7, 1967 and cited in the following publication:

U.S. Veterans Administration. The VA Nursing Home Program - An Examination Into Quality And Cost. Department of Medicine and Surgery. Washington, D.C. January 1968 p.83

Estimated Cost of Approved State Nursing Home Bed Projects
September 14, 1967

Location	Number of Beds	Cost of Construction (Thousands) Total	VA Share	Cost Per Bed
TOTAL	1,362	$19,308	$9,066	$14,176
Georgia	192	1,964	982	10,229
Illinois	200	3,239	1,619	16,195
Iowa	80	1,064	532	13,300
Kansas	88	800	400	9,091
Nebraska	100	2,002	744	20,020
New Jersey (Menlo Park)	100	1,640	820	16,420
New Jersey (Vineland)	100	1,215	555	12,150
Oklahoma	50	418	209	8,360
Rhode Island	30	599	299	19,967
Vermont	22	252	123	11,455
Wisconsin No. 1	200	2,726	1,181	13,630
Wisconsin No. 2	200	3,389	1,602	16,945

Source: U. S. Veterans Administration. The VA Nursing Home Program - An Examination Into Quality And Cost. Department of Medicine and Surgery. Washington, D.C. January 1968. p. 21

SOURCES OF INFORMATION
(Organizations)

The following list of organizations are furnished to reflect the vast array of "sources" contacted or utilized during the course of this study:

STATE OF MINNESOTA

Administration Department
- Office of the Commissioner
- Budget Division
- Architectural Engineering Division

American Legion, The
- State Headquarters
- Office of the Department Adjutant
- The Minnesota Legionnaire
- Women's Auxiliary (especially St. Louis County)

Attorney General
- Offices of Special Assistant Attorneys' General

Civil Service Department
- Office of the Director

County Veterans Service Officer
- (Committee)

Disabled American Veterans and
- Womens' Auxiliary

Governor of the State of Minnesota
- Office of the Governor

Governor's Citizen Council on Aging

Health Department
- Administrative Services Division
  - (Vital Statistics)
- Medicare Services Unit
- Hospital Services Division
  - Office of the Director
  - Licensing Unit

Jewish War Veterans, State Organization

Legislative Building Commission
- Office of Executive Secretary
- (Individual and group members)

Military Order of the Purple Heart &
- Women's Auxiliary

Public Welfare, Department of
- Office of the Commissioner
- Office of the Special Assistant on Aging
- Administrative Services Division
  - Institutions Administration
  - Research and Statistics
- Medical Services Division
  - Office of Director
  - Public Assistance Division
- Rehabilitative Services Division

State Planning Agency
- Office of the Director
- Governmental Resources
- Health and Vocational Rehabilitation Planning
- Social Research Planning

United Spanish War Veterans and
- Auxiliary

Veterans Affairs
- Office of the Commissioner

Veterans of Foreign Wars of the U.S.
- State Headquarters
- Women's Auxiliary
- Gopher's Oversea'r

Veterans Home Board of Trustees
Veterans' Home Member

U. S. GOVERNMENT

Census Bureau, Dept. of Commerce

Health, Education, and Welfare,
Department of

House of Representatives,
U. S. Congress
Committee on Veterans Affairs

Small Business Administration

Social Security Administration

Veterans Administration

NATIONAL ASSOCIATIONS

National Association of State
Veteran Homes

VETERANS' ORGANIZATIONS - WASHINGTON, D.C.

American Legion, The
National Rehabilitation Commission

Disabled American Veterans - National Headquarters
Post Services

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NATIONAL ASSOCIATION OF STATE VETERANS' HOMES

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STATE OF MINNESOTA

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Board of Trustees

MINNESOTA VETERANS HOME

The Minnesota Veterans Home is maintained as a home for needy, ailing,disabled Minnesota veterans of the armed services and their eligible wives, widows and mothers, as provided by statute, where they may live in the comradeship of a common cause; in dignity and self-respect, without welfare stigma; and with the knowledge that a state and nation gratefully provide for those who offered their lives but were not required to make the total sacrifice and in a sense, in memory of those who did.

Residents of the Minnesota Veterans Home should be provided dignified housing and care, including:

1. Modern, attractive, adequate living quarters
2. Good, wholesome meals, with specialized diets as required
3. Adequate medical care, or the assurance that such care is available, if needed
4. An extensive, expanding program of diversionary, restorative and inspirational activities for the maintenance of the health, well-being and optimal physical capabilities of both ambualtory and chronically ill residents, and for both aged and younger residents.

BUILDING PROGRAM

1. Domiciliary construction for ambulatory residents

   Urgent, to provide suitable, modern, attractive housing for present residents so outdated, deteriorated, inconvenient domiciliaries can be abandoned. To serve future continuing needs for this type or resident, in accordance with projected Home population figures.

   (Comment: If central food preparation facilities can be included in domiciliary for which funds have already been appropriated, would release kitchen in women's building for special diet food preparation, also a pressing need.

   Meals should be served in each domiciliary, negating the necessity of going outdoors for meal service. (Snack areas on each floor desirable.)

2. Nursing home care construction for chronically ill patients
   (To be financed with matching federal funds for construction and equipment)

   To serve present backlog and increasing future requirements, in accordance with projected Home population figures.

   (Comment: Wiring provisions so residents may listen to religious services and other programs would be desirable.)

3. Centralized food preparation facilities, to be incorporated in new construction

   For maximum economy of equipment, personnel, and food purchasing, storage and handling.

4. Diet kitchen, for preparation of specialized diet food (therapeutic and infirmary)

   To protect the health of the increasing number of residents requiring special diets.

5. Activities center, to house canteen, craft shop, barber shop, library; provide areas for reading, television, card playing, billiards, shuffleboard, etc.

   To replace and centralize fragmented activity areas now housed in various domiciliary buildings, which will be lost as old buildings are abandoned and new construction replaces them.

   To create interest and invite participation of more residents through the motivation of sights and sounds of many activities in evidence.

To provide stimulation on an individual and group basis in the activities of daily living, and increase communication between residents.

To secure more efficient utilization of staff, materials and equipment.

To create a general atmosphere of stimulation, creativity and involvement in living.

6. Administrative headquarters, possibly incorporated into design of other construction

   Modern, efficient offices with adequate space needed for maximum efficiency of staff and ease of accessibility to residents (elimination of stairs, etc.)

7. Other buildings

   The infirmary, the auditorium-chapel, the power plant building and the carpenter shop are considered adequate for present and foreseeable future needs, with proper maintenance and repair.

EQUIPMENT AND FURNISHINGS

1. All new construction should include complete equipment and furnishings, with provision for replacements as needed.

2. All residential buildings should be adequately and completely equipped and attractively furnished with provision for replacements as needed.

3. All service buildings and equipment should be maintained in good repair.

4. Grounds should be well maintained, with a regular program of improvement, to preserve and enhance the beauty of the site and delight the eye of the resident.

VEHICLES

Sufficient vehicular equipment - trucks, buses, ambulance, etc. - is essential to meet the requirements of the Home and its residents. In the interests of safety, such vehicles must be kept in good condition and replaced when they cease to function properly.

ADMINISTRATION

Funds. Sufficient funds should be provided for the businesslike and efficient operation of the Home, with all normal requests for supplies, etc., necessary to such operation honored without undue delay.

Personnel. An adequate staff of full-time classified employees is essential to properly conduct the business of the Home, and should be sufficient to cover vacation and sick leave vacancies without impeding the regular program of the Home. There is an urgent need for additional personnel in some areas. Additional staff, commensurate with Home population growth, will be required at a later date.

Unclassified member help, particularly in food service, infirmary and janitorial services, should be discontinued and replaced by civil service employees. Such member help cannot function fully in areas where dependability, efficiency, physical stamina or some specialized training are required. Member help can serve satisfactorily in such areas as building sergeant positions, switchboard operation and in light buildings and grounds service, and used be employed to some extent for purposes of therapy and other reasons.

Additional employees necessary to carry out the present work load and restorative programs for the residents include:

Licensed physical therapist, to assist residents and patients achieve optimum physical level of function and self-care through education and retraining of activities of daily living.

Occupational therapist, to promote activities adapted to the individual's needs and desires, which encourage a sense of usefulness and involvement in living.

Male nurse, to serve as circulating field nurse in men's domiciliaries, an area presently neglected.

Social services director, to serve as volunteer services coordinator.

Adequate diet kitchen staff, to handle all special diet food preparation - diabetic, bland, salt-free, liquid, weight reduction, etc., and provide needed variety in such diets. Continued increase in special diet residents and patients.

Dietitian, to closely control food handling, preparation, planning, serving, special diet problems and supervision of diets.

PROGRAM FOR RESIDENTS

1. A beginning and continuously expanding program of stimulating, purposeful, therapeutic activities and recreation for the residents, mostly on a group basis, has already made significant changes in the lives of the residents. Much more is planned and needed, particularly on an individual basis, but more trained personnel is necessary to accomplish this. Emphasis must be focused on helping residents achieve their highest possible level of function, primarily through restorative activities.

Adequate staff to reach these goals, in addition to the present activities director, would include a licensed physical therapist, occupational therapist, social services director, assistants, and related clerical help. Valuable consultative services covering physical therapy activities and occupation therapy activities and occupational therapy programs are available through the Division of Public Health, and are now being utilized to the extent possible. If the University of Minnesota accepts a grant from the Kellogg Foundation to improve geriatric programs and upgrade standards of nonprofit homes for the aging, the Home will be considered for the program, with resultant personnel assistance in the activity program of the Home. However, this would not eliminate the need for any of the above named personnel.

2. The passive resident, content with the serenity of the Home setting, will be encouraged to participate in selected activities.

3. More active and challenging programs for the younger veteran will be incorporated into the total activity program.

4. To the extent possible, residents will continue to be rehabilitated for return to community life.

5. Increased attention will be directed to the treatment of emphysema, arthritis, and other ailments of the aging.

6. An expanded program of help for those with drinking problems will be carried on in conjunction with the alcoholic unit at the Minneapolis Veterans Hospital and with the State Commission on Alcohol Problems.

7. The establishment of an activities center would stimulate a full-fledged appeal for volunteer help on a regularly scheduled basis, an invaluable contribution to the activities programs. With activities now scattered throughout the Home and insufficient supervisory personnel, this effort is not now possible.

POLICY

1. A manual will be compiled for and made available to associated agencies and organizations, containing:

a. Laws pertaining to the Minnesota Veterans Home, under Minnesota Statutes 198.
b. By-laws of the Home.
c. Rules and regulations of the Home.
d. Policies of the Board of Trustees in regard to residents.
e. Policy on admissions and discharges.
f. Copy of application for admission form.
g. Copy of contract between Home and residents.
h. Maintenance rate schedule and other charges.
i. List of benefits to residents (prescription drugs without charge, issuance of $10 per month and clothing to those with no incomes, etc.)
j. Brochure for new residents.
k. Map of grounds.
1. Long-range program of the Home.
m. Other pertinent information.

2. At least one meeting per year will be scheduled with representatives of veterans' organizations and the Board to establish and maintain rapport and to exchange views for the mutual benefit of the Home and its residents.

3. At least one meeting per year will be scheduled with the Commissioner of Veterans Affairs and the Board of Trustees for the mutual exchange of ideas for the benefit of the Home and its residents.

4. The Board of Trustees shall regularly review programs of nursing home care, medicare, infirmary accreditation, and other similar programs to ascertain their possible benefit to the Home and the residents thereof, and to determine whether any or all such plans should be instituted at the Home. Review would include advantages to residents of each plan, cost advantages, disadvantages of each plan, and other pertinent information.

5. The scope of those eligible for admission to the Home should be consistent with the definition of the word "veteran" as it appears in Minnesota Statutes other than in Minnesota Statutes 198.

Approved, Board of Trustees
Minnesota Veterans Home
June 5,1968

/s/ Otis C. Sherman
Secretary
July 10, 1968

CRITERIA BASE STUDY
100 BED RESTORATIVE CENTER

This Restorative Center is proposed as a 100 bed facility offering a comprehensive program of inpatient and outpatient rehabilitation to meet an existing need for such services in this community. The program available in this Center is to be sufficiently flexible to allow for change as change may be required to continue to meet the needs of patients.

The following statement defines the "goal" of the Restorative Center:

> "To assist individuals unable to maintain physical, social or economic responsibilities because of severe disabling circulatory, neuromuscular, respiratory and metabolic illness, to achieve a more normal existance through the provision of integrated and coordinated medical, psychological, social, vocational, education diversional services, and interfaced with a program for living."

It is anticipated that the Restorative Center will provide comprehensive programming to accommodate inpatients and outpatients with fractured hips, other traumatic orthopedic problems and strokes. It will also provide programming for rheumatoid arthritis and cardio-pulmonary disabilities and to be sufficiently flexible to permit the introduction of new therapy regimes as the medical needs of the community are identified (such as alcoholism). Mental Hygiene programming is to be restricted to that which is associated with physical disabilities. There is not to be an age restriction for admission within the definitions of veteran dependents to this Center.

Comprehensive programming for spinal cord injuries and for specialized areas of medicine is not contemplated for this Center but for affiliate medical institutions. Effective programs for these specialties are currently available in other facilities. The anticipated length of inpatient stay will

represent a span of thirty to ninety days with an average of sixty days. Outpatient service is contemplated at a level equal to, or greater than, that of the inpatient therapy load. Certain long term patients will be considered on an individual basis. For the purpose of determining a criteria base concept these assumptions are made.

In the initial planning for this project, existing rehabilitation facilities were studied. This review included an analysis of published programs and statistics of approximately thirty institutions with an in-depth study of seven facilities located in the San Francisco Bay area. The objectives included the determination of the following: age groups, diagnoses, costs, space requirements, referral sources, disposition and identification of program specialization. The findings of this study were used as a basis upon which the program planning was based for this Restorative Center. Adjustments have been made for Minnesota.

The major concepts and principles used in developing the "Design and Planning Requirements" for the Restorative Center are briefly summarized as follows:

1. Full utilization of existing services in an adjacent hospital is essential and included in the planning. Connecting these services with some direct form of communication will be required to insure efficiency. The identification and extent of these services appear in the section on "Administrative Areas" in the "Design and Planning Requirements".
2. Multi-use is contemplated for a number of programmed areas to achieve effective space-savings and improved utilization of space.

3. Conference space is considered to be an essential part of the space requirements due to the need for meetings to plan an integrated, multidiscipline and comprehensive approach to patient-centered care. This same type of space is necessary in the in-service program which provides for staff development and improvement in patient care.

   It is recognized that various types of educational programs in affiliation with a professional school or university will undoubtedly be a part of the Restorative Center. The conference areas, as planned, will help make these programs possible.

4. Research space is not included in the program; however, we do assume that research will still be possible within the present program and whatever limits it might establish. Within these limits, research should be encouraged.

5. Staffing predictions have been established and include a high degree of flexibility in personnel utilization. It is proposed that medical specialists be utilized part-time, as needed, until a sufficient demand for their services warrants full-time appointments. (See Table of Staffing).

TABLE OF STAFFING

POSITION	F.T.E.	ON-CALL	POSITION	F.T.E.	ON-CALL
Administrator	1		Medical Director	1	
Asst. Administrator (Bus. Mgr.)	1		Staff Physician	2	
Supply & Service Supervisor	1		Prosthetist		x
Director of Nursing Service	1		Orthotist		x
Supervisor, Nursing Service	2		Psychiatrist		x
In-Service Coordinator	2		Speech Pathologist		x
Head Nurse	2		Audiologist		x
Asst. Head Nurse	1		Other Specialists		x
Registered Nurses	12.2		Physical Therapists	7	
Licensed Vocational Nurse, Nurse Aides & Orderlies	28.2				
Engineer	1		Occupational Therapists	3	
Maintenance Helper-Handyman	3		O. T. Aides	2	
Cleaning Service Personnel	7		Dietitian (ADA)	1	
Kitchen Helpers	10		Psychologist		x

TABLE OF STAFFING (Cont'd)

POSITION	F.T.E.	ON-CALL	POSITION	F.T.E.	ON-CALL
Secretarial, Clerical & Receptionist	17		Social Service	3	
Medical Records Librarian	1		Vocational Counselor		x state
Ward Clerks	3		Teacher		x state
Clerks & Storekeepers	10		Coffee Shop Manager		P.T.

TOTAL F.T.E. = 118.4

The Medical Director of the Restorative Center is the focal figure in a successful program of patient rehabilitation. The selection of this individual should be made after carefully defining requirements of the position. These requirements must include the following:

Physician with a deep interest in rehabilitation and experience in the field.

Individual who believes in the necessity of a multi-dicipline approach to successful planning for rehabilitative care.

Individual who relates well to medical and all other groups.

Individual may be an Internist, Orthopedist, Psychiatrist or other specialist. This person should be selected on the basis of his personal qualifications rather than his specialty.

It is recommended that a selection committee be formed to recruit a qualified individual for the position of Medical Director. Leaders in the field of Rehabilitation should be sought for membership on this committee.

The appointment should be made at least a year before the opening of the Center. If recruitment proves to be difficult, it is recommended that a local, practicing physician be selected upon the basis of personal qualifications and interest in the field and that this physician be sponsored for a year of preparation in an established and effective rehabilitation program. The Texas Institute for Rehabilitation at Baylor University is one example recommended for consideration in study.

SPACE SUMMARY

Administrative Areas	8,129
Evaluation and Treatment Areas	10,978
Patient Care Areas	18,166
General Areas	3,002
Total Net Square Feet	40,275

40,275	Net square feet
18,125	Estimated circulation @ 45%
58,400	Gross square feet

ESTIMATED PRESENT RESTORATIVE TREATMENT LOAD

AND NEEDS - INPATIENT REHABILITATION FACILITIES

East Bay

1. Present Patient Load - East Bay (Alameda, Contra Costa and Solano Counties) - Inpatient rehabilitation facilities (restorative treatment centers):

   100,000 inpatient days
   40,000 outpatient visits

2. Breakdown in Type of Inpatients Presently Being Handled -

CVA	25%
Orthopedic	20%
Fractures - 12	
Other - 8	
Other	55%
Total	100%

3. Total Present Needs - 2 to 3 times load presently being handled. This is based on specific statistical analysis, beyond mere generalities.

4. Future Needs - Further growth with population, and also the number of elderly (which for a while, for California, will remain about as now, percentage-wise).

5. Expected Load for Proposed Facility - 28,000 inpatient days (90 beds and 85% occupancy)
   21,000 outpatient visits (75% of 28,000 is proposed and expected)

PROJECT COST

Land		$ 0
Construction		2,237,025
Site survey and soil analysis, plan check, materials tests	$ 12,600	
Site improvements and utility connections	200,000	
Building - 58,400 sq. ft. est. for 1967-68 construction at $34 (excluding 1% construction contingencies, 1% planning consultant fees and 10% general budget contingency listed below)	1,986,560	
Construction contingencies - 1% of $1,986,650	19,866	
Supervision during construction	18,000	
Total Construction Cost	2,237,025	
Equipment, Group II and Group III (Construction plus equipment - $2,387,025)		150,000
Planning Consultant - 1% of $2,387,025 (Construction plus equipment plus Planning Consultant total $2,410,895)		23,870
General Budget Contingency - 10% of $2,410,895		241,089
Architect/Engineer Services - 8% of $2,237,025		178,962
Legal and Other Professional Fees, Administrative and Other Expense		50,000
Project Promotion and Fund Raising		50,000
Pre-opening Expenses		20,000
Miscellaneous Financial Costs (fees, etc.)		15,000
Working Capital		300,000
Losses Likely to be Incurred in First 3 Years (Sum of above - $3,665,946; less working capital and losses first 3 years equals $2,965,946)		400,000

PROJECT COST (Cont'd)

Interest and Other Loan Charges During Construction - Interest at 6½% on average of half of $2,965,946 less $750,000 campaign fund to be raised, or $2,215,946, for about 1½ years, or, roughly, 10% of $1,107,973	110,797
Grand Total for Project	$3,776,743 or $3,800,000
Total Without Working Capital and Losses First 3 Years	$3,100,000

EXPENSE

Annual and Per Patient Day or Visit

		Annual
Personnel Costs - estimated as 73% of total (see next page)		$ 805,000
Salaries and wages (129 persons)	- $700,000	
Fringe benefits - estimated 15% of $700,000	- 105,000	
Other Costs - including ancillary services, depreciation of equipment, and rental of equipment, but excluding franchise taxes and licenses, depreciation of buildings, amortization of improvements, and amortization of long-term loan (if applicable) estimated as 27% of total (see next page)		298,000
Subtotal		$1,103,000
Taxes (franchise) and Licenses		10,000
Depreciation on Buildings and Amortization of Improvements - $2,680,946 over 40 years		67,000
Amortization of Estimated Long-Term Loan of $1,139,446 for Project - to provide for cash needs and initial operating losses, above that supplied by Hill-Harris funds and private donations, with interest at about 6½% over 30 years	as applicable ($87,000)	
Total		$1,180,000
Inpatients are assumed to bear 75% of the costs (see second page ff.)		$ 885,000
Outpatients are assumed to bear 25% of the costs (see second page ff.)		$ 295,000

PERSONNEL COSTS - PERCENT OF TOTAL COSTS

	Restorative Facilities				Acute General Hospitals Hospital Conference 1964 Data	
	Median of 5 In-Patient Centers*	Average of 5 In-Patient Centers*	Fairmont	04-49**	East Bay	San Francisco
1. Personnel - $1,000s a. Salaries and wages b. Fringe benefits			3,530.			
2. Other, excluding depreciation, taxes and licences, interest and financing, equipment and building rent, and amortization of leasehold improvement - $1,000s			1,063.			
3. Sub-total			4,593			
4. ((1) as percent of (3))	76%	67%	77%	75%	75%	72%
5. Add depreciation of equipment only, and equipment rental						
6. Total of ((3) and (5))						
7. ((1) as percent of (6))				73%	73%	70%

* Basil J.F. Mott, Financing and Operating Rehabilitation Centers and Facilities, National Society For Crippled Children and Adults, Inc., Chicago, 1960

** Hospital 04-49, San Francisco 80-bed hospital, apparently with 74% of patient days attributed to "long-term" patients and average stay of 26.27 days for all patients.

COST FOR INPATIENTS - 75% OF TOTAL

	(1) Operating Expenditures - $1,000 Inpatient Service	(2) Total Operating	(3) ((1) As % of (2))
Louisville	162	217	75
Morrison	150	298	51
Hamarville	290	329	88
Kessler	275	368	75
Woodrow Wilson	636	805	79
Median			75

Source: Basil J.F. Mott, Financing and Operating Rehabilitation Centers and Facilities, 1960

COSTS AS REPORTED BY

OTHER REHABILITATION FACILITIES

	$ Per Patient Day	
Laguna Honda	$ 26.29	
Fairmont	33.00	
Maimonides	33.60	
Crystal Springs	26.75	intensive care
	19.75	intermediate care
	7.50	self-care
Santa Clara	54.00 *	(30 for room & board; 24 * for treatment)
Stanford (Experimental)	60.00	(would be lower if not for limited number of patients and training purposes)

* Actually lower? Figures are as reported to us.

REVENUE

1. Inpatient fees at $37.77 per day room charge, for 28,000 patient days		$ 1,057,560
2. Outpatients fees at $16.67 per visit, charge for visit for 21,000 visits		350,070
	Total	$ 1,407,630
3. Revenue from ancillary services - Included with 1 and 2		
4. Allow 10%, estimated roughly (to be refined with experience) - for unreimbursed charges:		
a. Outpatients		35,007
b. Inpatients		105,756
	Sub-total	$ 140,763
5. Gross less unreimbursed charges		$ 1,266,783
6. Annual expense		$ 1,267,000

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA

APPROVED LICENSED NURSING HOME CARE RATES

MARCH 15, 1968

These rates are the maximum rates for the various classifications of care. Rates for individual homes in the county are set within these maximums.

* County welfare department used a base figure to which is added fees which have been set for the various services listed on the DPW-60 form.

** County welfare department has set a dollar value per point which is added to a base figure.

*** For a special care facility available to the county welfare department used in lieu of hospital care.

County	Minimum Care	Moderate Care	Maximum Care	Exceptional Care
Aitkin **	$165	$5/pt. over	minimum rate	Not to exceed $9 per diem actual cost plus 2%
Anoka	$9.50	per		diem
Becker	$155	$185	$215	$225
Beltrami	$8.00	per		diem
Benton	Good Shepherd Helgeson	Lutheran Nursing	Nursing Home Home	$8.50 per diem $7.75 per diem
Big Stone	~~$162~~ $8 per diem	~~$182~~		
Blue Earth	$140	$175	$200	$225
Brown	$200	$225	$260	$300
Carlton	~~$180~~ Mercy Hosp. Comm. Hosp.	~~$210~~ 10.06/diem 12.87/diem		~~$270~~
Carver	$150	$170	$195	$275
Cass	$8.00	per		diem
Chippewa	$211	$241	$265	$307
Chisago	$145	$175	$210	$235

1 Individual Consideration
2 $4 additional for each point over 27
3 Or possibility of using $5 per point over 225 for those with more than 17 points.

County	Minimum Care	Moderate Care	Maximum Care	Exceptional Care
Clay	$145	$175	$240	$265
Clearwater	$150 Good Samaritan	$175 Nursing Home	$200 $8.00	$250 per diem
Cook	~~$205~~	~~225~~	~~245~~	$250 ~~265~~
Cottonwood	$179	$194	$214	$245
Crow Wing	$190	$205	$220	$250
Dakota *	$225		$325	I.C.
Dodge	$140 Fairview	$160 Nursing Home.	$200 $8.00	$220 per diem
Douglas	~~$140~~ All others ~~$150~~ ~~$168~~ per diem Bethany Home Knute Nelson	Nursing Home	~~$203~~ ~~$9.00~~ 10.00 $7.50	~~$280~~ per diem per diem
Faribault	$8.75		per	diem
Fillmore	$8.60		per	diem
Freeborn	$165	$190	$215	$280
Goodhue	$10.00/diem $ 9.00/diem	for Medicare for Homes providing	Certified or 16 hr./day licensed	ECF Care coverage
Grant	ALL HOMES RANGE from $8-9 per diem ~~$140~~	~~$160~~	~~$185~~	~~$235~~
Hennepin *	$220		$310	$440
Houston	~~$265~~ 300	~~Per P.R.~~	Month	
Hubbard	$150	$165	$180	$200
Isanti	$180 Cambridge	Nursing Home	$10.00	$290 per diem
Itasca	Leisure Hills Itasca County	Nursing Home Nursing Home	$10.00 $ 9.50	per diem per diem
Jackson	$195	$218	$238	$255
Kanabec	$160			~~$260~~ 290
Kandiyohi	$180			$300
Kittson	$9.00		per	diem
Koochiching	$8.50	per	diem	or $255
Lac Qui Parle	$193	$223	$253	$300
Lake	$8.65		per	diem

County	Minimum Care	Moderate Care	Maximum Care	Exceptional Care
Lake of the Woods	$185	$200	~~$235~~ 250	~~$275~~ 300
LeSueur Class A Class B	$265 Per Month $230 Per Month			
Lincoln	$150	$150+$5/pt.	$150+$5/ pt.	$275
Lyon	$155	$180	$205	$120+$5/pt. to max. $310
McLeod	Alice Haney Remaining	Nursing Home Homes	$7.50 $9.00	per diem per diem
Mahnomen	$140	$160	$180	$220
Marshall	Good Samaritan Emmaus	Nursing Home Nursing Home	$9.00 $10.25	per diem per diem
Martin **	~~$160~~ $235/mo. for ALL	~~$160+$5/pt. to $210~~ NURSING	~~$210+$4/pt. to $235~~ HOME	~~$235~~ PATIENTS
Meeker	$8.10 ⊙		per	diem
Mille Lacs	$8.00		per	diem
Morrison	LUTHERAN SR. CITIZENS + ST. MARY'S — $8 PER DIEM ~~$125~~ ST. OTTO'S $8.25 PER DIEM	~~$141~~	~~$161~~	~~$225~~ 2
Mower	$8.00	per diem	or $240	$300 ⊙
Murray	MAPLE LAWN ~~$185~~ $230 PER MO FLAT RATE SLAYTON MANOR ~~$210~~ $245 PER MO. " " ⊙		~~$235~~	~~$275~~
Nicollet *	$175		$285	
Nobles	$125	$150	$175	$240
Norman	$165	$190	$215	$240
Olmsted	CLASS 1 $9.25 PER DIEM ~~$195~~ CLASS 2 8.35 " " ~~$220~~		~~$245~~	~~$310~~
Otter Tail	$175	$190	$225	$245
Pennington	OAKLAND PARK $10.86 PER DIEM $200	$225	$250	$300
Pine	$140+$5 per	point to	$250	$300
Pipestone	Non-certified Homes Certified Homes	$230 per mo. $255 per mo.	plus $5/pt. plus $5/pt.	
Polk	All Homes	per diem	range from	$9 to $10
Pope	175 + 4 pts. ~~$170~~	$175 + $6 PER POINT ~~$195~~	NONE ~~$220~~	~~$255~~
Ramsey	$210 Ramsey County	Home	$300 $10.50 per diem	$305 - $375 or $315 monthly
Red Lake	$175	$225	$250	$325

County	Minimum Care	Moderate Care	Maximum Care	Exceptional Care
Redwood	~~$150~~/89	~~$178~~ 229	~~$213~~ 269	~~$269~~ 349
Renville	$180	$190	$205	$280
Rice-Schedule A	~~$200~~ 220	~~$225~~ 245	~~$250~~ 270	~~$275~~ 295
Schedule B	~~$165~~ 185	~~$190~~ 210	~~$215~~ 235	~~$240~~ 260
Rock	$185	$210	$235	$265
Roseau	$175	$200	$225	$280
St. Louis	All Homes	per diem range	from	$9.00 to $12.50
Scott	$150	$180	$205	$300
Sherburne *	High Point Lodge	$8.00	per	diem
	St. Cloud	$8.50	per	diem
	St. Joseph	$8.50	per	diem
	Elk River	$11.65	per	diem
Sibley	Good Samaritan	$7.25	per	diem
	Winthrop	$7.75	per	diem
	Arlington	$8.35	per	diem
Stearns	$8.00-$8.75	per day	per	Classification
	KORONIS MANOR	$9.75 PER diem		
Steele	$8.75		per	diem
Stevens	$8.00		per	diem
Swift	$138	$158	$178	
Todd	$150	$200	$225	$250
Traverse	$150			Not to exceed $300
Wabasha	$150	$175	$200	$225
Wadena	GREEN PINE PARKS $190	195	230	260
	~~$145~~	~~$170~~	~~$200~~	~~$225~~
	SHADY LANE $120	~~$150~~ 150	~~$180~~ 180	220
Waseca	$9.00		per	diem
Washington	$9.50		per	diem
	$7.00	Pine Point	per	diem
Watonwan	$180	$205	$235	$255
	Good Samaritan	$7.00	per	diem
Wilkin	$165	$185	$210	$235
Winona	$165	$190	$220	$9.00/diem
Wright	$150	$175	$225	$275
Yellow Medicine	$175	$210	$235	$285

VETERAN COMPENSATION AND PENSION*

Another major source of finances which is available to the veteran to pay for his nursing home care are the compensations and pensions which the veteran may receive from the Veterans Administration. Compensation is available for veterans of the Spanish-American War, World War I, World War II, Korean Conflict period, Viet Nam era, and peace time service with service-connected disabilities.

Eligibility - Veterans who are disabled by injury or disease incurred in or aggravated by active service in line of duty during wartime or peacetime service and discharged or separated under other than dishonorable conditions, are eligible for wartime disability compensation.

Nature of Benefit for Wartime Disabilities - Veterans found eligible for wartime disability compensation are entitled to monthly payments ranging from $21 to $300, depending on the degree of disability, with specific rates to $850. The monthly rates are:

Service-Connected Disability	Wartime Rate[1/]
(a) 10 percent	$ 21
(b) 20 percent	40
(c) 30 percent	60
(d) 40 percent	82
(e) 50 percent	113
(f) 60 percent	136
(g) 70 percent	161

*Veterans Administration. Federal Benefits for Veterans and Dependents. Washington, D.C. January 1968, pp. 2-6.

Service-Connected Disability (Cont'd.)

		Wartime Rate[1]
(h)	80 percent	$186
(i)	90 percent	209
(j)	Total disability	301
(k)	Anatomical loss, or loss of use of one or more creative organs, or 1 foot, or 1 hand, or both buttocks, or blindness of 1 eye, having only light perception, or has suffered complete organic aphonia with constant inability to communicate by speech, or deafness of both ears, having absence of air and bond conduction, rates (a) to (j) increased monthly (not exceeding $400) for each loss, or loss of use of, by	47
	Anatomical loss, or loss of use of a creative organ, or 1 foot, or 1 hand, or both buttocks, or blindness of 1 eye, having only light perception, or has suffered complete organic aphonia with constant inability to communicate by speech, or deafness of both ears, having absence of air and bone conduction, in addition to requirements for rates in (1) to (n), rate increased monthly (not exceeding $600) for <u>each</u> loss, or loss of use of, by. .	47[2]
(l)	Anatomical loss, or loss of use of both hands, or both feet or 1 hand and foot, or blind both eyes with 4/200 visual acuity or less, or is permanently bedridden or so helpless as to be in need of regular aid and attendance, month compensation . . .	400[2]
(m)	Anatomical loss, or loss of use of 2 extremities at a level or with complications, preventing natural elbow or knee action with	

Service-Connected Disability (Cont'd.)

	Wartime Rate[1]
prosthesus in place, or has suffered blindness in both eyes, rendering him so helpless as to be in need of regular aid and attendance, monthly compensation	$450[2]
(n) Anatomical loss of 2 extremities so near shoulder or hip as to prevent use of prosthetic applicance or suffered anatomical loss of both eyes, monthly compensation.	525
(o) Suffered disability under conditions which would entitle him to 2 or more rates in (1) to (n), no condition being considered twice, or suffered bilateral deafness (and hearing impairment in either one or both ears is service-connected) rated at 60 percent or more disabling and service-connected total blindness with 5/200 visual acuity or less, monthly compensation	600
(p) In event disabled person's service-connected disabilities exceed requirements for any of rates prescribed, Administrator in his discretion, may allow next higher rate, or intermediate rate, but in no event in excess of $600. If veteran suffered service-connected blindness with 5/200 visual acuity or less and (1) has also suffered bilateral deafness (and hearing impairment in either or both ears is service-connected) rated at 40 percent or more disabling, Administrator shall allow the next higher rate or (2) has also suffered service-connected total deafness in one ear, Administrator shall allow the next intermediate rate, but in no event in excess of	600

Service-Connected Disability (Cont'd.)

		Wartime Rate[1]
(q)	Minimum rate for arrested tuberculosis	$ 67
(r)	If any veteran, otherwise entitled to the compensation authorized under (o) or the maximum rate authorized under (p), is in need of regular aid and attendance, he shall be paid, in addition to such compensation, for periods during which he is not hospitalized at Government expense,[2] a monthly aid and attendance allowance at the rate of	250
(s)	Service-connected disability rated as total, and (1) additional service-connected disability or disabilities independently ratable at 60 percent or more, or (2) by reason of service-connected disability or disabilities, is permanently housebound. (The requirement of "permanently housebound" will be considered to have been met when the veteran is substantially confined to his house [ward or clinical areas, if institutionalized] or immediate premises due to a service-connected disability or disabilities which it is reasonably certain will remain throughout his lifetime.) Monthly compensation	250

Allowance for Dependents - Veterans whose service-connected disabilities are rated at 50 percent or more are entitled to additional allowances for dependents.

The current wartime rates are listed below and are based upon 100 percent disability. The rates for 50 percent or more are payable at the same ratio that the degree of disability bears to 100 percent.

Dependency	Wartime Rate[1]
Wife[2] and	
No children	$25
1 child	43
2 children	55
3 children	68
Additional children, each	13
No wife and	
1 child	17
2 children	30
3 children	43
Additional children, each	13
Child attending school[3]	40[4]
Dependent parents	
1 parent	21
2 parents	42

(See next page for footnotes)

Footnotes for "Service-Connected Disabilities":

1/ Compensation for disabilities incurred under non-extra-hazardous conditions during peacetime are 80 percent of the wartime rate.

2/ Veterans receiving a statutory award either because of the need for regular aid and attendance under subsections (1) or (m), or the additional special monthly aid and attendance allowance of $250 a month under subsection (r), will have the amount provided for aid and attendance continued until the first day of the second month which begins after they are hospitalized or maintained by the Veterans Administration or at Veterans Administration expense if under subsections (1) or (m) or hospital against medical advice, and is thereafter readmitted within 6 months from the date of such departure, the aid and attendance allowance during such period of hospitalization will be discontinued from the date of readmission.

Footnotes for "Allowance for Dependents":

1/ If the disability was incurred under non-extra-hazardous conditions during peacetime, additional compensation for dependents is 80 percent of the wartime rate.

2/ The term "wife" includes the husband of a female veteran if he: (1) is incapable of self-maintenance, and (2) is permanently incapable of self-support due to physical or mental disability.

3/ The term "child attending school" means a child who has attained the age of 18 but not 23 years and who is pursuing an approved course of instruction.

4/ Rate payable is in addtion to that payable for a wife and/or any other children.

Chronic and Tropical Disease Presumptions - Generally, a veteran with wartime, Korean Conflict, or post-Korean Conflict service who develops a chronic or a tropical disease to a degree of 10 percent or more disability within 1 year of release or separation from such service may be presumed to be service-connected for disability compensation. In the case of active tuberculosis or leprosy, the law provides a 3-year presumptive period. In the case of multiple sclerosis, the law provides a 7-year presumptive period. Under certain conditions, the 1-year tropical disease presumption is applicable to peacetime veterans.

Nature of Benefits for Peacetime Disabilities - Veterans found eligible for peacetime disability compensation are entitled to monthly payments at 80 percent of the foregoing wartime rates.

The peacetime rates range from $17 to $240, depending on the degree of disability, plus statutory awards for amputations, blindness, etc., up to a maximum of $680.

Where the disability resulted from injury or disease received as a direct result of armed conflict, while engaged in extra-hazardous service, including such service under conditions simulating war, the veteran is entitled to the foregoing wartime rates.

Peacetime veterans rated 50 percent or more disabled may be entitled to additional compensation for a wife, minor children, or dependent parents.

Social Security Benefits - Benefits received from Social Security for total and permanent disability will not be reduced by the amount of any service-connected disability compensation received from the Veterans Administration.

VETERANS PENSIONS

In regard to pensions this source of income is available for veterans of World War I, World War II, Korean Conflict period and Viet Nam era with non-service-connected disabilities.

Eligibility - Wartime veterans discharged under other than dishonorable conditions after 90 or more days service, or because of a service-connected disability, who are permanently and totally disabled from reasons not traceable to service, with veterans 65 years of age or older considered permanently and totally disabled, are eligible for pensions.

Periods of wartime service for pension eligibility:

WorldWar I - April 6, 1917 To November 11, 1918; extended to April 1, 1920, for those veterans who served in Russia; also extended through July 1, 1921, for those veterans who had at least one day of service before November 12, 1918, and who served after November 11, 1918, and before July 2, 1921.

World War II - December 7, 1941 to December 31, 1946.

Korean Conflict - June 27, 1950 to January 31, 1955.

Viet Nam Era - August 5, 1964 to date to be determined later.

Nature of Pensions - There are two systems under which this pension may be paid:

Current Pension System: All veterans who come on the pension rolls on or after July 1, 1960, will receive pension under the current system.

The same eligibility rules apply in the current pension system.

Major differences between the pension systems are reflected in the rate structure, income limitations and net worth features. Under the current system the less income a veteran may have, the more pension he will draw; the more income a veteran may have, even though still eligible for pension payments, the less monthly pension he will draw. Pension may be discontinued or denied if net worth is excessive.

A veteran with no dependents may receive --	Per Month
Income not in excess of $600 per year	$104
Income between $600 and $1,200 per year	79
Income between $1,200 and $1,800 per year	45
Over $1,800 per year	--

A veteran with dependents may receive --	
Income not in excess of $1,000 per year	
and 1 dependent	109
and 2 dependents	114
and 3 or more dependents	119
Income between $1,000 and $2,000	
any number of dependents	84
Income between $2,000 and $3,000 per year	
any number of dependents	50
More than $3,000 per year	--

(Veterans within the income limits and in need of regular aid and attendance will receive $100 a month or if housbound, $40 a month in addition to the rates listed above. A patient of a nursing home is considered in need of regular aid and attendance for pension purposes.)

Prior Pension System: For those veterans who were on the pension rolls on June 30, 1960, pension is payable if the otherwise-eligible veteran's income from other sources does not exceed $1,400 a year if unmarried, or $2,700 a year if he is married or has a minor child.

The monthly rate is $66.15, which is increased to $78.75 after continuous receipt of pension for 10 years or upon attainment of age 65.

(Veterans who are entitled to the pension and who become blind or are so helpless as to need the regular aid and attendance of another person, may be eligible for $135.45 per month or if housebound, $100 monthly in lieu of the rate otherwise payable). These veterans, receiving pensions under this prior system, have the right to choose the current system. Once this choice is made, however, it cannot be changed again.

Determining Income - If the income of a veteran's spouse is all earned income -- that is, received as wages or salary -- it is not counted as income for pension purposes. If the income of the veteran's spouse is all unearned income -- that is, received as dividends, interest, etc. -- the first $1,200 is excluded from consideration but all the rest is counted as income.

If the income of the spouse includes both earned and unearned income, the amounts to be excluded or counted will vary with individual cases. These two examples may help: (1) the spouse earned $1,300 and received an additional $1,200 in unearned income. The $1,300 would be excluded but the $1,200 unearned would be counted as income, (2) If the spouse earned $800 and had an unearned income of $1,100, then the $1,200 of the total would be excluded and $700 counted as income. In other words, the combination of earned and

unearned income leads to the exclusion of (a) all of the earned income or (b) a total of $1,200 of both earned and unearned combined, whichever exclusion, (a) or (b) is greater.

At the same time, pension will not be paid to those veterans having sizable estates. His home and his personal effects used in ordinary living will not be counted as a part of his estate. Because of the many possible complications, all the rules cannot be outlined here but each case will be judged on its individual merits and consideration given to the type of property owned by the veteran, the amount of his income, the number of his dependents, his age and state of health.

Reduction While Hospitalized - Under the current system, there is generally no reduction of pension because of hospitalization or maintenance by the Veterans Administration in cases of veterans who have a wife or child. The pension of a veteran without a wife or child is reduced to $30 a month after 2 full calendar months of care. He would draw full pension payment upon release from the hospital or Veterans Administration maintenance, but the moneys reduced from his pension would not be recoverable.

Service Pension for Veterans of Spanish-American War - This pension is for those veterans who had 70 to 90 days of service in the Spanish-American War, with discharge under other than dishonorable conditions, or who were discharged sooner for a service-connected disability.

Nature of Benefits - For 90-day service and disability discharge cases, the monthly pension rate is $101.59; and for regular aid and attendance, $135.45.

For 70-day service cases, the monthly pension rate is $67.73; and for regular aid and attendance, $88.04.

Those entitled to receive $101.59 monthly may elect to receive pension under the current system described in the preceding section, subject to the conditions which apply to veterans of later wars. Once having made this choice, they may not change back. (Spanish-American War veterans who are entitled to additional pension of $135.45 for aid and attendance may receive pension under either the service pension program or the current pension system, whichever provides the greater benefit. In this limited instance, elections between programs are not required, and if previously made do not affect entitlement.)

Any Spanish-American War veteran coming on the rolls after June 30, 1960, or who is receiving pension under the current system may (if he has no wife not child) have his pension cut to $30 a month after the first 2 full calendar months of Veterans Administration hospitalization or maintenance. The full pension would become payable upon release from Veterans Administration care, but the amounts previously reduced from his pension would not be paid to him.