



**Department of Health
and Human Services**

*Maine People Living
Safe, Healthy and Productive Lives*

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

Department of Health and Human Services
Licensing and Regulatory Services
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For Department Use Only:	CON ID	Facility Name:		
	Review Type			
	Working Title			
	LOI Author	LOI Submit Date	LOI Received Date	

LETTER OF INTENT

Section 1 – Facility Information

Facility Name Amenity Manor		
Telephone (207) 725 - 7495 ext.		Fax (207) 725 - 4424
Address 1 29 Elm Street		
Address 2		
City Topsham		
County Sagadahoc	State ME	Zip Code 04086 -

Section 2 – Applicant Organization Information (if different from section 1)

Legal Name of Applicant Rousseau Management, Inc.		
Telephone (207) 725 - 4071 ext. 1111		Fax (207) 725 - 4424
Address 1 11 Bank St		
Address 2		
City Brunswick	State ME	Zip Code 04011 -
E-mail mrousseau@reimaine.com or ldavison@reimaine.com		

Section 3 – Contact Information

Salutation Mr.	First Name Mitchell	Last Name Rousseau
Title President	Organization Rousseau Management, Inc.	
Telephone (207) 725 - 4071 ext. 1111		Fax (207) 725 - 4424
Address 1 11 Bank Street		
Address 2		
City Brunswick	State ME	Zip Code 04011 -

E-mail mrousseau@reimaine.com

Section 4 – Correspondence 'CC' Information

Salutation Mr. First Name Craig Last Name Nelson
Title Attorney Organization Doyle & Nelson
Telephone (207) 622 - 6124 ext. Fax (207) 623 - 1358
Address 1 150 Capitol Street
Address 2
City Augusta State ME Zip Code 04330 -
E-mail cnelson@doylenelson.com

Section 5 – Facility Type

- | | |
|---|--|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Long Term (Acute) Care Hospital |
| <input type="checkbox"/> Hospital Long Term Care Unit | <input checked="" type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Freestanding Outpatient Surgical Facility | <input type="checkbox"/> Psychiatric Hospital |
| <input type="checkbox"/> Inpatient Psychiatric Unit | <input type="checkbox"/> Critical Access Hospital |
| <input type="checkbox"/> Residential Care Facility | |
| <input type="checkbox"/> Other: Not a Licensed Health Facility (specify): _____ | |

Section 6 – Project Title/Summary

Replacement Facility

Section 7 – Project Type (Applicable categories)

Type of Project/Proposal (Check all that apply):

Inpatient Service(s):

- | | | |
|---|--|---|
| <input type="checkbox"/> Medical/Surgical | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Pediatric |
| <input type="checkbox"/> Maternity | <input type="checkbox"/> Trauma Center | <input type="checkbox"/> Transplantation Programs |
| <input type="checkbox"/> Behavioral Health (Psychiatric and/or Substance Abuse Services) | | |
| <input type="checkbox"/> Rehabilitation (specify): _____ | | |
| <input checked="" type="checkbox"/> Other Inpatient (specify): <u>Long Term Care Facility</u> | | |

Outpatient Service(s):

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> New Hospital Satellite Facility | <input type="checkbox"/> Emergency | <input type="checkbox"/> Urgent Care |

<input type="checkbox"/> Central Services Facility	<input type="checkbox"/> Behavioral Health (Psychiatric and/or Substance Abuse Services)	
<input checked="" type="checkbox"/> Rehabilitation (specify): <u>Outpatient therapy to our Residential Care Facilities</u>		
<input type="checkbox"/> Other Outpatient (specify): _____		
Imaging:		
<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scanner	<input type="checkbox"/> PET Scanner
<input type="checkbox"/> CT Simulator	<input type="checkbox"/> PET/CT Scanner	<input type="checkbox"/> Linear Accelerator
<input type="checkbox"/> Cineangiography Equipment	<input type="checkbox"/> New Technology (specify): _____	
Non-Clinical:		
<input type="checkbox"/> Facility Development	<input type="checkbox"/> Non-Medical Equipment	<input type="checkbox"/> Renovations
<input type="checkbox"/> Change in Ownership/Control	<input checked="" type="checkbox"/> Land and/or Building Acquisitions	
<input type="checkbox"/> Organizational Structure (Mergers, Acquisitions, & Affiliations)		
<input type="checkbox"/> Other Non-Clinical (specify): _____		

Section 8 – Service Change

Service Change	Type of Change
N/A	

Section 9 – Beds/Treatment Positions

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
SNF/NF	57	57	8	65

Section 10 – Project Costs

1. Land	468,500.00
2. Building (Acquisition Cost Only)	
3. Building (Construction/Renovation Portion Only)	
Total Gross Square Feet 38,000 approx	

4. Construction Contingency (% of Line 3)	TBD
5. Site Improvements	TBD
6. Major Medical Equipment Purchases*	TBD
7. Medical Equipment Purchases*	TBD
8. Non-Medical Equipment Purchases*	TBD
9. Bond Premium	TBD
10. General Requirements	TBD
11. Builder Overhead	TBD
12. Builder Profit	TBD
13. Permits	TBD
14. Engineering	TBD
15. Architectural	TBD
16. Environmental Studies	TBD
17. Construction Period Taxes	TBD
18. Construction Period Interest	TBD
19. Construction Period Insurance	TBD
20. Financing costs/Loan Fees	TBD
21. Other _____	TBD
22. Subtotal Construction/Acquisition	TBD
23. Accounting Fees	TBD
24. Legal	TBD
25. Title and Recording	TBD
26. Appraisal	TBD
27. Subtotal Lines 23-26	TBD
28. Total New Project Costs (Lines 22 and 27)	TBD
29. Balance on Existing Mortgage(s)	TBD
30. Total Project Costs	TBD

*Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

Section 11 – Major Medical and/or Imaging Equipment Acquisition

Equipment Type	Name	Model	Cost per Unit	Number of Units
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TBD

* Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

Section 12 – Changes in Personnel

Number of Additional Positions	Additional Costs
Physicians: N/A	Additional Staffing Costs: TBD
Nurses: TBD	Additional Operating Costs: TBD
Other: TBD	

Section 13 – Source of Funds

Lender/Source	Type	Loan Amount	Interest Rate	Term (years)	Comments
TD Banknorth	Mortgage	TBD	TBD	25	Pending approval

Section 14 – Facility/Replacement

Does the project involve the replacement/relocation of licensed beds from one licensed site to another geographic location?		
Yes	Distance 3 miles	County Sagadahoc

Section 15 – Ownership

Form/Type of (Proposed) Ownership (Check all that apply):		
<input type="checkbox"/> Existing	<input type="checkbox"/> Individual	<input type="checkbox"/> Bond for Deed

<input type="checkbox"/> To be Formed	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Corporation
	<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Partnership
		<input type="checkbox"/> Limited Liability Co.
<input type="checkbox"/> Other (specify): _____		

Section 16 – Site/Building Information

Applicable to Nursing Home Facilities and Residential Care Facilities ONLY...

Existing Building:		
Age		years
Type Construction (wood, masonry)		
Type Foundation (crawl, slab, full, partial)		
Utilities:		
Water	<input checked="" type="checkbox"/> Public	<input type="checkbox"/> Private
Storm Sewer	<input type="checkbox"/> Public	<input checked="" type="checkbox"/> Private
Natural Gas	<input type="checkbox"/> Public	<input checked="" type="checkbox"/> Private
LP Gas	<input type="checkbox"/> Public	<input checked="" type="checkbox"/> Private
Other (specify): _____	<input type="checkbox"/> Public	<input type="checkbox"/> Private
Electricity		
Is electricity on-site	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Distance to nearest line		feet
Is new line needed	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Water		
Is a water line on-site	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If no, distance to nearest line		feet
Estimated cost of bringing to site		\$
Who/what is source of information		
Wells currently dug or drilled	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, pumping at depth of		feet

New well needed	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Sanitary/Sewer		
Municipally served		
Distance to nearest line	TBD feet	
Estimated cost to developer to bring line to site	\$ TBD	
Hook up charge	\$ TBD	
No municipal service		
Type of septic planned/existing	Town Sewer	
Approvals received from		
State	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Local	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Zoning:		
Is rezoning/variance required	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, please describe: _____		
Are off-site improvements necessary? (i.e. public roads, sidewalks)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, please describe and indicate the dollar amount in the development budget associated with these improvements:		
Lot:		
Gross	7 acres	
Net (gross minus easements and unusable portions)	TBD square feet	
Located in flood zone	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
To the extent known, will any of the following present obstacles to the development of the proposed project (Check all that apply):		
<input type="checkbox"/> Railroad lines	<input type="checkbox"/> Hazardous waste disposal site	
<input type="checkbox"/> Electronic transmission lines	<input type="checkbox"/> Drainage problems	
<input type="checkbox"/> Bodies of water	<input type="checkbox"/> Wetlands	
<input type="checkbox"/> Ledge	<input type="checkbox"/> Grade	
<input type="checkbox"/> Underground oil tanks	<input type="checkbox"/> Soil quality	

<input type="checkbox"/> Contaminated water source	<input type="checkbox"/> High water table
If renovations/rehabilitation is involved, will the following be proposed? (Check all that apply)	
<input type="checkbox"/> Replace plumbing	<input type="checkbox"/> Install new flooring
<input type="checkbox"/> Replace roof	<input type="checkbox"/> Install new windows
<input type="checkbox"/> Replace heating system	<input type="checkbox"/> Alter room layouts
<input type="checkbox"/> Install new electric service	<input type="checkbox"/> Alter footprint of building
<input type="checkbox"/> Install new bathrooms	<input type="checkbox"/> Add bedrooms
<input type="checkbox"/> Install new kitchen	<input type="checkbox"/> Handicapped accessibility
Building and Unit Sizes	
Gross square feet in finished building	38,000 approx square feet
Deduction of mechanical/furnace area and/or unfinished attic, if included above	TBD square feet
Net square feet	TBD square feet
Net square feet divided by # of licensed beds	TBD square feet per bed
Maximum bedroom size	TBD square feet

Section 17 – Project Type Description

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services that are currently being provided.
2. List the types of services being proposed.
3. Identify the current population served and the target population to be served. Include primary and secondary service areas.
4. Identify any unmet need and describe how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Maine.
7. Who will be responsible for providing the service?
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed

SECTION 17 – Project Type Description

- 1) Skilled Rehabilitation and long term care.
- 2) Skilled Rehabilitation, long term care and outpatient therapy
- 3) Our primary population served will be the elderly, however we are hoping with a brand new rehab room we can attract a younger population for short term therapy and provide outpatient therapy to our residential care facilities.
- 4) Outpatient therapy to our residential care facilities and other facilities within the community.
- 5) Midcoast Senior Center
- 6) In a brand new state of the art long term care facility we will be able to provide services to our residents in a setting that will be cost effective for all parties involved.
- 7) Peter A. Davison the current Administrator at Amenity Manor (Peter has over 18 years of Administrative experience) and the entire Amenity Manor team that is currently in place.
- 8) The current payers are Private, Medicare and Mainecare – we anticipate an increase to our Medicare and Private pays once this project is completed.

project becomes operational.

Section 18 – Applicant Licensing History

During the last three (3) years, check all of the following that apply:

Name of Licensed Facility/Program	Full License	Conditional License	Fined	Directed Plan of Correction	Other Licensing Penalty	Comment
Amenity Manor	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Owned by Richard A. Rousseau
Montello Manor	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Owned by Richard A. Rousseau
D.C. Holdings, Inc. dba Dionne Commons	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitch Rousseau purchased this facility from his father 3/1/2006
S.H. Holdings, Inc. dba Skolfield House	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitch Rousseau purchased this facility from his father 1/1/2008
Montello Heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72% owned by Richard A. Rousseau and 28% owned by Mitchell Rousseau
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Section 19 – Certification

I certify that, to the best of my knowledge and belief, the information submitted is true and correct. I further certify that I am authorized to submit this Letter of Intent on behalf of the applicant.

Signature Mitchell Rousseau Date 1/6/09

The information on this form was prepared for the Applicant by:

First Name Mitchell **Last Name** Rousseau
Job Title President