

**Department of Health and Human Services  
Division of Licensing and Regulatory Services  
11 State House Station, Augusta, ME  
Preliminary Analysis**

**Date:** March 7, 2012

**Project:** Construction of New Nursing Facility in Bucksport, Maine.

**Proposal by:** First Atlantic HealthCare

**Prepared by:** Phyllis Powell, Assistant Director, Division of Licensing and Regulatory Services  
Larry D. Carbonneau, Senior Health Care Financial Analyst

**Directly Affected Party:** None

**Recommendation:** Approve with Condition

	<b>Proposed Per Applicant</b>	<b>Proposed per Applicant as Revised</b>	<b>Approved CON</b>
<b>Estimated Capital Expenditures</b>			
Nursing Facility Care	\$ 6,364,707	\$ 9,555,756	\$ 9,555,756
Residential Care	\$ 3,179,439	\$ -	\$ -
Assisted Living Care	\$ -	\$ -	\$ -
Exempt Expenditures	<u>\$ 1,165,250</u>	<u>\$ 1,165,250</u>	<u>\$ 1,165,250</u>
Total Capital Expenditures	\$ 10,721,006	\$ 10,721,006	\$ 10,721,006
<b>Nursing Facility Portion Only</b>			
Capital Expenditure	\$ 6,364,707		\$ 9,555,756
Maximum Contingency	<u>\$ 317,211</u>		<u>\$ 477,788</u>
Total Capital Expenditure with Contingency	\$ 6,681,918		\$ 10,033,544
Incremental Operating Costs	\$ 4,428,950		\$ 4,705,736
<b>MaineCare Neutrality:</b>			
Calculated System Savings			\$ (2,090,966)
New NF Costs to System			\$ -
Change in number of NF Beds			6
Provider Retained Value			\$ -
(Subject to Additional Project Review)			\$ -
Change in Value to Maine Care Funding Pool			\$ 0

## I. Abstract

### A. From Applicant

#### Project Description

“This application seeks approval to build a new nursing facility in Bucksport, Maine.”

“The replacement facility will offer 61 dually certified NF beds, 30 residential care level IV beds. We plan to both private and semi-private accommodations in the NF and 20 companion suites coupled with 10 studio rooms in the residential care portion of the building.”

“Our analysis of potential need indicate that using state averages as of 2009, over 300 additional beds will be needed by 2020 in Hancock County, and allowing that Bucksport is located on the fringe of Waldo County, another 200 additional NF beds are needed in Waldo County by 2020 which can be seen as partially served by from Bucksport due to its proximity. Therefore, our proposed project marginally answers the projected NF bed need of nearly 500 more beds between Hancock and Waldo Counties.”

“If possible, our Ellsworth and Bucksport projects will follow the same building design to minimize A&E fees and increase construction and design efficiency.”

“Ownership of the Bucksport facility will be a joint venture with Eastern Maine Health System’s affiliate Ross Care and First Atlantic Healthcare of affiliate. The project will use an LLC corporate solution.”

“In this application, we will show that through the use of energy credits and relocated MaineCare resources from CA Dean, Collier’s Marshalls’ reserved beds, Atlantic rehabilitation and possibly from sources yet to be identified the planned project will be MaineCare neutral.”

“Our required pro-forma financial analysis will show the new facility will be financially feasible, that it will attain a minimum of 90% occupancy within a reasonable time-line and conform to applicable regulations governing the reimbursement of licensed nursing facilities in Maine.”

“Finally, all three existing facilities: (1) Atlantic Rehabilitation located in Calais and (2) Collier’s located in Ellsworth, and (3) Penobscot located in Penobscot are listed on the Department’s list of facilities to be replaced.”

## II. Fit, Willing and Able

### A. From Applicant

#### History of Healthcare quality

“Facilities under the management of First Atlantic Healthcare have had isolated deficiencies that have been corrected in a timely manner. As of the submission date all facilities under our management are in compliance with State and Federal licensing standards.”

#### Ability to plan, permit, construct and operate the proposed project

“First Atlantic has significant experience with design, construction and operation of nursing and residential care facilities. Seal Rock Healthcare a 105 bed, dually licensed nursing facility and The Inn at Atlantic Heights, an 80 bed residential care and assisted living facility both located in Saco, Maine are examples of the applicant’s ability to plan, design and complete projects of the scale and type proposed here.”

#### Bucksport Facility

“As noted above, the Bucksport facility will be jointly owned by First Atlantic Corporation d.b.a. First Atlantic Healthcare and RossCare. RossCare is an Affiliate of Eastern Maine Health Systems. RossCare and First Atlantic Healthcare have been successful joint venture partners for approximately 20 years, owning Stillwater HealthCare, Dexter Healthcare, Colonial HealthCare, Dexter Manor, Katahdin HealthCare and Ross Manor. Day-to-day management will be provided by First Atlantic Healthcare similar to the other jointly owned properties.”

#### **Profile of First Atlantic Corporation:**

“The following individuals comprise the senior executives at FAH:

Kenneth Bowden, CEO	20 years with FAH
Craig Coffin, COO	28 years with FAH
Vicki White, VP/Corporate Compliance Officer	17 years with FAH
Wanda Pelkey, CFO	14 years with FAH”

“The facilities managed by First Atlantic Healthcare are as follows”:

Atlantic Rehab & Nursing. Calais, Maine	Collier’s Rehabilitation & Nursing Center Ellsworth, Maine	Colonial Healthcare Lincoln, Maine	Dexter Healthcare Dexter, Maine
Falmouth By the Sea Falmouth, Maine	Freeport Place Freeport, Maine	Hawthorne House Freeport, Maine	Katahdin Healthcare Millinocket, Maine
Portland Center for Assisted Living Portland, Maine	Marshall’s Healthcare Machias, Maine	First Atlantic HealthCare Bangor, Maine	Seal Rock Healthcare Saco, Maine

Seaside Healthcare Portland, Maine	Stillwater Healthcare Bangor, Maine	Washington Place Calais, Maine	Woodlawn Rehabilitation and Nursing Center Skowhegan, Maine
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“The applicant refers the Bureau to the Division of Licensing and Certification for confirmation that the above named entities has had isolated deficiencies that have been corrected on a timely basis.”

“Neither First Atlantic nor Rosscare or any of the principals of either organization been barred from participation in the Medicare or Mainecare programs at any time or found guilty of any infractions that would eliminate their participation in this project.”

“Principal profiles for First Atlantic Corporation are as follows”:

**Ronald C. Coffin.**

“Mr. Coffin is Founder and President of First Atlantic Healthcare. He has been involved in healthcare services since 1964. A graduate of University of Maine and Boston University School of Law, Coffin has strong ties with Maine’s long-term care community. From 1968 through 1984 he was the owner and operator of First Allied Corporation, which owned and operated nursing facilities in Maine, Massachusetts, Florida and California. First Allied was sold to Hillhaven corporation in 1984. One year later Mr. Coffin started First Atlantic Corporation the successor to First Allied.”

“In the intervening years of 1985 through 2003, Mr. Coffin and First Atlantic Corporation/Healthcare have acquired and managed all of the facilities named above and additionally have operated and owned an institutional pharmacy known as Downeast Pharmacy and First Allied Home Health, a twelve office home health company which operated in Maine.”

“Mr. Coffin’s operations have a reputation for quality and sound fiscal management. Today, his enterprises employ nearly 1,500 individuals ranking on a combined basis in the top fifteen employers in Maine.”

**Kenneth W. Bowden**

“Mr. Bowden serves as First Atlantic Corporation’s Chief Executive Officer and is responsible for overall First Atlantic activities including management, consulting, development and regulatory compliance.”

“A graduate of Ellsworth High School in 1973, he continued his education at the University of Maine at Orono, earning a Bachelor’s degree in Accounting in 1977 and an M.B.A. in 1979. Employed by Ernst & Whinney from 1979 to 1981 in public accounting, many of his audit client’s were from the health care field; including St. Mary’s General Hospital, Penobscot Bay Medical Center and Northern Maine Medical Center to name a few.”

“In 1981, Bowden joined St. Mary’s as their Cost and Reimbursement Specialist where he had responsibility for preparation of that organization’s annual operating budget and all cost reports. In addition to hospital operations he also had responsibility for Marcott Nursing Home, a 350-bed facility owned and operated by the Sisters of Charity. In 1984, Bowden became the first Chief Financial Officer at Jackson Brook Institute, a newly opened Psychiatric and Drug Rehabilitation Hospital located in South Portland, Maine. In 1991, he joined First Atlantic Corporation as Chief Financial Officer where his duties included financial oversight of the nursing, pharmacy and home health divisions. Promoted to Chief Executive Officer in 1995, he continues to serve in this capacity today.”

“For more than 20 years, Mr. Bowden has been involved with healthcare services. He is a past board chair of Maine Healthcare Association and Goodwill Northern New England. Bowden is currently a member of the Council of Ministries at the Falmouth Congregational Church.”

### **Craig G. Coffin**

“Mr. Coffin is the company’s Chief Operating Officer and as such he oversees all operational and development aspects of the company. A licensed Nursing Facility Administrator in Maine (license number AD 523) and Florida, Mr. Coffin began working in the field of geriatric healthcare in 1985. He has run several nursing facilities including the flagship facility Falmouth by the Sea from 1990 to 1993. He was instrumental in the development and construction of First Atlantic HealthCare a 119 bed facility with 83 skilled and long term care beds, 24 Residential Alzheimer’s beds and 12 Assisted living beds. In 1994 he joined the company’s corporate offices and held the position of Vice-President. Promoted again in 1995 to the position of Chief Operating Officer, Coffin is responsible for all land acquisition, permitting, development and operations of the company. Most recently, he oversaw our development in Saco Maine.”

“Born in Massachusetts and educated at Proctor Academy, Dean College and the Florida State College of Healthcare for his AIT program, he has for nearly 20 years, been involved with the provision, direction and management of healthcare to the elderly.”

### **Profile of Rosscare:**

“As a member of Eastern Maine Health Systems ([EMHS](#)), Rosscare’s philosophy is to value aging and strive to improve the lives of older adults through a network of senior services that provide resources, education, housing, and support services for older adults, their families, and caregivers throughout the EMHS service region.”

“Rosscare, a tax-exempt organization, provides or supports a continuum of nonacute health care services including a boarding home facility, an emergency responder program, a telephone reassurance program, primary care to geriatric patients and a continuing care information center. Rosscare is the sole shareholder of Rosscare Nursing Homes, Inc ("RNHI") and is a 50% owner in Dirigo Pines Inn, LLC ("DPI").”

“RNHI is also a 50% partner in four separate partnerships that own and operate nursing homes.

On a combined basis, the nursing homes offer 300 long-term care beds and a 24-bed Alzheimer unit to the residents of central maine.”

“DPI is a limited liability company formed for the construction and operation of an apartment style retirement community in Orono, Maine. Operations to date have been restricted to start-up activities of this project.”

**Principal profiles of Rosscare, Inc. are as follows:**

“Lisa Harvey-McPherson, RN, MBA, MPPM is Vice President, Continuum of Care EMHS with responsibility for overseeing all Rosscare operations. Lisa has been with Eastern Maine for 13 years and affiliated with Rosscare since joining Eastern Maine.”

“Amy Cotton MSN, GNP-BC, FNP-BC, FNGNA is Director of Operations for Rosscare was originally employed at Eastern Maine Medical Center and has been with Rosscare 23 year.”

**B. CONU Discussion**

**i. CON Criteria**

Relevant criterion for inclusion in this section are specific to the determination that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards.

**ii. CON Analysis**

This facility is expected to in part replace capacity at the following two facilities: Atlantic Rehab in Calais, Maine and Collier’s Nursing Home in Ellsworth. Both facilities are on the Department’s list of facilities that need to be replaced.

Atlantic Rehab is located at 32 Palmer Street in Calais, Maine. The administrator is Mr. John Wood. Mr. Wood is a licensed administrator in good standing according to records on file with the department. The facility has multiple levels of care including 52 nursing home beds and 30 Level IV residential care beds. The nursing beds are Medicare and MaineCare certified. The facility’s current license was issued in June 2011 and carries an expiration date of June 30, 2012.

Collier’s Nursing Home is located in Ellsworth, Maine. The facility has a single level of care with 40 nursing home beds. The nursing beds are all Medicare and MaineCare certified. The facility’s current license was issued in September 2011 and carries an expiration date of September 30, 2012.

In the latest available Roster Occupancy report prepared by the Muskie School, Atlantic Rehab had a 98.08% occupancy rate with 84.31% MaineCare, 5.8% Medicare and 9.8% private pay patients. Collier’s Nursing Home had an 80.00% occupancy rate with 68.75% MaineCare, 18.75% Medicare and 12.5% private pay patients. First Atlantic Corporation, since its founding

in 1985, has proven to be a steady and reliable provider of care. First Atlantic Corporation has submitted several projects for CON review since 2005 including:

- The development and opening of Seal Rock Healthcare in Saco;
- The acquisition of Marshall Healthcare in Machias;
- The renovation and addition of capacity at Seaside Healthcare in Portland;
- The acquisition of Katahdin Nursing Home in Millinocket; and
- The expansion of services at Ross Manor in Bangor.

To date, all nursing facilities owned and/or operated by First Atlantic HealthCare are in compliance with State and Federal Regulations.

**iii. Conclusion**

CONU recommends that the Commissioner find that First Atlantic HealthCare is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards.

### III. Economic Feasibility

#### A. From Applicant

“Our enclosed proforma financial statement demonstrates feasibility of the proposed project now and in the near future. Historically, rates have kept pace with inflation and while in any given year or few years NF funding lag the rate of increasing costs, Maine’s legislature has shown a willingness to provide inflation adjustments and rebase NF rates periodically.<sup>1</sup>”

“The Ellsworth facility for its NF and RCF beds will require \$3,186,541 in MaineCare resources provided from the following sources including energy efficient equipment and replacement equipment not subject to neutrality:”

Table 1: Sources and Use of MaineCare Funds (provided by the Applicant)

<b>Sources and Use of MaineCare Funds</b>		
<b>Sources</b>	Amount	Beds
Ross Manor	1,573,014	14
Marshall's	201,635	10
Colliers’s	616,092	31
<b>Total</b>	<b>2,390,741</b>	<b>55</b>
<b>Uses</b>		
Replacement NF	2,577,694	61
RCF	745,907	
Less excluded items:		
Parking lot	(31,880)	
Replacement Equip	(86,329)	
	<b>3,205,392</b>	<b>61</b>
	(814,651)	

“As noted above, the project at this juncture needs additional resources (\$815,000 to be neutral. We have hopes that with the Department help the necessary resources to be located and at a minimum and if all other aspects of our proposal are agreed to by the department. That a CON approval, conditioned on meeting the final neutrality requirement, would be issued.”

“Our proforma assumes that in 2013 dollars and today’s payment limits and thresholds the MaineCare NF rate will be approximately \$202.09 with a residential care rate of \$118.01. These

<sup>1</sup> The last rebasing occurred in 2008. This past session a small increase was budgeted to reflect the increase in the provider tax to Federal levels.

rates are comparable to other NF & RCF rates despite the replacement cost impact to interest and depreciation components. Once stabilized, our planned debt service coverage ratio is expected to be 1.27 assuming an effective maximum interest rate of 7%. However, we are in a lower rate environment than the seven percent (7%) used in our analysis depending on whether a variable or fixed rate is chosen and also depending on term. We would like to discuss the various financing options with department representatives as it may be wise to secure a ten year fixed rate instrument to finance our project. However, that would lead to a higher interest cost in the short term over variable rates and that of course impacts neutrality. In any event it's an issue we are open to exploring with the Department.”

“The project is expected to cost approximately \$10,721,006 including land acquisition costs of \$650,000. This cost is comparable to the costs of recent First Atlantic projects in Bangor and in Saco.”

“The project proposes a variety of room configurations featuring both semi-private and private rooms. At present, the nursing facility and residential care facility averages 540 and 550 square feet per bed respectively. These averages are nearly identical to our Seal Rock facility in Saco, Maine. We will comment more on our room configurations in the section which deals with outcomes. But in summary here, the room and bath design promote healing, good health and follows industry clinical best practices for various specific resident conditions such as antibiotic resistant infections. The following chart (TABLE 2: Provided by the Applicant) depicts our room profile.”

Table 2: Room Configuration (Provided by the Applicant)

Room Configuration	Beds/Units	Room Sq Ft	Resident Room/Unit	Circulation Sq Ft	Total Sq Ft
NF semi-private	36	183	6,588	11,858	18,446
NF private	25	207	5,175	9,315	14,490
RCF - Semi Priv	20	201	4,020	4,703	8,723
RCF Studios	10	359	3,590	4,200	7,790
					49,449

“Based upon our proforma and integral assumptions we have shown feasibility and assert that our firm’s track record of compliance, ability to manage costs and maintain high occupancy in our facilities augers well for this project, now and in the foreseeable future.”

## Neutrality

“We estimated the costs of exempt items such as the parking lot and equipment that we consider to meet the definition of replacement however we have not off-set energy efficient features. As a result, we seek guidance from the Department to define and identify those elements of additional excludable, neutrality off-sets.”

### **B. CONU Discussion**

#### **i. CON Criteria**

Relevant criterion for inclusion in this section are specific to the determination that the economic feasibility of the proposed services is demonstrated in terms of the:

- a. Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and
- b. The applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.

#### **ii. CON Analysis**

The facilities contained in this application are operated by First Atlantic HealthCare. The organization has demonstrated fiscal responsibility which is evidenced in the prior year audited costs reports. The organization has demonstrated the financial capability of completing projects larger than the one proposed in this application.

The Certificate of Need unit has authority to grant a Certificate of Need that covers the nursing facility portion of the project. The Certificate of Need unit does not have the authority to approve residential care projects as it is beyond the scope of the Maine Certificate of Need Act of 2002. Therefore, this project will be reviewed as a nursing facility with 61 beds. The applicant will have the opportunity to make changes in the plan through the subsequent review process if plans change or approval for a Residential Care unit is obtained from the Office of Elder Services.

The cost per square foot of the new Bucksport facility is \$161.94 (\$8,008,006 total building costs divided by 49,449 square feet). When compared to Marshall & Swift valuation service standards, this figure is similar to a Good Class C convalescent hospital (\$156.68) and a Good Class D convalescent hospital (\$148.90). It is unclear in the application which class of building the applicant plans to build, yet it is clear that they fall within a reasonable range that is acceptable.

The applicant provided an estimate of the amount of MaineCare resources necessary to offset the resources used in this project based on calculations completed by the CONU staff. Changes to the methodology have occurred since the MaineCare Funding Pool was established. The changes were implemented to ensure that resources were reasonably estimated. These resources can now

be compared to other resources in the reserve bed pool as well as the remaining resources in Table 3 below:

TABLE 3

<b>MaineCare Neutrality – Nursing Facility</b>		
	<b>\$</b>	<b>Beds</b>
<b>Resources Available:</b>		
Marshall – Reserved Beds	\$ 201,635	10
Savings Ross Manor	1,573,014	14
Collier’s	840,121	31
<b>Total Program Revenues</b>	<b>\$2,614,770</b>	<b>55</b>
<b>Resources Needed:</b>		
First Atlantic HealthCare Proforma	\$4,705,736	61
<b>Remaining Resources (Shortfall)</b>	<b>\$(2,090,966)</b>	<b>(6)</b>

Table 3 shows that the available MaineCare resources from savings at the Collier’s project and Ross Manor and the reserved beds at Marshall’s leave a significant shortfall of \$2,090,966 in resources and 6 beds short. The CON unit cannot authorize new beds; therefore, this certificate will have to be conditioned on the applicant identifying these additional resources. The applicant can scale back the programs or include other services that would share the costs of these facilities. This decision is the applicant’s responsibility to determine and present to the CON unit.

A key operational strategy to be employed by the applicant is to care for more needy (skilled) patients. This can be seen from the prospective utilization rate for Medicare services. The utilization rate is higher than most of the applicant’s peers. (Information was derived from Census Reports from the Muskie School.) The applicant plans to offset the lower reimbursement rate from MaineCare with this higher rate from Medicare.

The new facility’s proforma financial statements demonstrate adequate cash flow for operations.

### **iii. Conclusion**

CONU recommends that the Commissioner determine that First Atlantic HealthCare has met their burden to demonstrate: (1) the capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and (2) the applicant’s ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules subject to the following condition.

Condition: The applicant must present a plan to CONU that identifies MaineCare Resources totaling \$2,090,966 and includes at least 6 bed rights prior to the commencement of this project.

## IV. Public Need

### A. From Applicant

“The project seeks approval to construct, operate and maintain a new 61 bed NF facility with an attached residential care level IV component. This project specifically addresses the need to provide a stable, modern health care facility within Bucksport, Maine. Further the project specifically addresses the need for services in the Greater Bucksport area that meet all the regulatory requirements including room size, common areas, reasonable accomodation for those with disabilities and that improve the operational efficiency of services including energy efficiencies.”

“The project will also help met the projected need for NF beds over the coming decades.”

“Services will be available to all residents in the planned service areas who qualify for nursing facility or residential care based upon their health and payor status. All facilites will have and will follow non-discrimination practices for admission and employment at the facilities.”

### **Maine’s Population Trends and Implications for Proposed Projects**

“The 2010 U.S. Census report and a 2010 report by the Muskie School of Public Service titled Older Adults and Adults with Disabiites: Population and Service Use Trends in Maine 2010 are referenced in this section and each provides unique insight helpful in understanding the projects expected contribution to health problems as measured by health needs in the areas to be served.”

#### “Pertinent Muskie Report Highlights

- Maine has one of the oldest populations in the country, ranked 4<sup>th</sup> in 2008 and is projected to rank 2<sup>nd</sup> by 2020
- Rural Maine has a higher proportion of older adults ~ approximately 80% of Maine’s towns are classified as rural by CMS
- The number of working age adults available to care for older adults is declining
- Older adults in Maine often live in poverty and with a disability, particularly in rural areas resulting in poor health status
- In 2007, Maine ranked 38<sup>th</sup> among states in the number of nursign facility beds per 1,000 persons age 65-and –above
- Nearly two-thirds of the 14 nursing facility closures or conversions in Maine between 2001 and 2008 were among the samller facilities, those with fewer than 50 beds
- In 2008, nearly half of Maine’s nursing facilities were larger than 60 beds
- Nearly 3-out-of-10 Maine nursing faciity beds are in buildings in need of replacement – 30%
- In 2008, Washington County has 61 NF/Rescare beds per 1,000 age 65+ compared to state average of 56 (35 NF 21 Rescare)

- In 2008, Hancock County has 43 NF/Rescare beds per 1,000 age 65+ (25 NF 18 Rescare) compared to state average of 56 (35 NF 21 Rescare)”

#### Census 2010 Highlights

- Last 20 years population shift away from Washington County<sup>2</sup>
- Largest growth in Waldo and Hancock Counties
  - Ellsworth centrally located in Hancock – fastest growing city in Maine

#### Need - Population and Census Data Conclusions

“As noted above according to the 2010 census report, there continues to be a significant population shift away from Washington County. The declining population trend has impacted our Calais facility over the years and resulted in a de-licensing of over fifty (50) NF beds since 1994.<sup>3</sup>”

“Hancock County has a lower than average ratio of total beds per 1,000 persons 65+ as of 2008 and if service level and bed count remained static over the next twenty years that ratio would decline significantly based upon the expected growth in age cohorts most likely to utilize either residential care services or nursing facility services. According to Muskie data, the age 65+ cohort in Hancock County will grow by 47% to 13,049 persons by 2020, eight years from now. Applying the state average of 56 beds per 1,000 over 65, results in a need for Hancock County of 731 total beds by 2020. Hancock County has as of 2007, 227 NF beds and 160 residential care beds for a total of 387 beds or 52% of the potential need in eight years. Sixty-five percent of persons over the age of 65 were living with an annual income below the federal poverty level.”

“Bucksport has many formal and informal ties to Waldo County. It serves as the regional retail hub for several Waldo County towns including Verona Island, Prospect and Stockton Springs,. Its school system also formally hosts students from towns in Waldo County most commonly based on proximity to Bucksport.”

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<sup>2</sup> According to Census 2010 Washington County has seen a population decline of 3.9% or 1,367 persons from 1990 to 2000 and an additional population decline of 3.2% or 1,085 persons from 2000 to 2010. Since WWII there has been a decline of 15% in population which given the baby boom effect is somewhat surprising though most likely explained by loss of employment opportunities. Further based on Muskie School data, Washington County shows a projected 6% decline in the population age 85+ between 2008 and 2020.

<sup>3</sup> The nursing facility was licensed for 100 beds when it was purchased by First Atlantic Healthcare from Charles Barnard in 1995. Today we are licensed for 52 NF beds but the occupancy regularly is between 44 and 47 patients. Population forecasts show that even fewer NF beds will be needed in Washington County by 2020.

**B. CONU Discussion****i. Criteria**

Relevant criterion for inclusion in this section are specific to the determination there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

- a. Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;
- b. Whether the project will have a positive impact on the health status indicators of the population to be served;
- c. Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
- d. Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

**ii. CON Analysis**

The CONU informed the Office of Elder Services (OES) about the proposal and provided the office with copies of the application. OES reviewed this application and determined that the project met OES's criteria for consistency with their expected demands for nursing care beds for the area served by the facility.

The project will increase the availability of beds. The new facility serves primarily the Bucksport Area. Facilities in this area typically demonstrate higher occupancy levels. Bed need is a measurable health need.

First Atlantic HealthCare has a higher ratio of skilled care occupancy compared to its peers. The current operators of the facility provide competent care and have provided evidence that the programs in place will assure positive health outcomes.

**iii. Conclusion**

CONU recommends that the Commissioner find that First Atlantic HealthCare has met their burden to show that there is a public need for the proposed project as demonstrated by certain factors, including, but not limited to: (1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project; (2) Whether the project will have a positive impact on the health status indicators of the population to be served; (3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and (4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

## V. Orderly and Economic Development

### A. From Applicant

“Our project will incorporate and meet the budget neutrality standard set for nursing facility projects and is more fully detailed in the Economic Feasibility section located above. However, it is worth noting that project costs while limited to currently available resources, are also further constrained by reimbursement regulations governing nursing facilities in Maine. This further consideration is taken into account in our pro-forma filing.”

“So while the project will conform to immediate limitations on costs it will continue to do so into the future. Therefore, the energy efficiencies for lighting, heating/cooling, low maintenance and so forth will accrue to the benefit of future consumers. Thus we expect our project to have a stabilizing impact on total health care expenditures. To assure proper productivity, we are proposing 61 NF beds to efficiently staff for the most likely conditions which will be cared for.”

“As noted above, our project meets the budget neutrality standard and therefore we are not seeking additional state funds to cover state costs associated with anticipated utilization.”

“As noted earlier in this application the Department has identified each of the buildings we propose to replace as needing replacement rather than renovation. We accept and affirm the department’s determination that replacement of the forty plus year old buildings is the cost effective alternative.”

### B. CONU Discussion

#### i. CON Criteria

Relevant criterions for inclusion in this section are specific to the determination that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

- a. The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;
- b. The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and
- c. The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available.

**ii. CON Analysis**

As a result of the project, the state's MaineCare expenditures would be expected to decrease. MaineCare neutrality ensures compliance with this provision.

State reimbursement would be for care for persons otherwise eligible to receive that care, alternatives to this care are considerably more expensive to the state of Maine. The facility closest to this one is currently under receivership, which adds considerably greater costs while limiting the number of patients who choose to receive care there.

The application provides for a low-cost alternative to the beds that were available at C.A. Dean. Recent cost estimates for new facilities have resulted in estimated costs of greater than \$100,000 per constructed bed for a new facility. It would be more expensive for a 24 bed facility on an individual bed basis. A 24 bed facility operating as a nursing facility would not be financially viable for the provider or the payer of the service. Reimbursement for nursing bed care will not be at the higher hospital-based reimbursement level.

**iii. Conclusion**

CONU recommends that the Commissioner find that First Atlantic HealthCare has met their burden to demonstrate that the proposed project is consistent with the orderly and economic development of health facilities and health resources for the State.

## VI. State Health Plan

Relevant criterion for inclusion in this section are specific to the determination that the project is consistent with the State Health Plan.

The most recent State Health Plan was developed in the summer of 2010. This State Health Plan developed priorities to be considered when assessing hospital-based CON projects. The criterion for approving an application still requires the project to be consistent with the goals of the State Health Plan. In order to accomplish this, CONU requires the applicant to address the following:

***Priority: Please describe your population-based health and prevention programs and involvement in state-wide programs such as the Pressure Ulcer Task Force. Please describe any training programs you provide staff to identify and mitigate health concerns in the facility, especially those that may have an impact on reducing non-emergent emergency room use by your residents.***

**a. Applicant's Discussion on Priority**

“We believe that the services we propose in our application do not contradict the state health plan developed by the Department.”

“First Atlantic Healthcare is dedicated to proper, individualized, high quality, cost-effective healthcare and services to the consumers we serve. To fulfill this vision, our firm has adopted evidence based clinical best practices, some based on the NHQF's effort to reduce negative outcomes in the areas of dehydration, pressure sores, treatment of depression in elderly and fall prevention. The effort entails implementation of best practices, tracking results against prescribed standards to ascertain variation, employ root cause analysis to understand variations and act on what is learned to improve processes leading to improvement/desired outcomes.”

“In addition, over the last few years First Atlantic Healthcare has implemented an electronic medical record [EMR] at its facilities for care planning, MDS preparation and submission and for monitoring quality. The EMR platform creates an extremely reliable IT infrastructure to provide for the use of clinical best practices by unifying evidence based best practice knowledge in a single data base used by all First Atlantic Healthcare practitioners. Said simply, through the EMR care planning module we are able to imbed clinical best practice guidelines appropriate to the patients identified problem(s). Once a problem is identified, the ECS system points the practitioner to care plan interventions that are specific for the nurse and for the CNA; interventions are based on evidence based best practices. For example, if redness is identified during a skin assessment the care plan interventions would be based upon the U.S. Department of Health and Human Services, Public Health Service, and Agency for Health Care Policy and Research – Pressure Ulcer Treatment, Clinical Practice Guideline Number 15.”

“American Data Systems, the vendor of our EMR, technology provides secure access to vital health information in the event of a disaster. It also highlights documentation voids, those areas of the record where information is either expected or required but which is missing. For example

this feature helps to ensure proper medication management by noting when scheduled medications are not given.”

“Electronic charting also enhances productivity - here are but a few worth mentioning:

1. Information must flow TO and FROM the staff member. Collecting data might have many useful purposes, but unless information is also flowing to the caregiver, greater quality of care is hard to achieve. Electronic charting makes retrieving information easy and reliable for front line workers. It’s accuracy and the real time availability of information is critical to quality, especially on a shift-to-shift basis.
2. Charted information populates many fields thus duplication is eliminated.
3. Critical documentation such as incidents, critical lab values, the MAR, physician orders, weight loss, and acute condition changes to name but a few will be reported instantly and automatically to the Director of Nursing and Unit Managers among others within the organization when it occurs, not just when requested in some graphic summary or report after the fact.
4. Our system is easy to use and requires minimal computer knowledge or typing skills to operate.”

“Other quality based initiatives include First Atlantic Healthcare’s participation in the Maine LANE (Local Areas Networks for Excellence) project. LANE, identifies, disseminates and/or develops practical and evidence-based technical assistance resources to help nursing homes achieve their quality and organizational goals. The national Campaign’s Technical Assistance Work Group makes available targeted resources to support Campaign goals, which the LANE is able to promote and disseminate to Campaign participants. In addition, LANEs develop and host local educational events for participating nursing homes, staff, and consumers and encourage the sharing of best practices among all participants.”

“A few of the initiatives undertaken in Maine and which First Atlantic Healthcare utilizes in its operations include:

- Consistent assignment
- Resident and family satisfaction studies
- Monitoring with the goal of reducing pressure ulcers
- Limiting the spread of infectious disease through immunizations and use of proper hand washing techniques”

“Organizationally we follow the PDSA process of quality improvement (plan, do, study, and act) and more specifically with regard to LANE goals.”

“As noted above, FAH utilizes its Regulatory Compliance Committee coupled with the partnership Quality of Care committee, in the case of joint venture homes with Rosscare, to facilitate peer reviews in all of our facilities and to provide a mechanism for communicating compliance information throughout our company. Because we place such emphasis on this

committee and require every Administrator and DON to serve on it and on peer review teams, we believe our leadership teams are always in command of the appropriate knowledge they need to set policy and systems into motion that generate appropriate outcomes that benefit consumers.”

“Please see our Mission and Values statement which is included as Exhibit V. It is the foundation of our company culture and it speaks directly to our quest for therapeutic interventions that are curative, comforting and dynamic. As well, it speaks to consumer satisfaction and quality of residential environments that are comfortable, clean and appropriate for consumer needs thus enabling providers under our banner to become the place of choice in the communities we serve.”

**b. CONU Findings**

The applicant has demonstrated consistency with the priority.

*Priority: Please describe the facility’s culture of patient safety. Please provide a quality improvement plan that uses evidence-based protocols, a patient safety improvement strategy for the project under consideration and for other services throughout the facility.*

**a. Applicant’s Discussion on Priority**

“The narrative provided previously speaks directly to this area and we refer the department to our mission and values statement for evidence of the company’s effort to promote a culture of caring, safety and cost-effectiveness.”

**b. CONU Findings**

The applicant has demonstrated consistency with the priority.

*Priority: Describe how the project leads to lower cost of care / increased efficiency.*

**a. Applicant’s Discussion on Priority**

“The project will first look at construction best practices that will provide for energy efficiency and low maintenance. For example, at Seal Rock we utilized Hardie plank siding which will not need painting and is warrantied<sup>4</sup> for 30 years. Our HVAC system is also highly automated, providing heating and cooling based on ambient conditions in an effort to avoid energy spiking. Appliances will all be energy star<sup>5</sup> rated.”

**b. CONU Findings**

The applicant has demonstrated consistency with the priority.

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<sup>4</sup> [http://www.jameshardie.com/homeowner/products\\_siding\\_hardieplankLapSiding.py](http://www.jameshardie.com/homeowner/products_siding_hardieplankLapSiding.py)

<sup>5</sup> <http://www.energystar.gov/>

***Priority: If applicable, describe how the project meets at least “Gold Standard” certification by the Leadership in Energy and Environment Design (LEED) by incorporating “green” best practices in building construction, renovation and operation to minimize environmental impact both internally and externally.***

**a. Applicant’s Discussion on Priority**

“LEED principles will be used to guide our design wherever cost effective and we agree that attaining LEED Gold Standard criteria provides for a facility that is at once environmentally sensitive and energy efficient. With that said, there a variety of considerations to be resolved in order for our project to move forward using LEED Gold Standard benchmarks.”

“For example, our Architect is LEED certified and indicates we can expect 15% higher construction costs by incorporating LEED efficiency without LEED certification. The LEED construction premium moves to 20% greater costs if we seek certification. The added costs impact neutrality and our net operating income which directly impacts our debt service coverage ratio. Therefore, we want to discuss the LEED benefit in light of these issues and with Department help move forward with LEED principals such as high efficiency water faucets, low heat loss glass, energy star appliances and consider geothermal heating and cooling but not burden the project with full certification costs.”

“Therefore in the proforma we are submitting today the additional estimate of costs for LEED certification has not been included in our analysis. As we design the building we will seek to achieve a LEED score between 60 and 79 points (the LEED gold standard). If the Department supports the added cost. We do not know of any nursing facility project that has attempted this goal and as noted above, MaineCare budget neutrality restrictions, determined by existing costs of non-LEED design may make this objective difficult to attain. Therefore, the best approach may be to work with a LEED certified architect and incorporate reasonable LEED principals again depending on how costs are treated for neutrality purposes.”

“In sum, we are interested in using LEED standards in this project and we seek the Department’s advice on how best to follow LEED principals to achieve our requested approval, keeping in mind MaineCare resource limitations.”

**b. CONU Findings**

The applicant has demonstrated consistency with the priority.

**iii. Conclusion**

CONU recommends that the Commissioner find that the project is consistent with the State Health Plan.

## VII. Outcomes and Community Impact

### A. From Applicant

“As noted in our response to the financial feasibility section, we will incorporate enlightened room configurations and design to promote healing, good health, resident safety and follow industry clinical best practices by offering both semi-private and private rooms<sup>6</sup>. While offering private rooms increases the average per bed square footage to 540 square feet, the benefits to clinical quality out-comes are numerous. For example, medication errors have been shown to be lower using one patient to one room and managing as well as preventing infections is improved. Private rooms are much more family centered, provide emotional sensitivity<sup>7</sup> lacking in semi-private rooms. They also permit specialized equipment to be used more effectively, especially with orthopedic

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<sup>6</sup> By Aricka Flowers

Several European countries, including France, Britain and the Netherlands, either already have or are working toward exclusively single-room hospitals. Now it's time for America to get on the single-room hospital bandwagon, according to Toronto physicians, Michael E. Detsky and Edward Etchells. The pair co-authored a report in the August 2008 edition of *Journal of the American Medical Association* suggesting that all new hospital construction in America feature single-room facilities.

In their report, Detsky and Etchells argue the hospital layout would help lower infection rates and reduce medical errors; and it appears there is evidence to back their claim. According to an article in the *Los Angeles Times*, Methodist Hospital in Indianapolis experienced a 67-percent drop in medication errors in its coronary intensive care unit when it switched to single rooms. Meanwhile, officials at Bronson Methodist Hospital in Kalamazoo, Mich. saw an 11-percent decrease in infection rates when it switched to a single-room institution in 2000.

"Private hospital rooms are a significant step forward in patient safety compared to semi-private rooms or open wards," says Richard Van Enk, PhD, director of infection control and epidemiology at Bronson Methodist Hospital. "Patients in semi-private rooms eventually share their microbial flora as they share their space, and staffs are less likely to wash their hands between patients in a semi-private room environment than when they leave each private room to enter the next. Private rooms are also safer with regard to medical errors. Most errors are caused by distractions or momentary lapses of concentration by staff, and such distractions are more likely when there are two or more patients in a room, each requiring different medications, monitors and procedures for the healthcare staff to keep track of."

<sup>7</sup> Huntsinger went on to say that single rooms not only improve patient care, they go a long way toward improving patients' emotional and psychological wellbeing and, ultimately, their overall health. Huntsinger worked at single-room hospitals and witnessed firsthand how private rooms help patients and families through stressful times.

"Single rooms help create a more culturally-sensitive environment and provide more privacy," says Huntsinger. "Patients can bring more items from home to make them comfortable. In a single-patient room, family members can come and go without worrying about disturbing other patients and vice versa.... families and friends help provide emotional support for patients to relax and get better."

cases where patient lifts are often used to move patients from their beds. A private room removes gender issues from admitting decisions and because the room is solely their own, opportunity to inculcate their prior home environment into their new space is enhanced. Making the new space look and feel like your bedroom at home can significantly reduce transfer trauma from home to facility. Private rooms also help in managing resident's whose behavioral issues make them unsuitable for a roommate. If we could, we would hop on the single-room bandwagon as hospitals are doing and provide for all private rooms. Doing so is in the patient's best interest and is the best design to promote a home-like environment, rich with cultural, gender and disease and/or ADL loss management. The privacy of a single room promotes greatest dignity in all situations but in particular at end of life. In fact, when we consider all the quality of life, quality of care specific regulations, cannot think of one licensing regulation in these domains where a private room would not enhance and promote the intent of the regulation."

"While this proposal adds 61 NF beds in Bucksport, it is in answer to the increase in population demographics<sup>8</sup>."

"Due to population growth across all age groups and particularly in the age 65+ cohort, competition is not expected to change as a result of the project, any impact on system wide cost of healthcare while minimal will be beneficial."

"In summary, the project is expected to neither increase nor decrease competition in a manner that is likely to impact the supply of services locally available in the markets served by the project."

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<sup>8</sup> Census: Ellsworth is Maine's fastest growing city

The Associated Press Posted April 05, 2011, at 9:46 a.m.

ELLSWORTH, Maine — The most recent U.S. Census figures show that Ellsworth is Maine's fast growing city.

In the last decade the Hancock County community grew by about 20 percent, or 1,200 people, to about 8,000.

City Manager Michelle Beal says the growth is no coincidence.

She says the city has worked hard to expand and is always looking for new development opportunities.

Beal tells WLBZ-TV she and other officials are happy because it shows their investments in infrastructure and beautification are working.

“The following table sets forth the census of Hancock County from 1790 to 2010. Hancock County is one of only two Maine counties that showed growth in population in the 2010 U.S. census and as the table reports it has had steady growth from 1960 with a few years reporting double digit expansion. The only other county to report an increase in population from 2000 to 2010 was Southern Maine’s Cumberland County home to Portland, Maine’s most populous city.”

Table 4 (Provided by the Applicant)  
Hancock County

<b>Historical populations</b>		
<b>Census</b>	<b>Pop.</b>	<b>%±</b>
<a href="#">1790</a>	9,542	—
<a href="#">1800</a>	16,358	71.40%
<a href="#">1810</a>	30,031	83.60%
<a href="#">1820</a>	31,290	4.20%
<a href="#">1830</a>	24,336	-22.2%
<a href="#">1840</a>	28,605	17.50%
<a href="#">1850</a>	34,372	20.20%
<a href="#">1860</a>	37,757	9.80%
<a href="#">1870</a>	36,495	-3.3%
<a href="#">1880</a>	38,129	4.50%
<a href="#">1890</a>	37,312	-2.1%
<a href="#">1900</a>	37,241	-0.2%
<a href="#">1910</a>	35,575	-4.5%
<a href="#">1920</a>	30,361	-14.7%
<a href="#">1930</a>	30,721	1.20%
<a href="#">1940</a>	32,422	5.50%
<a href="#">1950</a>	32,105	-1.0%
<a href="#">1960</a>	32,293	0.60%
<a href="#">1970</a>	34,590	7.10%
<a href="#">1980</a>	41,781	20.80%
<a href="#">1990</a>	46,948	12.40%
<a href="#">2000</a>	51,791	10.30%
<a href="#">2010</a>	54,418	5.10%

**B. CONU Discussion****i. CON Criteria**

Relevant criterions for inclusion in this section are specific to the determination that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

**ii. CON Analysis**

The applicant has met the criteria for demonstrating need for the requested beds. that the applicant's assessment demonstrated that the area could use the additional capacity and would not strain the resources of the facility or negatively affect the ability of other existing providers to maintain adequate levels of service. The proposal will ensure high-quality outcomes for the patients served in the enlarged facility.

**iii. Conclusion**

CONU recommends that the Commissioner find that First Atlantic HealthCare has met their burden to demonstrate that this project will ensure high-quality outcomes while not negatively affecting the quality of care delivered by existing service providers.

## VIII. Service Utilization

### A. From Applicant

“The Maine Quality Forum is geared towards Hospital and Physician based healthcare and thus its evidence-based medicine principals are generally not applicable to this application. Yet the underlying theme of inappropriate admissions, services or testing is very pertinent in all healthcare delivery settings; nursing facility and residential care included.”

“There is a combination of ways inappropriate NF and residential care utilization is mitigated.”

“Consumers seeking NF admission and who will rely on MaineCare to pay for their care must have a physician’s order, meet the strident medical eligibility standards of DHHS and qualify based on an assessment of their income and assets. They must also receive a Gould (Gould is independent organization contracted with DHHS to perform assessments using DHHS criteria) assessment that documents NF level of care is needed based on DHHS medical eligibility standards. Generally speaking, MaineCare consumers who seek NF admission must have a three ADL loss or have cognition challenges which qualify them under Maine’s eligibility standards. The assessments continue on a set schedule to assure continuing need for NF level of services.”

“Residential Care has lower medical eligibility standards but individuals have to meet similar financial criteria and are also subject to Gould clinical assessments. Prior to Med 94 many consumers who now rely on residential care settings for their care resided in nursing facilities at much higher costs. In fact, if one uses the number of NF beds that came off line, approximately 2,000 at the average Medicaid utilization of 65% or 1,300 beds) after Med 94 as a proxy for consumers resettled in residential care settings and an average cost to Maine’s general fund of \$20 per day in residential care settings compared to \$52 per day in nursing facilities over the eighteen years since Med 94 the \$32 per day savings amounts to approximately \$227 million dollars of savings in 2010 dollars. Obviously creating the residential care infrastructure to support elders in need of long term care services was brilliant and effective for both consumers and the State of Maine taxpayer.”

“Medicare also establishes medical necessity standards for skilled care thus insuring only appropriate cases are served. Prior to the expansion of skilled care in nursing facilities most cases were treated in hospitals at significantly higher cost.”

“Lastly, First Atlantic Healthcare has written corporate compliance policies that require all employees to follow State and Federal laws governing the provision of nursing facility and residential care services. We offer employees a compliance hot line whereby they can anonymously contact Vicki White, our corporate compliance officer, who follows up on all reports. The hot line is a vital component for learning of and stopping inappropriate practices that do not comply with laws and regulations.”

**B. CONU Discussion****i. CON Criteria**

Relevant criterion for inclusion in this section are specific to the determination that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

**ii. CON Analysis**

The applicant has met the criteria for demonstrating need for the requested beds. that the applicant's assessment demonstrated that the area could use the additional capacity and would not strain the resources of the facility. The Maine Quality Forum has not adopted any principles for nursing facilities that are applicable to the facility or this particular application.

**iii. Conclusion**

CONU recommends that the Commissioner find that the First Atlantic HealthCare has met their burden to demonstrate that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

## **IX. Funding in MaineCare Nursing Facility Fund**

### **A. From Applicant**

“At our technical assistance meeting, we discussed using the MaineCare Nursing Facility Fund for the project. It remains to be determined if the fund will be available or not to off-set neutrality. This is an additional area where we seek guidance from the department.”

### **B. CONU Discussion**

#### **i. CON Criteria**

Relevant criterion for inclusion in this section are related to the needed determination that the project can be funded within the MaineCare Nursing Facility Fund.

#### **ii. CON Analysis**

There are no funds being requested from the MaineCare funding pool. This proposal demonstrates MaineCare neutrality.

#### **iii. Conclusion**

CONU has determined that there are no incremental operating costs to the healthcare system there and will be no MaineCare Nursing Facility Fund dollars needed to implement this application.

## **X. Timely Notice**

### **A. From Applicant**

“We believe that our letter of intent coupled with this application following the DHHS CON template complies with all timely notice requirements of the applicant at this stage of the review process.”

### **B. CONU Discussion**

Letter of Intent filed:	March 29, 2011
Technical Assistance meeting held:	May 3, 2011
CON application filed:	July 27, 2011
CON certified as complete:	July 27, 2011
Public Information Meeting Notice (Augusta):	July 30, 2011
Public Information Meeting Held:	September 20, 2011
Public comment period ended:	October 19, 2011

## **XI. Findings and Recommendations**

Based on the preceding analysis, including information contained in the record, the CONU recommends that the Commissioner make the following findings and recommendations:

- A. That the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards.
- B. The economic feasibility of the proposed services has been demonstrated in terms of the:
  - 1. Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and
  - 2. The applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules;
- C. The applicant has demonstrated that there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to;
  - 1. The extent to which the project will substantially address specific health problems as measured by health needs in the area to be served by the project;
  - 2. The project has demonstrated that it will have a positive impact on the health status indicators of the population to be served;
  - 3. The project will be accessible to all residents of the area proposed to be served; and
  - 4. The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;
- D. The applicant has demonstrated that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:
  - 1. The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;
  - 2. The availability of State funds to cover any increase in state costs associated with utilization of the project's services; and

3. The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available was not demonstrated by the applicant;

In making a determination under this subsection, the commissioner shall use data available in the state health plan under Title 2, section 103, data from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner. Particular weight must be given to information that indicates that the proposed health services are innovations in high quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

- E. The applicant has demonstrated that the project is consistent with and furthers the goals of the State Health Plan;
- F. The applicant has demonstrated that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers;
- G. The applicant has demonstrated that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum; and
- H. That the project need not be funded within the MaineCare Nursing Facility Fund.

For all the reasons contained in the preliminary analysis and in the record, CONU recommends that the Commissioner determine that this project should be **Approved** with the following condition:

Condition: The applicant must present a plan to CONU that identifies MaineCare Resources totaling \$2,090,966 and includes at least 6 bed rights prior to the commencement of this project.