

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

**Date:** 09/18/2007

**Project:** Proposal by First Atlantic Healthcare to Purchase Nursing Facility assets of Marshall's Nursing Services, Inc and Healthcare Limited Partnership including residential care bed rights.

**Prepared by:** Phyllis Powell, Certificate of Need Manager  
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**Directly Affected Party:** None

**Recommendation:** APPROVAL WITH CONDITIONS

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Estimated Capital Expenditure per Applicant	\$2,271,536
NF Component	\$1,560,522
RCF Component	\$711,014
Approved Capital Expenditure per CON	\$2,325,347
NF Allocation	\$1,563,736
RCF Allocation	\$741,611
Maximum NF Contingency per CON	\$0
Maximum RCF Contingency	\$27,930
Total Approved Capital Expenditure with Contingency	\$2,353,277

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The following report is the Certificate of Need Unit's preliminary analysis and recommendations regarding the above-referenced proposal.

## **INTRODUCTION**

### **I. Project Description**

#### **A. From Applicant**

The applicant provided the following information regarding the project:

“Ronald C. Coffin, Craig G. Coffin and Kenneth W. Bowden through an LLC to be formed propose to purchase the assets (Exhibit I, *on file with CONU*) of Healthcare Limited Partnership (HLP), Marshall Nursing Services, Inc. (MNS) and the residential bed rights of MNS. First Atlantic Healthcare (FAH) will manage the facility under agreement. Officers of FAH are Ronald C. Coffin, President, Kenneth W. Bowden CEO/Treasurer and Craig G. Coffin COO/Clerk.”

“Further, we propose to add an addition to the Beal Street property, which currently consists of the fifty-bed (50) nursing facility that will house the relocation of all or a portion of the fifteen residential beds. The integration of the residential beds into the nursing facility will change the existing license from its present status to that of a multilevel facility.”

“The additional construction will take approximately 10 months, and will be financed with proceeds from the acquisition-financing package. During the interim, Peter C, Marshall will continue to operate the fifteen residential care beds in their present location. It is anticipated that current residential consumers will relocate into the new assisted living section of the multi-level facility upon completion. Therefore, we do not expect significant issues or any material start-up costs with the newly integrated assisted living program”

“Peter C. Marshall, a licensed Administrator since 1981 (license number MLA576) has agreed to continue as Facility Administrator. Peter obtained his multi-level license on April 2, 1990.”

#### **B. CONU Discussion**

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

The following criterion is applicable to this section:

Whether the services affected by the project will be accessible to all residents of the area proposed to be served. Accessibility is determined through analysis of the area including population, topography and availability of transportation and health services. [See Criterion C.]

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

The applicant, First Atlantic Healthcare, states that, as a sole proprietor, Mr. Marshall may not be able to continue operating the facility. This is apparently related to the poor results of the prior year’s survey and the financial effects of not being able to admit patients for a limited period of time. The applicant has stated their intention to maintain and improve the facility, initially through the integration of rehabilitation programs found in other First Atlantic nursing

facilities. Involvement of the applicant allows for the maintenance of the beds in the local community because First Atlantic is willing to operate the facility at its present location. The application does not make mention of any health safety upgrades or needs.

The applicant proposes to build an addition to the Beal Street property, which currently consists of the fifty-bed (50) nursing facility that will house the relocation of the fifteen residential beds. The integration of the residential beds into the nursing facility will change the existing license from its present status to that of a multilevel facility.

Construction will take approximately 10 months, and will be financed with proceeds from the acquisition-financing package. During the interim, Peter C, Marshall will continue to operate the fifteen residential care beds in their present location. It is anticipated that current residential consumers will relocate into the new assisted living section of the multi-level facility upon completion. Start-up costs with the newly integrated assisted living program should be minimal.

### **iii. Conclusion**

This project will not change the accessibility of the proposed services because the applicant has expressed the intent to improve the facility by consolidating the residential care beds of MNS with the purchase of the current facility located on Beal Street.

## **II. Profile of the Applicant**

### **A. From Applicant**

“The applicant for this project is a yet to be formed LLC whose members are Ronald C. Coffin (majority member) Craig G. Coffin and Kenneth W. Bowden. The applicant(s) provided the following information:

“Each of these individuals is well known to the Department. Each of these individuals has several years of experience owning, operating and managing healthcare facilities. Additionally, First Atlantic Healthcare, a Maine corporation currently manages fourteen facilities through out Maine and Marshall’s if approved will be fifteen. Several of the managed locations are multi-level facilities that offer skilled care, long term care and residential/assisted living services. Also, the management group has experience offering programs for qualified individuals who present with mental illness.”

“The following individuals comprise the senior executives at FAH:”

Ken Bowden, CEO	16 years with FAH
Craig Coffin, COO	23 years with FAH
Vicki White, VP/Chief Compliance Officer	13 years with FAH
Wanda Pelkey, CFO	10 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	Portland Center for Assisted Living Portland, Maine
Stillwater Healthcare Bangor, Maine	Ross Manor Bangor, Maine	Seal Rock Healthcare Saco, Maine	Seaside Healthcare Portland, Maine
Washington Place Calais, Maine		Woodlawn Rehabilitation and Nursing Center Skowhegan, Maine	

“Marshall’s Healthcare would be the 15<sup>th</sup> licensed facility to be associated with First Atlantic Healthcare.”

“The applicant refers the Bureau to the Division of Licensing and Certification for conformation that the above named entities has had isolated deficiencies that have been corrected on a timely basis.”

“Neither First Atlantic nor any of the principals has 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.”

“Profiles of the principals as provided by the applicant are as follows:”

“Mr. Ronald C. 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.”

“Mr. Kenneth W. 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(e) 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 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."

"Mr. Craig G. 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 Ross Manor 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."

"Craig Coffin was "born in Massachusetts and educated at Proctor Academy, Dean College and the Florida State College of Healthcare for his AIT program. For nearly 20 years, Mr. Coffin has been involved with the provision, direction and management of healthcare to the elderly."

"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."

"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 homey, 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 Discussion**

**i. Criteria**

Relevant criteria for inclusion in this section are related to the needed 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;

The following nursing facility-specific review criteria are relevant to this section:

Whether the quality of any health care provided by the applicant in the past meets industry standards. [See criterion G.]

Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project. [See Criterion H.]

**ii. Analysis**

The applicant filed a copy of the current license for the facility. Statements of deficiencies are *on file with CONU*. There are no management agreements for this facility. An organizational chart for the applicant is available and *on file at CONU*.

A survey of the facility on April 5, 2006, found it was not in substantial compliance with Federal participation requirements for nursing homes. The survey found the most serious deficiencies to be a pattern that constituted no actual harm, potential for more than minimal harm, but not constituting immediate jeopardy.

The follow-up surveys showed that the previous findings had been corrected. The facility was found to be in substantial compliance with the rules. All Statements of Deficiencies are on file with the Department or may be viewed on the Internet. In general, the quality of care at this facility meets industry standards.

Since this application relates to a change in ownership, it is important to discuss the performance of both the facility (the administrator will remain the same) and the new operations group it will be associated with. As discussed in the paragraph above, the facility had some issues that were appropriately corrected. At the present time there are no deficiencies in the record. First Atlantic Healthcare (FAH) is well known to the division and has assets available to support this facility.

Both the administrator and the applicant have explained that the additional resources of the applicant will improve the quality outcomes by providing for additional infrastructure which allows the applicant to ensure quality control across facilities. Because the applicant already operates several facilities within an hour or two of this Machias facility, the applicant will be able to maintain a supervisory role with this facility.

FAH has demonstrated an ongoing commitment to quality care. Based upon their reputation for quality and commitment as demonstrated, in part by the length of service of its managers, it can be determined that FAH can and does deliver high quality health care.

### **iii. Conclusion**

CONU recommends that the Commissioner find 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.

## **III. Capital Expenditures & Financing**

### **A. From Applicant**

“The applicants “propose an asset purchase equal to the historic reimbursable basis of the facility including equipment and fixtures. Therefore, our project does not result in material non-reimbursable basis – a key concern when considering the effect on proposed budgets and overall feasibility.”

“Capital costs for the project are summarized below and the signed Purchase and Sale agreement is enclosed (*on file with CONU*) for further clarification of terms and conditions.”

Real property from HLP	\$939,594
Personal property from Services	\$620,928
Bed Rights from Services	\$77,434
New Construction	<u>\$633,600</u>
Total	\$2,271,556

“The applicant based these amounts on contractor and vendor estimates in addition to its experience operating the facility. The applicant project capital costs will be \$2,271,536. First year annual operating costs will amount to approximately \$3,970,151 according to the applicant. Management services of the new project will commence on the date the transaction closes.

The applicant indicated that the “financial proforma includes a patient increase in Medicare utilization based upon our management and implementation of our therapy program. The census increase is not great and replicates similar Medicare census achieved at the facility in past years. The assumptions aids our budget neutrality efforts even though our calculations show slight dissavings. The Marshall facility like many others that are integral to the needs of our elders in rural areas is in need of financial and operation stability and without a new owner it appears to both the Marshall's and us that the facility's continued ability to serve the area is at risk.”

“We look forward to working with the Department to find a responsible solution to the neutrality issue and to insuring continued services to the greater region.”

“Our financial pro-forma, which is an exhibit to this application, demonstrates the feasibility of the project in the near term. As to the long term time frame Marshall's is like all rural health providers very susceptible to regulators funding decisions. The Department can better assess the long-term-viability in response to this question than the applicant; however the applicant is vitally interested in the answer! That said, certainly the any project that has as its basic feature

100% reimbursable basis is in the best position to weather the vagaries of State budget decisions. Our proposal is a good fit to this axiom.”

“Attached, as Exhibit VHS our project financial statement pro-forma including the pro-forma cost report, which illustrates its financial feasibility. As the proforma demonstrates, with the desired room rates all of the costs typically associated with a nursing facility are met. The proposal does not contain features that are likely to materially change the historic level of operating costs. We have no plans to change the current charge structure at the facility as a result of this ownership transfer request. As noted above, our purchase price is set at the historic basis of the property and as an asset purchase (with the Marshall’s responsible for depreciation recapture) we believe that this project stands the best chance of dealing with challenges over the long haul. However, as we have previously noted, regulators are in direct control of the financial feasibility of the facility over the long term assuming that historic levels of cost and census is maintained. Since our review of national statistics suggests that the Marshall’s facility has the appropriate capacity for a rural, small town and given that the population is growing older in greater numbers than at present we expect that facility demand will be appropriate to the bed offering overtime. In short, demand is expected to be firm, costs will be well managed to historic levels and thus the real question emerges concerning funding at levels that ensure solvency. Again the answer lies more with regulators, governors and legislators. The best we can conclude in answer to this question is to say simply that rural healthcare providers are vital for elderly in their service areas and the need will remain as demand for long-term-care increases due to an aging population.”

## **B. CONU Discussion**

### **i. Criterion**

The following review criterion is applicable to this section:

That economic feasibility of the proposed services is demonstrated in terms of:

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

Whether the project is financially feasible in both an intermediate and long-term time frame. [See criterion E.]

Whether the project would produce a cost benefit in the existing health care system of the State and the area in which the project is proposed. [See criterion F.]

### **ii. Analysis**

As noted above, the overall cost per day may decrease because the total costs will be divided over more patient days.

Upon review of the application, CONU determined that the numbers provided by the applicant were not compiled in a consistent manner and did not completely reflect the costs to the applicant. CONU staff made the following changes to the totals to reflect the actual amounts requested to be approved.

	<u>From Applicant</u>	<u>CONU</u>	<u>NF</u>	<u>RCF</u>
Real Property from HLP	\$939,594	\$939,594	939,594	
Personal property from Services	620,928	620,928	620,928	
Bed Rights from Services	77,434	77,434		\$77,434
New Construction	<u>633,600</u>	653,600		653,600
Financing Fees		<u>33,791</u>	<u>23,214</u>	<u>10,577</u>
Totals	\$2,271,556	2,325,347	1,583,736	741,611

The \$77,434 used for acquiring bed rights, along with \$1,253 of financing fees are non-reimbursable expenses (Allocated to RCF).

Depreciation categories for the facility allocation are as determined by CONU staff.

	<u>Total</u>	<u>RCF</u>	<u>NF</u>	<u>Life</u>	<u>Depr.</u>
Land	20,000* <sup>1</sup>	0	\$20,000		0
Building	1,537,338	\$578,600	958,738	35	\$27,393
Land Improvements	2,500	0	2,500	15	167
Major Equipment	612,431	75,000	537,451	10	53,743
Vehicles	41,853		41,853	5	8,371
Financing Fees	33,791	10,577	<u>23,214</u>	<u>20</u> * <sup>2</sup>	1,161
Bed Rights	<u>77,434</u>	<u>77,434</u>			<u>0</u>
	\$2,325,347	\$741,611	\$1,563,736		\$90,834

\*<sup>1</sup> – No allocation was made by applicant for land.

\*<sup>2</sup> – Financing Fees were amortized over the proposed 20 year term of loan, not 25 years as proposed.

The applicant expects to spend \$558,600 for constructing the RCF. A 5% contingency of \$27,930 is included in the approval for this expense.

The proposed transaction includes the purchase of assets from the current nursing facility at the 9/30/05 depreciation schedule historical costs. The parties will have to provide an appropriate pool of funds for the recapture of excess depreciation. The proposed transaction will increase depreciation expense by \$15,685. (Proposed depreciation less current depreciation expense – 2005 Cost report) Additional marginal expenses include \$116,000 in interest on the new debt to acquire the assets (NF Only). This means that new expenses for the facility include \$111,852. At 71% MaineCare occupancy, this amounts to \$79,415 in MaineCare dissavings. As such if approved the project should be conditioned that \$79,415 in MaineCare savings be determined to be allocated to provide MaineCare neutrality for this project.

The facility is fully licensed and certified to participate in MaineCare and Medicare federal reimbursement programs. This project appears to comply with rules and regulations of local, state and federal agencies. There is no information that indicates that the project will not comply.

### **iii. Conclusion**

CONU recommends that the Commissioner find that the economic feasibility of the proposed services is demonstrated in terms of:

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;

## **IV. Needs to be Met**

### **A. From Applicant**

“The Southwest Rural Health Research Center reports the following information in their policy brief: Nursing Homes in Rural America:

- One-fifth (24%) of the elderly live in rural area: 26% of those aged 75 and older live in rural areas.
- Compared to the elderly in metropolitan areas, rural elderly
  - On average are older.
  - Rate their health as worse.
  - Tend to have more limitations in physical functioning.
  - After age 75 – are more likely to live alone.
  - Are more likely to be poor.
  - Have higher use of nursing home care.
  - Rural residents were more likely to have some type of dementia and were least likely to have access to Alzheimer's Special Care Units.
- National census data from 2000 indicates that there is 58.1 nursing facility beds per 1,000 persons 65 and older in small towns (rural locales).”

“The national data is a close fit to the information concerning Marshall's and the communities it serves.”

“Marshall's is located in downeast Maine in the town of Machias and serves the following communities: Addison, Columbia, Columbia Falls, Cutler, East Machias, Jonesboro, Machias, Machiasport, Marshfield, Roque Bluffs, Wesley, Whiting, and Whitneyville. This area is home to 9,859 individuals according to the 2000 census with approximately one-third living in Machias and East Machias.”

“Machias is one hour away from Calais to the north and an hour and half from Ellsworth to the South.”

“According to the data obtained from the Southwest Rural Health Research Center, Nationally there are 58.1 NF residents per 1,000 people 65 or older living in small towns in 2000. One would expect as many as 88 licensed NF beds based upon 95% occupancy in this region using area demographics and the 58.1 resident standard. Marshall’s Healthcare is the only freestanding Nursing Facility provider in this area. And with 50 nursing facility beds; Marshall’s current licensed capacity falls within the standard. Further, like many communities served by regional healthcare providers, Machias has many living below the poverty line ( 23.6%) and as noted , a significant percentage of those are over 65 (18.5%) the age group most likely to rely on Government support for health care services. Like the national data for rural locations, ninety percent (90%) of Marshall’s revenues are derived from governmental payers demonstrating that these communities are highly dependent on government financing for their health care needs and highly dependent on Marshall’s to provide it.”

“The evidence demonstrates public need for 88 nursing facility beds in an area that is 50 miles driving time from Marshall’s excluding Jonesport and Beals ( Sunrise Care Services is located in Jonesport and Peter Marshall confirms that individuals in these communities prefer to stay there) and the information from the SWRHRC further demonstrated the critical need for adequate government payments to rural providers that are the sole nursing facility for persons 65 and older, who are mostly poor and rely on reasonable access for their healthcare needs.”

“The applicant provided the following:”

“Reported payer mix is as follows:”

MaineCare	11,336	71%
Medicare	2,391	15%
Private	2,051	13%
Managed Care	<u>307</u>	<u>2%</u>
Total	16,065	88%

“In 2006, the nursing facility had an occupancy level of 88% March and April 2006 were affected by the survey results discussed previously and not considered would have caused an occupancy average of 90%. December 2006 saw an occupancy level of 97.7%. The MaineCare % of the occupied beds was 70.47%. The Residential Care facility was operating at 92% occupancy level in 2006. The MaineCare % of occupied beds was 94%.”

## **B. CONU Discussion**

### **i. Criteria**

That there is a public need for the proposed services 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.

The following criteria are applicable:

1. Whether the project will substantially address specific problems or unmet needs in the area to be served by the project. [See criterion A.]
2. Whether the project will have a positive impact on the health status indicators of the population to be served. [See criterion B.]

## **ii. Analysis**

The applicant presented the CONU with information regarding the communities served by this facility. For a population of 9,859 persons with an expected over 65 population of 1,431 it is projected that, based on the national standard of beds per small town, 84 beds are needed in this area. (Data from Southwest Rural Health Research Center). Since services will remain in place, the applicant will ensure that these services continue in the community and since the facility has demonstrated a need for the services provided by the applicant.

The services offered at Marshall's will be accessible to all residents of the area proposed to be served through continuation of current operations. The applicant has no plans to further reduce the capacity of the facility and, in fact, the plans call for integration of NF and residential services at the nursing facility. The applicant believes this will increase access by insuring that all levels of need can be met.

The project encompasses the purchase of a facility that provides a vital role in the access of care in the community. The maintenance of existing services in this part of Maine will ensure that residents of this area will continue to receive care in the local area.

## **iii. Conclusion**

CONU recommends that the commissioner determine that there is a public need for the proposed services

## **V. Alternatives Considered**

### **A. From Applicant**

“The proposed ownership transfer is by sale of assets at their historic basis, which will result in the Marshall's paying any recapture amounts as per the department's regulations. Thus citizens of the state of Maine are not called upon to underwrite additional funding.”

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

“The purchase price per bed of our project is approximately \$35,000, which includes the addition for combining residential services at the facility. The alternative, which would be a new replacement facility, is likely to cost nearly \$100,000 per bed or more. Therefore, we do not feel that there is a less costly or more effective alternate of reasonably meeting identified health service needs of the project.”

“We do not see any significant changes in the cost of rendering services at Marshall’s. Rather we expect the project to be budget neutral.”

## **B. CONU Discussion**

### **i. Criteria**

Relevant criteria for inclusion in this section are that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by: 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. The availability of state funds to cover any increase in state costs associated with utilization of the project’s services; and the likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available. Additionally a further criterion is whether there are less costly or more effective alternate methods of reasonably meeting identified health service needs of the project. [See criterion D.]

### **ii. Analysis**

The proposed services are consistent with orderly and economic development of the area because a larger local, in-state nursing facility operator will assume operations. Since nearly all staff members are being retained it reduces financial impact of the purchases on the MaineCare budget. Since there is a demonstrated need for these services in this area, it is important to ensure the transition of a facility in such a manner that will allow for their continuation. Also, as a large corporation FAH has more resources to draw on in case of a crisis or emergency, or shift in market trends.

### **iii. Conclusion**

CONU recommends that the Commissioner determine that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State.

## **VI. State Health Plan**

### **A. From Applicant**

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

“Currently, our facilities host and are clinical sites for professional training programs throughout the State. Marshall’s is likely to become a clinical site for the University of Maine at Machias and the Washington County Community College.”

“We are interested in energy conservation and plan to evaluate the facility on the basis of insulation, ambient heat loss and heat source efficiency. Currently the facility is heated with electricity and we may determine that heating hot water by gas is more efficient and economical.”

## **B. CONU Discussion**

### **i. Criterion**

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

Additional criterion includes the special circumstances of health care facilities with respect to conserving energy;

### **ii. Analysis**

This project does not conflict with the State Health Plan, and will result in the continued operation of the facility. It is noted that the architectural plans should be developed by a LEED certified architect.

### **iii. Conclusion**

CONU recommends the Commissioner determine that the project is consistent with the State Health Plan as demonstrated by the applicant.

## **VI. Outcomes And Community Impact**

### **A. From Applicant**

“Earlier this year Marshall’s experienced a significant census decline due to the cessation of admissions while the facility corrected licensing violations. As a result the facility incurred severe financial losses that current owners have indicated would not be sustainable in the future thus risking facility closure without financial resources or the will to deploy them, a return to sustained compliance might be questionable. We believe that under first Atlantic management such serious problems will be avoided in part through our intense regulatory compliance culture, which features our Regulatory Compliance Committee. This committee oversees peer reviews of all facilities to ascertain compliance with all licensing regulations and reports directly to our Corporate Compliance Officer, Vicki White, RN. This dual reporting nature of the peer review effort, first to the facility management team and second to our corporate officers brings together immediate efforts for improvement and appropriate resources to improve compliance.”

“As noted above First Atlantic is committed to compliance, which is one indicator of providing services that will have a positive impact on the health status of consumers. In addition, we have joined the voluntary Northeast Health Care Quality Foundation’s pilot project known as STAR — Setting Targets Achieving Results - designed to implement best practices, track indicators and improve outcomes in the areas of pressure sore prevention treatment, pain management, physical restraints and depression. Our facilities began their participation earlier this year and are just

now receiving indications of outcomes. It is too early in the program to conclude on its benefit but we are seeing some success in those facilities that are diligent in their work. This collaborative effort will enhance their current quality assurance process and they will benefit from the oversight of Vicki White, RN. More information on this program can be found at [www.nhcgf.org](http://www.nhcgf.org).”

“We believe that Marshall’s integration into our company will provide demonstrable improvements in quality and outcomes for the following reasons:

As noted above we are involved with the NHQF’s effort to reduce negative outcomes in four defined areas. 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. Enclosed, as Exhibit VII is a copy of an email received from NHQF praising our Seaside Facility for progress towards STAR goals.”

“In 2007 we will implement electronic medical records that will among other things provide secure access to vital health information in the event of a disaster. Marshall’s will greatly benefit from this change in clinical software. In truth there has been little in the way of productivity enhancements in our profession over time even as the documentation requirements have increased. Electronic charting departs from this trend in several significant ways. Here are but a few worth mentioning:

- 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 and accurate real time information is key to quality, especially on a shift-to-shift basis.
- The charting information is interconnected within itself and with progress notes so that duplication is eliminated.
- 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.
- Our system is easy to use and does not require computer knowledge or typing skills to operate.

Lastly and as noted above, FAH utilizes its Regulatory Compliance Committee 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 for our clients.”

“We do not anticipate any changes as a result of the project on fees charged by other persons to the public. Our probable impact is identified in our proforma, which is included in this

proposal.”

**B. CONU Discussion****i. Criterion**

Relevant criterion 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. Analysis**

The project does not entail any changes to the applicant's NF care program. Indeed, it is expected that the current administrator remain. Staff will be retained also.

FAH facilities are involved with the NHQF's effort to reduce negative outcomes in four defined areas. 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.

**iii. Conclusion**

CONU recommends that the Commissioner determine that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

**VII. Service Utilization****A. From Applicant**

“As noted earlier, this proposal does not change the number of beds or the complement of services now offered. As competition is not expected to change as a result of the project, the impact on system wide cost of health care is anticipated to be minimal. 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 market served by Marshall's.”

**B. CONU Discussion****i. Criterion**

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. [See Criterion G]

**ii. Analysis**

The project does not include any new beds. The project as entailed for nursing home services does not include changes to its administrative staff or programs. As noted in the need section the area could conceivably be expected to support up to 84 beds, 50 beds maintained in the area

when utilization is 90% will not increase utilization. Capacity of the area will not be affected by the proposed transaction.

### **iii. Conclusion**

The project encompasses a change in ownership of a facility that does not result in increased utilization. CONU recommends that the Commissioner determine 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.

## **VIII. Timely Notice**

A letter of intent was filed October 4, 2006.

The application was provided to CONU on January 3, 2007.

Notice regarding the beginning of a review of this project was in the Kennebec Journal on April 23, 2007, and the Bangor Daily News on April 24, 2007.

A public information meeting was held at the facility on May 1, 2007.

No members of the public attended nor provided comment. All appropriate notice requirements have been met.

## **IX. Findings and Recommendations**

Based on the preceding analysis, the CONU makes 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. That economic feasibility of the proposed services is demonstrated in terms of:
  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;
- C. That there is a public need for the proposed services 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;
- D. 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;

In making a determination under this subsection, the Commissioner shall use data available in the State Health Plan, data from the Maine Health Data Organization established in Title 22, 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 available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

The decision must be based solely on a review of the record. The Commissioner shall approve an application if she determines that the project meets the criteria set forth above, and:

- E. That the project is consistent with the State Health Plan.
- F. That the project ensures high quality outcomes and does not negatively affect the quality of care delivered by existing service providers;
- G. Does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum

Based upon the findings cited above, the CONU recommends **APPROVAL** of this project with the following conditions.

1. MaineCare savings of \$79,415 be identified and used by the applicant to maintain MaineCare neutrality.
2. Sufficient funds are to be set aside at the closing of the transaction to satisfy depreciation recapture and any overpayments made pursuant to 22 MRSA.
3. Prior approval from the Certificate of Need, Housing Resource Developer for the RCF addition will be obtained before construction begins.