BRIEFING MEMO

Eastern Maine Medical Center
Construct New Eight-Story Inpatient Tower

DATE: October 1, 2008

TO: Brenda M. Harvey, Commissioner, DHHS

THROUGH: Catherine Cobb, Director, Division of Licensing and Regulatory Services

FROM: Phyllis Powell, Manager, Certificate of Need Unit
Steven R. Keaten, Healthcare Financial Analyst
Larry Carbonneau, Healthcare Financial Analyst

SUBJECT: Proposal by Eastern Maine Medical Center to construct a new eight-story inpatient tower at their hospital campus on State Street in Bangor, Maine at an estimated capital cost of $262,304,321.

ISSUE ACTIVATED BY: The referenced proposal requires Certificate of Need approval as defined in "The Maine Certificate of Need Act of 2002," 22 MRSA Section 326 et seq., as amended.

REGISTERED AFFECTED PARTIES: NONE

I. BACKGROUND:

- Eastern Maine Medical Center (EMMC) is a not-for-profit corporation and is a subsidiary of Eastern Maine Healthcare Systems (EMHS), a not-for-profit corporation. EMMC is licensed for 411 beds. EMMC has a transfer agreement for referral services with 12 critical access hospitals in the region. EMMC is verified as a Level II trauma center by the American College of Surgeons and is one of three state designated trauma centers in Maine. EMMC serves the largest geographic service area of any referral center in the State of Maine.

- The Division of Licensing and Regulatory Services, Medical Facilities Unit, confirms that Eastern Maine Medical Center is a general hospital licensed in the State of Maine and is MaineCare and Medicare certified. EMMC is accredited by the Joint Commission.

- In 2007, EMMC received Certificate of Need (CON) approval to move and consolidate diagnostic outpatient imaging services at Eastern Maine Healthcare Mall on Union Street in Bangor. The 2007 CON was for 33,200 square feet of space for outpatient imaging. A request to extend this project for one year, to August 2009, was recently received.

- In 2007, EMMC received CON approval to purchase a Surgical Robot. This robot was purchased in 2005 and had been placed in operation prior to the CON application. An operating room, sized to accommodate the robot, is included in the pending CON application.

- In 2006, EMMC received CON approval to develop the CancerCare for Maine. This project has commenced but EMMC has had to engage in a larger capital campaign due to CON restrictions on project specific borrowing/debt.

- In 2005, EMMC applied for and received approval to expand the ICU. This project was completed in August 2007.

- In 2004, EMMC received a CON to develop a "co-generation" plant. This project was completed in 2007.

- From the end of fiscal year 2004 to the end of fiscal year 2007, EMMC received CON approval for $54 million dollars in investments in plant and equipment.

II. Project Description:

The project under CON review involves the construction of an eight-story inpatient tower (un-named) and renovations to three distinct areas of the hospital. These areas include: modifications to the Grant Building, the Grant Tower, and the Kagan Building. This project will result in an increase in beds in private rooms from 169 to 305. It will also result in a reduction in beds in semi-private rooms from 181 to 106. This is a product of newly constructed private rooms and a conversion of existing semi-private rooms to private rooms. This will increase staffed bed capacity from 350 to 411, which is the applicant's existing licensed capacity.

CONU developed the following table to present the capacity changes:

Description	Existing	Proposed	Change
Licensed Beds	411	411	0
Staffed Beds			
Med/Surg Beds	199	233	+34
ICU/CCU Beds	44	62	+18
Pediatrics/PICU Beds	24	24	0
OB/GYN Beds	24	26	+2
NICU Beds	23	30	+7
Rehabilitation Beds	36	36	0
Total	350	411	+61
Operating Rooms			
Inpatient	11	14	+3
Outpatient	8	8	0
OB/GYN	3	2	-1
Total	22	24	+2
Emergency Dept. Rooms			
Exam/Treatment	26	26	0
Observation	0	8	+8
Total	26	34	+8
PACU Cubicles	32	28	-4
Pre-Op/Recovery Cubicles	24	30	+6

This project calls for new construction of approximately 252,530 net sq. ft. and renovation of 34,300 net sq. ft. Newly constructed vacant shell space will consist of 97,420 net sq. ft. in the new tower. In addition to the shell space in the proposed tower, additional vacant space will become available due to relocation of services from existing locations. It is not clear how much additional vacant/shell space will become available due to relocated services.

CONU concurs with Dr. Mills' (Maine CDC / DHHS) following observations in regards to EMMC's proposed shell space: "Such a large investment in shell space poses dilemmas regarding compliance with the State Health Plan since it is part of the project that does not take a defined step towards achieving the priorities. Even if the shell space achieves cost savings in the long-run, the arguments for its needs are long-term, theoretical and dependent upon a future CON approval process."

Additionally, it is not unusual for a project of this size and scope to be subject to value engineering. Although the applicant has engaged in "value engineering" for many aspects of this project, it is not evident that this has been done specific to less costly construction materials (glass, brick, etc.) than are proposed.

This application does not propose new services, although it is unclear whether an expansion of services is contemplated.

III. HIGHLIGHTS:

Letter of Intent dated Sept. 26, 2007
Subject to CON review letter issued Sept. 27, 2007
Technical Assistance Meeting held on Oct. 19, 2007
Application filed and certified as complete on Dec. 20, 2007
Application placed in review cycle on Jan. 1, 2008
Applicant's public informational meeting held on Jan. 17, 2008
A public hearing was held on Feb. 28, 2008
Preliminary analysis released on May 22, 2008
Preliminary analysis published in newspapers on May 28, 2008
Record closed on June 11, 2008

IV. PUBLIC COMMENTS RECEIVED IN RESPONSE TO THE PRELIMINARY ANALYSIS:

Numerous sets of public comments were received following release of the Preliminary Analysis in support of the project, including support letters from medical organizations, physicians, hospital administrators and legislators. In addition, CONU also received three letters from the general public that opposed this project on the basis of cost and utilization. One letter was anonymous and suggested we review past census data. Two other letters, not anonymous, stated concerns about access, affordability, and expansion in a "stagnant economy".

V. CONU ANALYSIS/EMMC COMMENTS

1) Capital Expenditures

The applicant commented on CONU's statement in the preliminary analysis that EMMC had $54 million dollars invested in plant and equipment in past years (2004-2007). CONU estimated that at that time, EMMC was projecting capital expenditures to exceed $443 million from 2009 to 2015. CONU has determined that this estimate was incorrect; the increase in capitalized assets on the balance sheet of EMMC was expected to increase from $317 million in 2008 to $766 million in 2015. This is an increase of $449 million dollars rather than CONU's estimate of $443 million. This amount includes the difference between the original purchase cost of assets being replaced, or eliminated, and the cost of the replacement equipment as well as expenditures on other fixed assets including this project. $449 million does not however, indicate the total actual expenditures of cash for fixed assets.

At the same time that EMMC was spending $54 million (2004-2007) on fixed assets the hospital was generating an increase in net patient service revenue of $111 million. For every $1 expended on fixed assets during this time period, they generated $2.05 in new revenues. In the next eight years with this project EMMC will spend at least $449 million on fixed assets. They project to increase net patient service revenue by $196 million during the same time frame (2008-2015). This means that during the next eight years, for every $1 expended on fixed assets, they will generate $ 0.44. This is a decrease in marginal return on assets of 78%. This is an indication of an extraordinarily large increase in the physical footprint of the hospital without a corresponding

significant increase in service revenue. Since the applicant did not project a significant increase in hospital utilization, the apparent alternative for generating additional revenue is to raise fees. It appears that without a significant increase in fees it will be extremely difficult to build out future shell space.

EMMC states that decisions on the shell space will be made definite when it is financially viable to do so depending on what needs must be met at that time. Information provided by the applicant reflects that the costs associated with the shell space includes an additional $34.85M to complete the build-out of the shell space in addition to $11.47M in construction costs included as part of this application.

2) Financing

The applicant responded to the preliminary analysis on June 11, 2008. In its response to the preliminary analysis the applicant did not amend financial projections. They did provide evidence that, prior to the submission of the CON application, they engaged a qualified consultant to forecast financial assumptions. The applicant refers to its assumptions as conservative. EMMC offered a summary of financial projections prepared by Besler Consulting dated 9/27/06 as an attachment. Besler Consulting assisted EMMC in updating its financial forecasts through the fall of 2007. Based on its own concerns of the size and cost of the master facilities plan, EMMC reduced the scope of this project before submitting its original application.

EMMC commented that they will improve the operating margin by continuing to focus on operating efficiencies. EMMC also stated that operating revenues are conservative given their projected growth of 1.3% annually on inpatient admissions and 2.1% annually on outpatient volume. CONU estimates that an additional 1% increase on inpatient admissions and a 1% increase on outpatient volume could improve the operating margin from 1.7% to 2.2% for the 3rd year of the project.

EMMC states that their projections only indicate one proposed set of circumstances. According to the applicant, EMMC has a history of sound fiscal management and is able to adjust its operations as needed. The projections include an annual adjustment to charge rates of 4% even though EMMC believes increases of 5% to 6% could be implemented.

In EMMC's 6/11/08 response, the applicant has forecasted alternative scenarios that include the addition of a parking garage, inpatient and outpatient volumes increasing greater than 1%, the completion of shell space by 2013 and additional patient rooms on the 8th floor, and a rate increase of 5% instead of the projected 4%.

CONU concedes that the applicant can finance this project. It is however, not possible to reliably determine whether this hospital can afford the entire scope of the projects envisioned in a reasonable period of time. The applicant stated that rate increases of 5-6% could be implemented if needed to finance this project. It is possible that this applicant will have to increase rates beyond the 4% that was originally forecasted. CONU believes that there is a potential for insurance premiums to be effected more than originally estimated; however, this may require further analysis.

EMMC offered to revise the financing plan based on available cash resources at the time of the project implementation. According to the applicant, "If MaineCare past-due receivables are paid, EMMC would plan to use at least $50 million (approximately 20% equity) applied to this project. Third year costs would be reduced by approximately $2.5M in interest expense." Because the applicant stated that they could contribute additional funds to the project if the project were to be approved, CONU would expect borrowing to be limited to 80%. This $52,461,000 would

marginally affect the cash position of the applicant. The applicant would be slightly above the state median. Days cash on hand would still be projected to be higher than the ratios reported for their most recent fiscal years. Savings on interest would exceed $6.33 million dollars in the first three operating years. The impact on the capital investment fund would be decreased by $1.49 million dollars. While increasing the annual charge to the Capital Investment fund by $38,500 this contingency eliminates 1 year of CIF debits.

CONU believes there will be significant pressure for this hospital to increase utilization, rates or both to make this project financially feasible in a shorter time frame. EMMC believes that additional pressures to expand the facilities of this hospital will continue.

3) <u>Needs to be Met</u>

Space Needs: The applicant believes that the CONU misinterpreted space needs for the rooms to be built as follows:

i. Telemetry rooms: The applicant plans on developing telemetry rooms that can be easily converted into critical care units. The reasoning behind the development of acuity adaptable rooms is to enable the applicant to react to needs as they arise in the future. The applicant has detailed the square footage of the rooms according to function as follows: patient area 250 s.f., bathroom 50 s.f., family alcove 30 s.f., hand washing 10 s.f. and wardrobe 5 s.f. equaling a total of 345 s.f. According to the applicant and supporting literature, the average room size will be 250 s.f., which are within space guidelines.

ii. Brain Lab: The applicant has provided additional information in regards to the anticipated uses of their "brain lab". They plan to use this space for specialized neuro-vascular procedures. The Future of Operating Rooms (The ABC Co.) states that the space requirements for a room of this type should be 700-1000 s.f. CONU has reviewed the applicant's clarification regarding the use of their proposed "Brain Lab". The square footage proposed is within space guidelines of 700 to 1,000 s.f. however, no rationale was provided that supports the need for the maximum size of 1,000 s.f. vs 700 s.f.

iii. NICU: The NICU rooms as listed in the AIA Guidelines and The Hospital of the Future do not include functional space. Once this is added, the NICU rooms are 2-7% above AIA Guidelines. The rationale given for the size of the NICU rooms is due to design features. The applicant elected to place the NICU rooms adjacent to the obstetrics unit. CONU understands that they are unable to change the width of the rooms because of the needed clearances around the patient beds and the location of existing structures within this area. As a result, the rooms are somewhat larger than recommended guidelines. This can not be modified now but could have been addressed during design conception.

iv. PACU: The applicant states that the PACU rooms are designed to be flexible / multiuse rooms for surgical prep as well as post-surgical recovery purposes. More space for surgical prep patients is needed versus recovery patients, which explains the need for 10 additional square feet than recommended guidelines. CONU accepts that, based upon this clarifying information, these rooms are within acceptable guidelines.

v. Eighth Floor/Shell Space: EMMC explored the option of building the eighth floor at a later date and concluded that the work that would have to be done to finish the seventh floor, in anticipation of an eighth floor, would still have to be done. It is estimated that the addition of the eighth floor after this project is completed would add an additional $4 million to construction costs versus constructing this space concurrently with the other seven floors. The applicant also mentions that "the mechanical systems could not be moved after the building is occupied without

closing down half of the new patient care tower." CONU discusses all shell and vacant space under sections II and V of this document.

4) Alternatives

i. Status Quo: An alternative stated in the original EMMC application was to do nothing. This alternative was not an acceptable alternative to EMMC as it would be ignoring community needs as stated by the applicant.

ii. Fulfill entire Master Facility Plan: The applicant has discussed their original plans of completing the entire tower in one project. This alternative was revised due to the applicant's inability to finance such a project. The applicant has scaled down their original plan to this proposed project.

iii. Shell Space: An alternative to partially build the inpatient tower with shell space and plans to complete the remaining spaces at a later date is more financially reasonable for this applicant. This is the alternative that the applicant is pursuing.

iv. Equity Contribution: CONU believes that the applicant could contribute, at a minimum, 20% equity to this project. CONU believes that the applicant has the capacity to do so without having a significant impact on its finances. Such a contribution would strengthen the proposal and reduce its potential impact on the CIF.

EMMC discusses their current major capital campaign for the CancerCare of Maine (CCOM) relocation. The applicant stated they are not able to provide additional capital for this project due to the amount of campaigning they are currently pursuing for their CancerCenter of Maine project that was approved by CONU in 2006.The capital campaign is larger due to constraints placed on the debt limitation requirements in the CCOM award.

EMMC reiterated its commitment to apply past due MaineCare receivables as equity in this project; potentially decreasing interest charges by $2.5 million annually. The applicant stated they would contribute at least $50 million towards this project when and if the State pays EMMC what they are due for MaineCare settlements.

v. Orderly and Economic Development: Total projected 3rd year incremental operating costs are projected to be $25,400,660 and of that amount MaineCare's 3rd year cost is $2,842,334 ($25,400,660 x 11.19%) (MaineCare payor mix projected by the applicant for CON project type of services only), which is both the Federal and State portions combined. Currently the impact to the State portion of the budget by the third year of operation (2013) would be approximately $994,817 ($2,842,334 x 35%). CONU is unable to determine if these funds will be available.

vi. Withdraw: While not contemplated, CONU believes that this applicant should withdraw this application and revise their plan to more effectively meet the needs demonstrated in this application. This may require downsizing their original plan into smaller phases.

5) State Health Plan

The State Health Plan is broken down into various priorities which CONU has addressed individually in the following sections.

i. Projects that protect public health and safety are of utmost importance;
An example of such a project includes: Projects that have, as a primary over-riding objective, the elimination of specific threats to patient safety (SHP).

The applicant has provided additional data that includes data on Left Without Being Seen (LWBS), Average Length of Stay (ALOS), Days on Diversions, Patients Diverted, and number of patients boarded. The data provided measures the percentage increase from this fiscal year to date (8 mo.) compared to last fiscal years' numbers. An increase was shown in each category as follows respectively: 10%, 7%, 138%, 228% and 126%. These metrics are relative to patient safety.

EMMC provided the following quantifiable data that demonstrates its commitment to public health and safety: 50% reduction in MRSA cases; LWBS reduction from 3.4% to 1.8%. Other measures were provided.

It is not clear what tracking and reporting mechanisms the applicant will employ.

ii. Projects that center on a redirection of resources and focus toward population-based health and prevention;
EMMC stated that it is committed to the investment in population-based health and prevention programs. EMMC provided detailed description of proposed redirection of resources over the period of this project amounting to annual investments of $670,000. EMMC outlines the purposes of these investments into the following: Chronic disease management; secondary prevention; reduce use of ED; acute care for care that would better be provided in primary care provider (PCP) practice and less costly settings; and improved integration of behavioral and medical health delivery. Outcomes for population-based health and prevention were not included.

iii. Projects that contribute to lower costs of care and increased efficiencies;
EMMC provided information on the following increases in efficiencies: Reduce OR turnaround time from 42 minutes to less than 30 minutes; decrease wait time for inpatient beds to less than 4.3 hours; reduce average length of stay from 5.4 to 5.0 days; and reduce NICU length of stay from 16.5 to 14 days. The applicant cites 15 potential efficiencies and benefits for which the cost savings have not yet been projected. CONU is unable to project these savings.

EMMC quantified how the Lean process can contribute to significant savings. EMMC has included $2 million in savings from consolidating surgical services.

iv. Projects that include a complementary preventive components that will lead to a reduced need for services at the population level;
EMMC provided an updated table of investments related to disease prevention and management and appropriate service utilization. The applicant provides information about specific chronic disease prevention and management initiatives tied to the goals of this project of assuring that patients receive high quality care in proper care settings. This section does not include measurable prevention outcomes. The applicant does not quantify a reduction in need at the population level.

v. Investment in the MHINT project and also investments in electronic medical records systems, such as HL7;
Although not part of this project, EMMC does show ongoing investments with HealthInfoNet.

vi. Projects that exercise less than 0.5% increase on regional insurance premiums shall be given priority consideration under the CON review process.
The State Health Plan (SHP) requires an assessment by the Bureau of Insurance to determine both the Regional and Statewide impact on insurance premiums. The regional limit established in the SHP is 0.5% for a project to be considered a priority project.

The Bureau of Insurance analysis "estimate(s) that the maximum impact of this CON project on private health insurance premiums in Eastern Maine Medical Center's service area for the project's third year of operation will be approximately 1.114% ($1.114 per $100) of premium. Further estimate[s] that this project, in its third year of operation, will have an impact on statewide private health insurance premiums of approximately 0.297% (0.297 per $100) of premium."

The applicant states that CONU should use the "State" insurance impact versus the "Regional" impact. The State Health Plan clearly states that the Regional Insurance Impact will be used to determine whether an applicant meets this priority. EMMC does not qualify for this priority as it is stated in the State Health Plan, nor has EMMC demonstrated that the benefits would outweigh the cost increase.

6) <u>Outcomes and Community Impact</u>

The applicant provided the following information:

Indicators/goals Hospital Wide	**Current Baseline**	**Desired outcome**
Decreasing potentially preventable complications (total # of potentially preventable events (central line infections, DVT, PE, surgical infections) in which the record does not document compliance with appropriate care measures.	Currently calculating	Zero complications
Increasing staff satisfaction (measured quarterly, scale 1 (not satisfied) to 5 (very satisfied))	4.39	4.65
Increasing patient satisfaction (overall satisfaction)	92.04	93.5
Average Length of Stay (ALOS)	5.4	5.0
Decreasing MRSA transmission (measured concurrently with # patients admitted with MRSA)	.046	.023
Surgery	**Baseline Outcomes**	**Goal**
Improve OR turnover time	41 minutes	30 minutes
Decrease duplication of equipment & supplies with combination of inpatient and outpatient surgical services	Inventory costs currently being determined	20% decrease
Decrease in clinical staff travel distance (improving productivity)	Being	25%

	determined with work with GE	improvement
Increase overall suite utilization	70%	80%
Emergency Department	**Baseline Outcomes**	**Goal**
Decrease ED length of stay for admitted patients	6.5 hours	< 4 hours
Decrease ED left without being seen (LWBS)	3.4%	<1%
Increase patient satisfaction	83.31	>90
Obstetrics	**Baseline Outcomes**	**Goal**
Increase overall patient satisfaction	90.07	94.0
Decrease in clinical staff travel distance (improving productivity)	Being determined with work with GE	25% improvement
Increase number of inductions that are done at 39 completed weeks of gestation	90%	100%
Neonatal Intensive Care	**Baseline Outcomes**	**Goal**
Increase overall family satisfaction	94.57	96.0
Decrease in clinical staff travel distance (improving productivity)	Being determined with work with GE	25% improvement
Reduce rate of line infections	4.3%	0%
Increase proportion of breast feeding mothers	48%	>60%

The applicant states that they have worked extensively with hospitals in Waterville/Augusta/Lewiston and that these hospitals support their proposed project as is evidenced by the letters of support received from other hospitals that also serve in this region as well as outside EMMC's service region. Letters of Support were received from 11 of 12 Critical Access Hospitals in the region, as well as St. Joseph's Hospital located in Bangor and MaineGeneral Medical Center in Waterville/Augusta.

The applicant has provided quantifiable information relevant to how this project will affect defined hospital outcomes. EMMC has stated what the current baseline is and what the goals are after this project is implemented. It is not clear whether the applicant will report all outcome measures stated in the outcomes table presented.

The applicant has worked extensively with other hospitals within and outside of their Region and have received letters of support for this project indicating that this project will not negatively affect other service providers. Although this is a popular project within the service area, CONU would have liked to see more effort directed at supporting hospitals within EMMC's service area. An example of this shortcoming appears in the Houlton Regional Hospital CON application. This hospital does not have Tier I hospital designation. It is conceivable that EMMC could assist Houlton in attaining Tier One designation. This would result in lower deductibles and greater access.

7) <u>Service Utilization</u>

The applicant has stated that the Maine Quality Forum has used outdated data to conclude their assessment. EMMC has provided more up-to-date information in regards to their project and relevant utilization. EMMC asserts that their project, when completed, will decrease inappropriate service utilization in the region.

EMMC is not proposing any new services as part of this project. EMMC states that when this project has been fully implemented that service utilization in the region should decrease as a result. CONU believes, with the clarifying information provided, that this project might not result in inappropriate service utilization although it may increase overall utilization.

VI. CONCLUSION:

The Preliminary Review by CONU staff, dated May 22, 2008, concluded that this application failed the following CON review criteria:

1) Capital Expenditures – In the next eight years with this project EMMC will spend at least $449 million on fixed assets. They project to increase net patient service revenue by $196 million during the same time frame (2008-2015). This means that during the next eight years, for every $1 expended on fixed assets, they will generate $ 0.44. This is a decrease in marginal return on assets of 78%. This is an indication of an extraordinarily large increase in the physical footprint of the hospital without a corresponding significant increase in service revenue. Since the applicant did not project a significant increase in hospital utilization, the apparent alternative for generating additional revenue is to raise rates.

2) Financing – The applicant has not committed to contribute a reasonable amount of equity to this project. The applicant states that rate increases of 5-6% could be implemented, if needed, to finance the project. It is possible that this applicant will have to increase rates beyond the 4% they originally forecasted. CONU believes that there is a potential for insurance premiums to be effected more than originally estimated. EMMC has stated that it is not financially viable to complete the shell space as part of this project. According to the applicant, future use will depend on what needs must be met at the time. Future use of shell space will require CON approval. The dilemma is that allowing 97,420 sq. ft. of shell space to be constructed prior to determination of need is counter to CON statute.

3) Public Need – The applicant states that due to financial limitations, they are unable to complete the shell space being proposed. CONU has determined that there are no public needs being met by this shell space. CONU maintains that the proposed shell space is theoretical and speculative.

CONU concurs with Dr. Mills' (Maine CDC / DHHS) following observations in regards to EMMC's proposed shell space: "Such a large investment in shell space poses dilemmas regarding compliance with the State Health Plan since it is part of the project that does not take a defined step towards achieving the priorities. Even if the shell space achieves cost savings in the long-run, the arguments for its needs are long-term, theoretical and dependent upon a future CON approval process."

CONU recognizes that it is difficult to predict inevitable technological advances or evolving health delivery methods. Over time technology changes and advancements in the delivery of health care services can create obsolescence in existing facilities. Considering the lack of funds to finance completion of the shell space and uncertainty about the need for this space, CONU cannot justify building this space now.

4) Orderly and Economic Development –The applicant has demonstrated that they have the capacity to provide a minimum of 20% equity investment in this project. They have proposed 96% financing of this project with 4% in funded depreciation.

The incremental 3rd year costs as proposed are $ 25,400,660. The incremental 3rd year costs with 80% financing are $ 23,323,083. This will eliminate one year's impact on the Capital Investment Fund (CIF).

This project as proposed will bring EMMC's available bed count to 411 beds, which is their current licensed capacity. Any additional beds to be proposed for the vacated spaces or shell space could require an increase in licensed beds beyond the 411 beds.

Although the applicant appears to enjoy popular support for this project, there is insufficient evidence that protocols are in place to prevent a negative impact on critical access hospitals. The magnitude of this project requires a systematic approach to service delivery.

6) State Health Plan – Although the applicant provided additional data relative to public health and safety metrics, they did not state what tracking and reporting mechanisms they will employ. Additionally, outcomes for proposed population based health and initiatives were not included. The applicant cites 15 potential efficiencies and benefits, for which cost benefits have not been projected. CONU is unable to calculate these benefits due to the lack of information provided by the applicant. The applicant does not include measurable prevention outcomes or quantify a reduction in need at the population level. Importantly, this project can not be considered a priority project under the State Health Plan because it does not exercise less than 0.5% increase on regional insurance premiums.

Although the applicant discussed evidence-based design for this project, and Evidence-Based Environmental Design improvements they did not specifically commit to LEEDS/Green Building Standards.

6) Outcomes and Community Impact – This application does not propose new services, although it is unclear whether an expansion of services is contemplated. CONU would have liked to see more effort directed at supporting Critical Access Hospitals in their mission that "the right care will be delivered at the right time and in the right place." This is a citation from the State Health Plan but there are others including: "needed health services should be reasonably located and available to all residents in a timely manner" and "health begins in the community and is more than treatment – health begins in our homes and with prevention."

7) Service Utilization – The applicant does not propose new services at this time. It is not possible to predict with certainty whether service utilization will increase due to this project.

Concluding Statement:
For all the reasons set forth in the Preliminary Analysis, in the record, and considering the clarifying information provided by the applicant, CONU determines that this application does not satisfy the overall CON review criteria.

VII. RECOMMENDATION:

The Certificate of Need Unit recommends this proposal be **Approved** with conditions:

1) submit a revised description of the project to decrease the total net square feet of shell space by approximately 86, 740 thereby eliminating excess capacity. This will require the applicant to submit revised capital expenditure estimates and third year operational costs for the reduced scope of the project to CONU;

2) submit a plan to CONU that limits financing of this project through debt to 80% of total capital costs;

3) submit quantifiable prevention outcomes specific to the reduction in service utilization, providing annual reports through 2016 on all outcomes and community impact measures included in the application, after first identifying the time period in which the current baseline was calculated;

4) state a commitment to employ green building methods (LEED) during construction;

5) engage in value engineering specific to facility construction materials, using an independent consultant, and report the results to CONU prior to finalizing the project costs and to awarding contracts.

Capital Costs	
$ 231,805,928	Capital costs as Approved
$ 17,814,900	Contingency
$ 249,620,828	Total Approved Capital Costs

Incremental 3rd Year Costs	
$ 21,589,468	Approved Incremental Costs

Capital Investment Fund	
$ 16,301,136	Approved CIF
$ 1,811,237	Charge for FYE 2008
$ 1,811,237	Charge for FYE 2009
$ 1,811,237	Charge for FYE 2010
$ 1,811,237	Charge for FYE 2011
$ 1,811,237	Charge for FYE 2012
$ 1,811,237	Charge for FYE 2013
$ 1,811,237	Charge for FYE 2014
$ 1,811,237	Charge for FYE 2015
$ 1,811,237	Charge for FYE 2016