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

Date: **August 23, 2013**

Project: **Acquisition of Control of Mercy Hospital**

Proposal by: **Eastern Maine Healthcare Systems**

Prepared by: **Phyllis Powell, Assistant Director, Medical Facilities**
Larry Carbonneau, Manager, Healthcare Oversight
Richard S. Lawrence, Senior Healthcare Financial Analyst

Directly Affected Party: MaineHealth and Maine State Nurses Association/National Nurses United

CON Recommendation: Approval

	Proposed Per Applicant	**Approved CON**
Estimated Capital Expenditure	$ 52,277,666	$ 89,000,000
Maximum Contingency	$ 0	$ 0
Total Capital Expenditure with Contingency	$ 52,277,666	$ 89,000,000
Pro-Forma Marginal Operating Costs	$ 13,666,825	$ 13,666,825

I. Abstract

A. From Applicant

Eastern Maine Healthcare Systems (EMHS) is the applicant in this certificate of need submission which proposes to change the ownership of Mercy Health System of Maine (MHSM/Mercy) from Catholic Health East (CHE) to be the newest member of EMHS' integrated delivery system. EMHS and Mercy's management and care philosophies are community-based and extremely well aligned. The proposed effective date for the Affiliation is September 30, 2013, subject to successful completion of due diligence and receipt of all necessary consents and approvals, including Certificate of Need (CON).

EMHS is an integrated delivery system providing a comprehensive continuum of healthcare services to communities of central, eastern and northern Maine. Based on revenues, EMHS is the second largest healthcare system in Maine. The System's core services include acute care medical-surgical hospitals, an acute psychiatric hospital, physician practices, ambulatory care centers, nursing homes, home care agencies, and ground and air emergency transport services. Since its creation in 1982, EMHS has evolved into a resource for primary, secondary, tertiary, trauma, home and community-based services. EMHS strives to maintain a culture of collaboration, integration and flexibility to meet the changing needs of Maine communities and to advocate on behalf of the residents of those communities. Member hospitals and other affiliates share common values and work to ensure the highest quality care.

Under the arrangement agreed to by the parties, Mercy will retain its Catholic tradition and mission. Vatican approval for the transfer of assets is being sought consistent with this commitment. The affiliation will result in EMHS becoming the sole corporate member of Mercy in place of CHE and assuming or discharging certain obligations of Mercy to CHE. This includes restructuring of Mercy's existing $73 million tax-exempt debt obligations currently included in the Master Trust Indenture of CHE and discharging certain intercompany debt. In addition and subject to the EMHS Board approval, EMHS will invest no less than $115 million over 5 years for a range of purposes, including to consolidate operations at the Fore River Campus, improve operating performance, develop required care models for success under healthcare reform and finance integration of Mercy into EMHS. The Federal Trade Commission has already completed its review under the Hart-Scott-Rodino Act giving the parties clearance to proceed with the transaction. The CON filing fee of $53,000 is based on Mercy's net assets.

The certificate of need application outlines the greater Portland market and the important role that Mercy plays in primary care, specialty and hospital services. The Financial Feasibility section describes the anticipated EMHS impact and the performance improvements underway by Mercy management. Healthcare costs within the service area will not be adversely impacted by this affiliation. As described in the application, this transfer of ownership will benefit Maine patients and families and improve care across the state.

B. CONU Comments

The transfer of ownership of Mercy Health System of Maine (MHSM/Mercy) from Catholic Health East (CHE) to Eastern Maine Health Systems is required to obtain a Certificate of Need. This requirement can be found at M.R.S. 22 §329 (1). "Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase,..."

The Certificate of Need is required for the acquisition of control of Mercy Hospital and assets that entity own. Other assets owned by Mercy Health System of Maine, namely MSHM Corporate Office and VNA Home Health and Hospice do not require Certificate of Need Approval.

The capital expenditure as calculated per the statute has been reviewed and determined to be at least $89,000,000. Consequently, the CON filing fee has been amended to $90,000. The fee has been collected.

The proposed restructure of the debt and the $115 million dollars have not been included by the applicant in is financial forecast and consequently not been considered by CONU as part of this analysis.

II. Fit, Willing and Able

A. From Applicant

Summary of the Project

In accordance with the terms of an Affiliation Agreement (Affiliation Agreement), Attachment A. by and among CHE, Mercy, VNA Home Health & Hospice (VNA), and EMHS, the Board of Trustees of MHSM, with the approval of the Sisters of Mercy and CHE, proposes to amend the Bylaws and Articles of Incorporation of MHSM to substitute EMHS for CHE as the sole corporate member of MHSM (the "Affiliation"). As sole corporate member of MHSM, EMHS will acquire direct or indirect control over substantially all of the assets and operations of MHSM, including Mercy and VNA. The VNA affiliation is not subject to CON review.

MHSM, Mercy, and VNA will continue to operate in their current form as 501(c) (3) tax-exempt Maine nonprofit corporations. The day-to-day operation of Mercy will continue, subject to oversight by EMHS, including EMHS approval of certain Mercy financial and service initiatives, as set forth more specifically in the Affiliation Agreement. The Affiliation Agreement provides that Mercy will retain its Catholic identity, traditions and mission. The Sisters of Mercy are seeking approval from the Roman Catholic Church for the transfer of Mercy's real property to EMHS. A letter from Bishop Malone of the Portland Diocese is included with other support letters in Attachment B.

B. Profile of the Applicant
Eastern Maine Healthcare Systems
43 Whiting Hill Road
Brewer Maine, 04412

http://www.emhs.org/

EMHS, based in Brewer, Maine, is a nonprofit, tax-exempt corporation. EMHS is a vertically integrated healthcare system serving central, eastern, and northern Maine. EMHS includes more than 30 organizations, including seven hospitals: Acadia Hospital (Acadia), The Aroostook Medical Center (TAMC), Blue Hill Memorial Hospital (BHMH), Charles A. Dean Memorial Hospital (C.A. Dean), Eastern Maine Medical Center (EMMC), Inland Hospital (Inland), and Sebasticook Valley Health (SVH). Acadia is a free-standing tertiary psychiatric hospital and the only psychiatric hospital in the United States to receive magnet status for excellence in nursing care. EMMC is the EMHS flagship hospital, providing a full complement of sub-specialty care, trauma services, and the latest in advanced technologies and imaging capabilities. Hospitals in the EMHS service area refer patients to EMMC for major operations and consultations with sub-specialists, and when sophisticated intensive care facilities are required. Other non-hospital EMHS members include Affiliated Healthcare Systems, Rosscare, Eastern Maine

HomeCare, and EMHS Foundation. Through its subsidiaries, EMHS also provides medical laboratory services throughout New England, operates a multi-state distributor of medical and surgical supplies to various healthcare organizations, operates four retail pharmacies, develops cooperative retirement housing units, and holds significant ownership interests in several non-subsidiary companies providing services, such as skilled nursing care.

EMHS has a vision to be recognized nationally as a model of excellence for healthcare delivery. Through collaboration with other community organizations, better coordination of care for patients and redefining what providing exceptional care means, EMHS is the architect of a promising new future of healthcare. As described herein, the proposed affiliation will support and enhance this mission.

EMHS has an established record in the pursuit of quality care, is nationally recognized for health information technology expertise, and is one of the 100 best integrated delivery networks as recognized by IMS Health, a leading provider of healthcare information, services and technology, covering markets in more than 100 countries around the world. EMHS member hospitals are recognized for their patient safety results. All of the affiliated primary care practices have achieved primary care medical home designation by the National Committee for Quality Assurance (NCQA). EMHS is one of 32 CMS Pioneer demonstration sites and was selected as one of only 17 federal Beacon grantees, which highlights collaboration across care sites as well as excellence in health information technology. EMHS was also recognized with the National Health System Patient Safety Leadership Award from the National Business Group on Health and the VHA.

EMHS has a long and successful history of integrating hospitals and other healthcare organizations into its system. The Maine DHHS CON Unit has consistently found EMHS to be fit, willing and able under past change of ownership reviews.

EMHS Hospital Affiliations

- 1992 EMHS opens Acadia Hospital
- 1998 Inland Hospital joins EMHS
- 1998 Charles A. Dean Memorial Hospital joins EMHS
- 1999 The Aroostook Medical Center joins EMHS
- 2001 Sebasticook Valley Health joins EMHS
- 2006 Blue Hill Memorial Hospital joins EMHS
- *Proposed 2013: Mercy Hospital joins EMHS*

Figure 1: Post-affiliation Organizational Chart

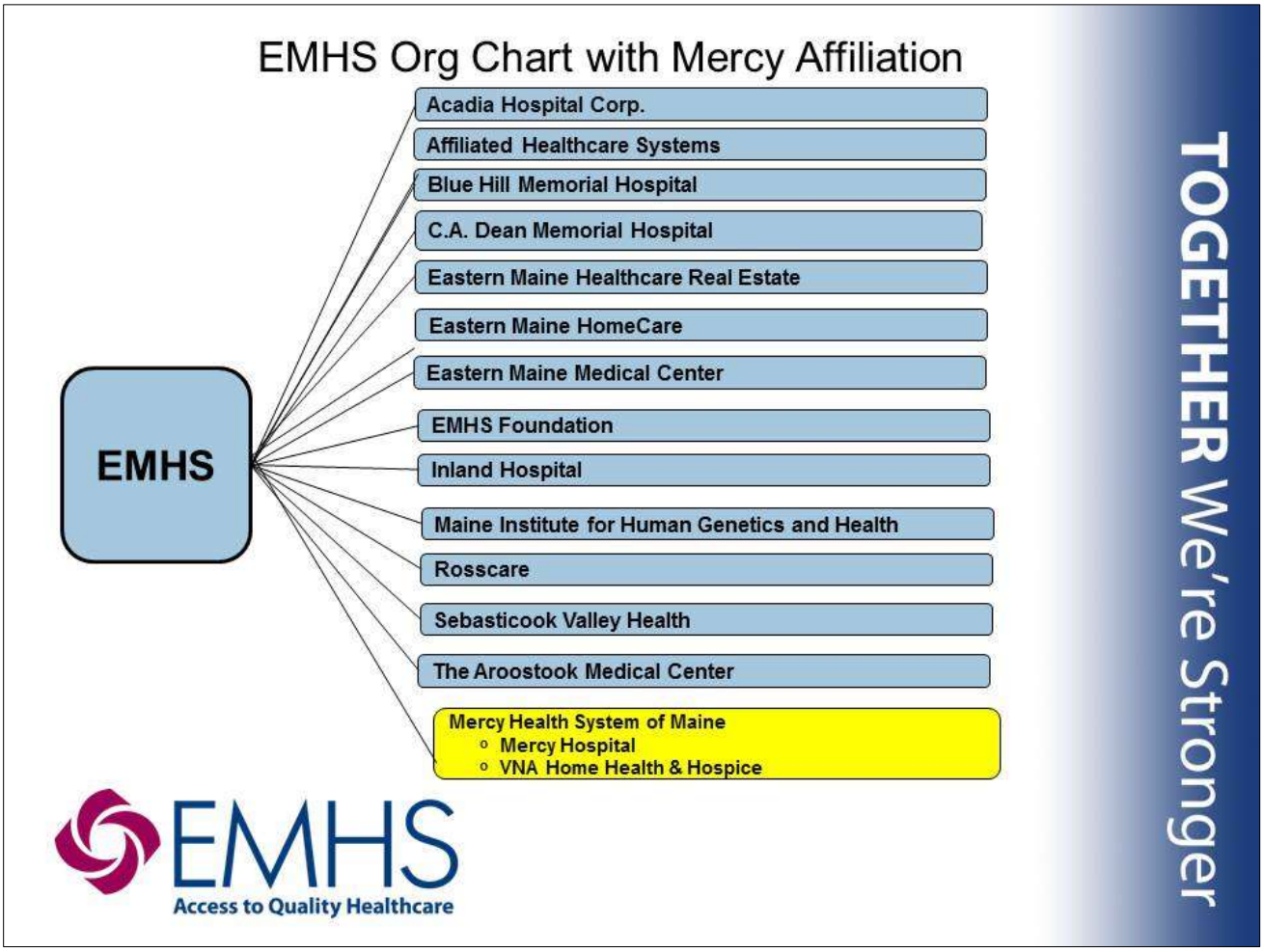

EMHS Org Chart with Mercy Affiliation
EMHS
Acadia Hospital Corp.
Affiliated Healthcare Systems
Blue Hill Memorial Hospital
C.A. Dean Memorial Hospital
Eastern Maine Healthcare Real Estate
Eastern Maine HomeCare
Eastern Maine Medical Center
EMHS Foundation
Inland Hospital
Maine Institute for Human Genetics and Health
Rosscare
Sebasticook Valley Health
The Aroostook Medical Center
Mercy Health System of Maine
Mercy Hospital
VNA Home Health & Hospice
EMHS
Access to Quality Healthcare
TOGETHER We're Stronger

Table 1: EMHS' Clinical Provider Organizations

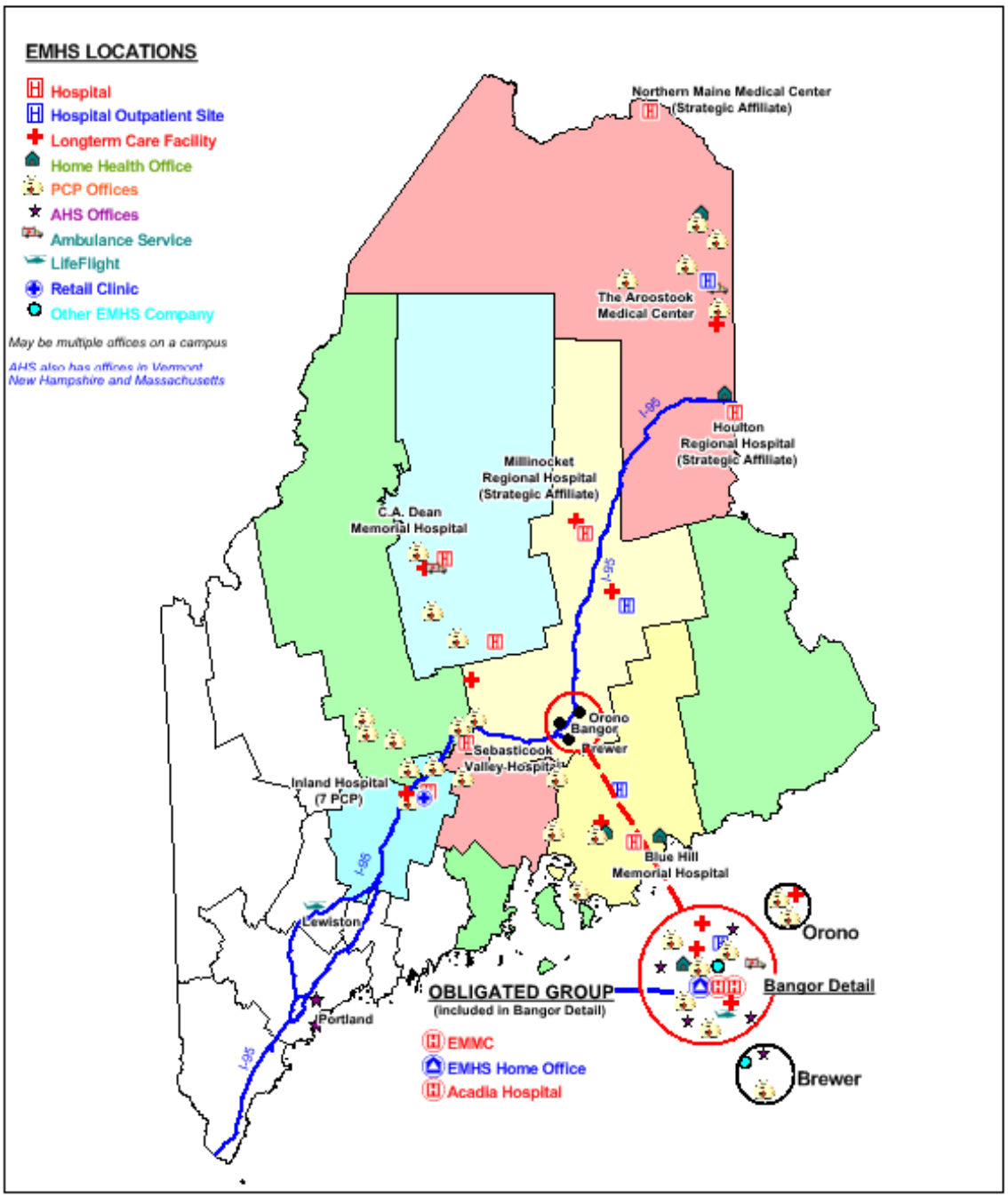
Acadia Hospital 268 Stillwater Ave Bangor, ME 04401	Acadia Hospital: Acadia is a 100 bed non-profit, acute-care hospital and community mental health agency, located in Bangor, Maine, providing both hospital-based and community-based mental health and substance abuse treatment services to the people of Maine.
Affiliated Healthcare Services (AHS) 931 Union Street PO Box 940 Bangor, ME 04401	Affiliated Healthcare Services (AHS): AHS is a Maine-based company that has built one of the largest integrated healthcare support networks in all of New England. AHS provides regional referral lab, pharmacy, materiel management, transcription, and collection services and offers ground ambulance transportation.
Blue Hill Memorial Hospital (BHMH) 57 Water Street Blue Hill, ME 04614	Blue Hill Memorial Hospital (BHMH): BHMH is a 25-bed critical access hospital, located in Blue Hill, Maine, offering primary and selected specialty healthcare services. Primary care practices are located in Blue Hill, Bucksport, Castine, and Stonington.
C.A. Dean Memorial Hospital (C.A. Dean) 364 Pritham Avenue Greenville, ME 04441	C.A. Dean Memorial Hospital (C.A. Dean): C. A. Dean is a 25-bed critical access hospital located near the shores of Moosehead Lake in Greenville, Maine. C.A. Dean is also the home to Northwood Healthcare, a primary care practice with offices in Greenville, Monson and Sangerville. C.A. Dean provides acute, skilled, and nursing facility beds, as well as 24-hour emergency medical services, ambulance and a full service Emergency Department.
Eastern Maine Medical Center (EMMC) 489 State Street Bangor, ME 04401	Eastern Maine Medical Center (EMMC): EMMC, located in Bangor, Maine, is a 411 bed hospital serving communities throughout central, eastern, and northern Maine. EMMC and its medical staff of more than 400 active medical physicians provide three-quarters of the primary-care hospital services offered in the Bangor area, as well as specialty and intensive services to the northern two-thirds of the state. EMMC is commencing a facility modernization project which will upgrade patient rooms, surgery, and heart services, among others. EMMC is a regional resource for healthcare and health information, a source of support and assistance for area physicians and other healthcare providers, and a training ground for the health professionals of the future. EMMC also provides outreach clinics to many local hospitals in the region, allowing easier access for patients and supporting the role of those hospitals in their communities. EMMC is Maine's only principal member of the Alliance for Clinical Trials in Oncology and is the nation's first and only general and bariatric robotic surgery epicenter. EMMC has been recognized for many other achievements; a selection follows: • October 2012 - EMMC's Trauma Program Successfully Re-verified by the American College of Surgeons • September 2012 - EMMC Named the First General and Bariatric Surgery Robotic Epicenter in the Nation

	• July 2012 - EMMC Named One of Nation's Most Wired Hospitals June 2012 - EMMC Received an "A" for Hospital Safety from The Leapfrog Group.
Inland Hospital 200 Kennedy Memorial Drive Waterville, ME 04901	Inland Hospital: Inland Hospital is a 48 bed hospital in Waterville, Maine. Inland affiliates include Lakewood, a 105-bed continuing care center on the hospital campus; and 18 primary and specialty care physician offices in Waterville and five surrounding communities. Hospital services include acute and critical care inpatient units for adults; ambulatory surgery; birthing center; radiology; rehabilitation; 24-hour emergency care with on-site LifeFlight helicopter pad, specialized clinics, and laboratory services. Hospital-based physician practices include cardiology, family practice, general internal medicine, general surgery, hospital care, neurology, obstetrics/gynecology, orthopedic surgery, osteopathic manipulative medicine, and rheumatology. Lakewood provides skilled nursing and rehabilitation services, secure dementia care and long term care services.
LifeFlight of Maine (LOM) **Bangor Crew Quarters** EMMC, Kagan 4 489 State Street Bangor, ME 04401	LifeFlight of Maine (LOM): Formed in 1998, LOM provides 24/365 critical care medical transport with LOM-owned helicopters and ground critical care using ambulances provided by Meridian Mobile Health in Bangor and United Ambulance in Lewiston. LOM has transported approximately 15,000 patients since inception. LOM is a non-profit LLC, equally owned by EMHS and Central Maine Healthcare Corporation.
Rosscare 885 Union Street Suite 221 PO Box 404 Bangor , Maine 04402	Rosscare: 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 is in a joint venture relationship with First Atlantic Corp to operate 5 nursing homes in northern and eastern Maine.
Sebasticook Valley Health (SVH) 447 North Main Street Pittsfield, ME 04967	Sebasticook Valley Health (SVH): SVH is a 25-bed, critical access hospital in Pittsfield, Maine, with a wide range of outpatient services and three primary care locations throughout central Maine. Additionally, SVH has been recognized for the following: • One of the top ten critical access hospitals in the United States for clinical excellence by the VHA • Workplace Wellness Excellence - Platinum by Well Workplaces of America (WELCOA) • All three SVH Family Care primary care practices received the highest level certification as a Patient Centered Medical Home from the National Committee for Quality Assurance (NCQA) For the second year in a row, recognition as one of the best rural healthcare hospitals in the United States by The Leapfrog Group
The Aroostook Medical Center (TAMC) 140 Academy Street	The Aroostook Medical Center (TAMC): TAMC is an 89 bed hospital and the leading provider of healthcare services in northern Maine. It is driven by its mission to restore, maintain and improve the health of friends and

Presque Isle, ME 04769	neighbors in a compassionate and professional environment. TAMC provides a full range of hospital, primary and specialty services and is affiliated with Mars Hill nursing home.

Figure 2 below displays the sites of care (pre-Mercy) throughout the EMHS provider network.

Figure 2:



C. Description of MHSM (Mercy)

Mercy Health System of Maine
144 State Street,
Portland, Maine 04101

http://www.Mercyhospitalstories.org

Background

MHSM (Mercy), the co-applicant, is a Maine nonprofit, tax-exempt corporation and is the sole corporate member of Mercy and VNA. The sole corporate member of MHSM is CHE. CHE is a multi-institutional, Catholic health system co-sponsored by 13 religious congregations, including the Sisters of Mercy, Northeast Community, based in Rhode Island. CHE's corporate offices are located in Newtown Square, Pennsylvania.

Mercy's long-standing commitment to the community began over 90 years ago during the devastating flu pandemic of 1918, when Mercy first opened its doors as Queen's Hospital on the corner of Congress and State Streets in Portland, Maine. At that time, Queen's Hospital had 25 patient beds. From the outset the Sisters of Mercy who ran Queen's Hospital were dedicated to its mission of compassionate healing; a mission that continues today.

In 1943 Mercy commenced operations at 144 State Street in Portland. The hospital was named for the Sisters of Mercy, who had assumed full responsibility for the new hospital. A major addition was built in 1952, and the entire facility was renovated in the 1980s. Westbrook Community Hospital was merged into Mercy in September 1999. The Westbrook campus includes 24 substance abuse inpatient beds and related outpatient services.

At the turn of this century, as market demand and new clinical technology exceeded the capabilities of the State Street facility, Mercy embarked on a campaign to create the Fore River campus. Phase I of Mercy Fore River opened in September 2008 with a state-of-the-art medical office building and an advanced new hospital facility providing inpatient and outpatient surgical services, diagnostic imaging, laboratory, and The Birthplace on a 42-acre site overlooking the Fore River in Portland.

As Mercy continues to fulfill its mission of service to the changing health needs of the greater Portland community, it will be working with EMHS staff to implement phase II of a plan that will ultimately relocate the State Street services to the Fore River campus. State Street will continue to operate in the meantime as a full-service hospital with a 24-hour Emergency Department.

Driven by a community-based care philosophy and a goal to enhance access to care, Mercy has expanded ambulatory services even further into the community over the past five years. The growing number of Mercy Primary Care Practices in Portland, Falmouth, Gorham, Standish, Westbrook, West Falmouth, Windham, and Yarmouth provide individuals and families with quality healthcare services close to home. Four of these centers also have Express Care facilities, providing walk-in patients with speedy attention to minor medical problems such as bumps, bruises, cuts, sprains, coughs and colds when their own primary care physician is not available. Figure 3 shows Mercy sites of care.

Mission and Vision

Mercy carries out the healing work of Christ by providing clinically excellent, compassionate healthcare for all, with special concern for the poor and disadvantaged. Mercy's values are visible components of Mercy's strategic planning, patient care, and human resource initiatives. Mercy's mission and values integrate well with EMHS' mission and values.

Mercy is committed to giving back to the greater Portland community. In 2012, Mercy provided $14.9 million in community benefits, including un-reimbursed medical treatments, pro bono medical services, community education, and prevention outreach. As one of Maine's largest employers, Mercy has a staff of 1,832 employees, 535 medical staff, and over 500 volunteers. In recent years Mercy has partnered with and supported many organizations through the development of collaborative grants.

Locations and Services

Mercy provides a broad array of both inpatient and outpatient diagnostic and therapeutic services including: medical, surgical, oncological, obstetrical, physical rehabilitation, imaging, laboratory, eating disorders, drug and alcohol detoxification and treatment services, and home care/hospice services. Mercy is comprised of the following entities:

- Mercy Hospital, which includes three hospital campuses (State St, Fore River, and Westbrook) licensed for 230 beds, additional off-site out-patient locations (e.g. physical rehabilitation, endoscopy, etc.), and Mercy Medical Associates. Mercy Medical Associates represents Mercy's multi-specialty physician practices. The network of Primary Care and Specialty Practices provides both inpatient and outpatient care in several communities in greater Portland. Each practice has a team of outstanding physicians, nurse practitioners, physician assistants, nurse mid-wives, and staff.
- VNA Home Health & Hospice is the premier Medicare certified provider of home care and hospice services in southern Maine and is accredited by The Joint Commission. Out of 8,000 companies nationwide, VNA has achieved recognition as one of the HomeCare Elite for five of the last six years. LifeStages, a division of VNA created in 2011, provides companion care; meal preparation, light housekeeping, errands, personal care and many more services to assist elders maintain their independence in their own homes.
- The Mercy Recovery Center is located at the Westbrook campus; this is the focal point for Mercy's substance abuse (alcohol and opioid addiction primarily) services. Inpatient and outpatient services offered at the Westbrook campus are unique to the Portland area and act as a statewide consultation service and receive referrals from state wide providers. The Recovery Center is the largest substance abuse provider in the state. This program will be continued and strengthened with the EMHS affiliation.

Mercy services are offered at a variety of locations throughout greater Portland with sites of care shown in Figure 3 and described in Table 2.

Figure 3: Mercy Health System Service Locations

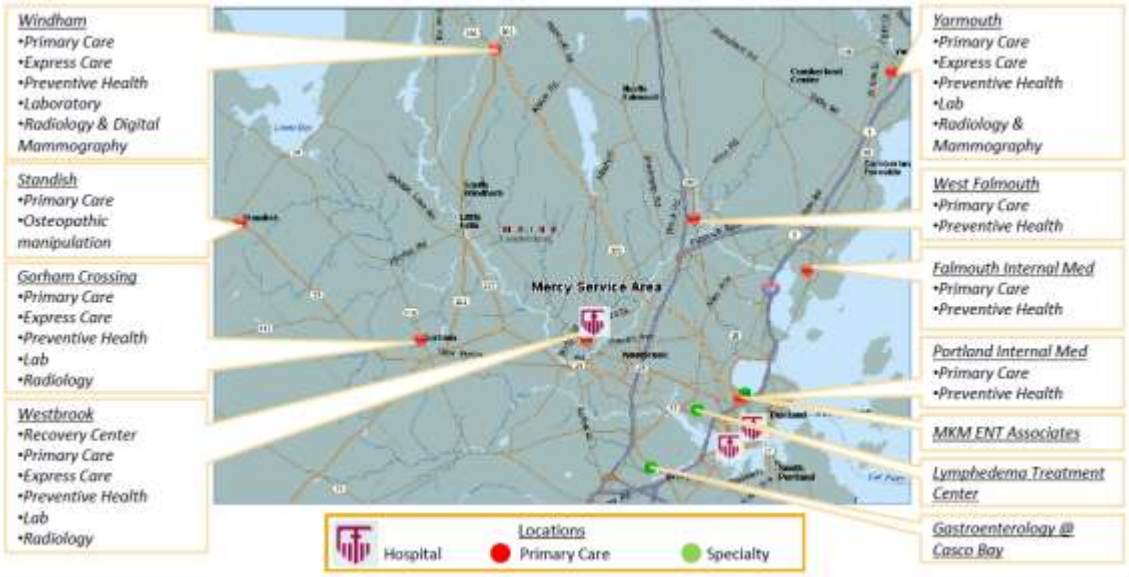


Table 2: Mercy Service Locations

Mercy Hospital Fore River 175 Fore River Parkway Portland, ME 04102	Mercy Hospital Fore River is home to The Orthopaedic Institute at Mercy and the Birthplace (Obstetrical Services). It provides inpatient and outpatient surgical services; laboratory services; Howard K. and Verna E. Dearborn outpatient imaging center including digital x-ray and advanced imaging and pharmacy.
Fore River Medical Office Building 195 Fore River Parkway Portland, ME 04102	Fore River Medical Office Building has several practices, including Breast Care Specialists of Maine; Fore River Family Practice; Fore River Urology and New England Urology Center for Women; New England Foot and Ankle Specialists; Portland Surgical Associates (providing general surgery and surgical oncology services); Maine Spine Surgery; All About Women (OB/GYN); Mercy Oncology-Hematology Center; Women's Imaging Center (providing bone densitometry; digital mammography; stereotactic biopsy and ultrasound); and additional private physician practices.
Mercy Hospital State Street 144 State Street Portland, ME 04101	Mercy Hospital State Street includes in-patient and out-patient medical and surgical services including an intensive critical care unit with e-ICE support; an Emergency Department, Cardiovascular Center; Interventional Radiology Center; Mercy Cardiology; Mattina Proctor Diabetes Center; Wound Healing Center (including two hyperbaric chambers); Mercy Pulmonary and Sleep Medicine; Portland Thoracic Surgery; New England Eating Disorders Program; endoscopy and infusion services; x-ray

	and advanced diagnostic imaging; Mercy Pain Center (interventional pain and medical pain management); and physical rehabilitation and laboratory services;
Mercy Westbrook 40 Park Road Westbrook, ME 04069	Mercy Westbrook has the Mercy Recovery Center; in-patient and out-patient substance abuse treatment with 24 inpatient beds. It also has Primary Care and Express Care. Ancillary services: digital mammography, x-ray, ultrasound and bone densitometry, laboratory services.
Mercy Windham Fam. Practice and Express Care 409 Roosevelt Trail Windham, ME 04062	Mercy Windham has Primary Care and Express Care, as well as ancillary services consisting of digital mammography, x-ray, and laboratory drawing services
Mercy Gorham Crossing Primary Care and Express Care 19 South Gorham Crossing Gorham, ME 04038	Mercy Gorham Crossing has Primary Care and Express Care, as well as ancillary services consisting of digital x-ray, laboratory drawing services, and physician therapy services.
Mercy Yarmouth Primary Care and Express Care 385 Route One Yarmouth, ME 04096	Mercy Yarmouth has Primary Care and Express Care, as well as ancillary services consisting of digital x-ray, mammography, ultrasound, and laboratory drawing services
Family and Internal Medicine Practices (other than those with collocated Express Care services noted above)	
Portland Internal Medicine 43 Baxter Boulevard Portland, ME 04101	Falmouth Internal Medicine 75 Clearwater Drive, Suite 106 Falmouth, ME 04105
West Falmouth Primary Care 66 Leighton Road West Falmouth, ME 04105	Fore River Family Practice 195 Fore River Parkway, Suite 160 Portland, ME 04103
Standish Family Practice 111 Ossipee Trail, Standish, ME 04084	
Mercy Gastroenterology 25 Long Creek Drive South Portland, ME 04106	The program specializes in gastroenterological disease management and screening and has an on-site endoscopy suite
MKM ENT Associates 43 Baxter Boulevard Portland, ME AND 413 Alfred Road, Biddeford	The program specializes in adult and pediatric otolaryngology; head and neck surgery; speech language pathology, hearing, tinnitus and balance disorders
Mercy Physical Therapy Center Westgate Shopping Plaza	The program provides comprehensive physical rehabilitation services including physical and occupational therapy. The Center

1364 Congress Street Portland, ME 04103	has a fully equipped gym and a therapeutic warm water pool on site.
Mercy Lymphedema Treatment Center Westgate Shopping Plaza 1364 Congress Street Portland, ME 04103	Lymphedema Treatment Center
McAuley Residence 68 High Street Portland, ME 04103	The program provides a safe environment and a comprehensive transitional living program for women in need. The residential program offers housing, life skills counseling, emotional support and mentoring, and helps women—with or without children—learn to live in a manner that improves their lives in a meaningful and lasting way. Women suffering with addiction come from all over the state of Maine with referrals from Mercy Recovery Center or other community agencies.
Gary's House 97 State Street Portland, ME 04103	The residence is a hospitality home for families of patients undergoing medical treatment in a Portland area hospital. Gary Pike, for whom the home is named, wanted families to find comfort knowing they had a place to stay near their loved one without being financially burdened.

Medical and Allied Professional Staff

The hospital has a total of 535 total medical staff, representing a full range of medical specialties. As shown in Table 3, Mercy employs 21% of active, courtesy and consulting medical staff and has developed a strong provider network.

Table 3: Mercy Medical Staff Composition

Type of Department	Number of	Number of	Number of	Total	% of Total
Division of Ambulatory Medicine					
General	22	28	11	39	71.80%
Allergy & Immunology	3	0	5	5	N/A
Dermatology	4	0	13	13	N/A
Integrative Care	1	0	3	3	N/A
Osteopathic Manipulative Medicine	5	0	8	8	N/A
Palliative Care	1	1	0	1	100.00%
Rehabilitative	6	1	4	5	20.00%
Total	**42**	**30**	**44**	**74**	40.50%
Division of Behavioral Medicine	**18**	**9**	**11**	**20**	45.00%
Division of Emergency Medicine	**1**	**21**	**0**	**21**	100.00%
Division of Inpatient Medicine					
General	4	1	10	11	N/A
Cardiology	7	4	26	30	13.30%
EICU	1	0	26	26	N/A
Endrocrinology	1	0	1	1	0.00%
Gastroenterology	4	3	4	7	42.90%
Hematology & Oncology	4	3	6	9	33.30%
Hospitalist Service	2	13	2	15	86.70%
Infectious Disease	1	0	5	5	N/A
Nephrology	1	0	11	11	N/A
Neurology	3	0	32	32	N/A
Pulmonary & Critical Care	1	5	2	7	71.40%
Rheumatology	1	0	5	5	N/A
Total	**30**	**29**	**130**	**159**	18.20%
Division of Maternal & Child Health					
OB/GYN	5	4	20	24	16.70%
Pediatrics	14	0	34	34	N/A
Total	**19**	**4**	**54**	**58**	6.90%
Division of Radiology	**3**	**0**	**31**	**31**	0.00%
Division of Anesthesia					
General	1	0	30	30	0.00%
Interventional Pain	1	1	0	1	100.00%
Total	**2**	**1**	**30**	**31**	3.20%
Division of General Surgery					
General	5	5	14	19	26.30%
Neurosurgery	1	2	0	2	100.00%
Ophthalmology	3	0	10	10	N/A
Plastic Surgery	3	0	10	10	N/A
Thoracic	1	1	0	1	100.00%
Wound Healing	1	1	0	1	100.00%
Total	**14**	**9**	**34**	**43**	20.90%
Division of Oral Surgery & Dentistry	**8**	**0**	**16**	**16**	N/A
Division of Orthopedics	**13**	**3**	**33**	**36**	8.30%
Division of Otorhinolaryngology	**6**	**2**	**7**	**9**	22.20%
Division of Pathology	**1**	**0**	**16**	**16**	N/A
Division of Podiatry	**10**	**2**	**13**	**15**	13.30%
Division of Urology	**3**	**4**	**2**	**6**	66.70%
Totals	**170**	**114**	**421**	**535**	21.30%

Source: Mercy Hospital Medical Credentialing Staff
Note: Includes Active, Consulting, Community and Health Professional Affiliate Staff.

Licenses, Accreditations, and Certifications

Mercy Hospital is accredited by the Joint Commission and licensed by the State of Maine. The hospital participates fully in Medicare, Medicaid, and all of the local managed care plans. Documentation of licensure, certifications, accreditations and recognitions are included as Attachment C.

EMHS member hospitals are surveyed regularly by national accrediting organizations or DHHS. All EMHS Member organizations maintain copies of their external accreditations and certifications, and those that are state-surveyed also have survey reports on file with DHHS. Any issues identified during surveys are addressed promptly in corrective action plans.

D. Key personnel

EMHS and Mercy have strong governance and management teams who are working together on affiliation transitional issues. A brief summary of the Board Chairs and management team and their areas of expertise follow. Resumes of key staff are included in Attachment D.

1. EMHS key personnel

EMHS Board Chair: P. James Nicholson, CPA:

Mr. Nicholson received a Bachelor of Science degree in 1968 from University of Maryland and Certified Public Accountant License in 1975. He is currently the managing stockholder in the public accounting firm of Nicholson, Michaud & Company. The Firm is a general practice accounting firm which specializes in the needs of for-profit and not-for-profit businesses and individuals. His professional affiliations include the American Institute of Certified Public Accountants and Maine Society of Certified Public Accountants. In addition, he has also served on the board of Inland Hospital, as Chair of the Waterville Development Corporation, Chair of the Advisory Council for Maine Small Business Center, and Advisory Council for Kennebec Valley Community College among other services. Mr. Nicholson is in his 4th term on the EMHS board with 10 years of service as of June 2013.

EMHS President and CEO: M. Michelle Hood, FACHE:

Ms. Hood received a Bachelor of Science degree in 1978 from Purdue University and a Master of Healthcare Administration from Georgia State University in 1981. She is a Fellow of the American College of Healthcare Executives. Ms. Hood came to EMHS in April 2006 from Billings, Montana where she was President and CEO of the Sisters of Charity of Leavenworth Health Systems, Montana Region, as well as President and CEO of its flagship hospital, St. Vincent Healthcare. In her more than six years as President and CEO of EMHS, Ms. Hood has provided leadership and vision that anticipates both advances and obstacles. In addition to overseeing a system of health delivery services, she focuses on healthcare policy developments at the state and national levels, positioning EMHS to innovatively address the very specific needs and challenges of improving the health status of the people of Maine. Ms. Hood works at making connections and building creative partnerships that work for Maine communities, strengthening the economic and educational climate of the state, and ensuring that EMHS is a desirable place to work for more than 8,000 dedicated professionals. She is active with both the American Hospital Association and the Maine Hospital Association, serves as Chair of the University Of Maine System Board Of Trustees, and serves on a number of other healthcare and community boards.

EMHS Senior V.P., CFO and Treasurer: Derrick Hollings, CPA:

Mr. Hollings is senior vice president, treasurer and chief financial officer for EMHS. He is responsible for system wide oversight of finance, treasury self-insurance programs, and property management, for

developing a financial roadmap to guide the System consistent with its strategic financial plan, and for insuring integrity and consistency of consolidated financial information reported by EMHS. Mr. Hollings came to EMHS in April, 2012 from United Medical Center where he served as the Executive Vice President of Hospital Operations and Chief Financial Officer at a 350 bed urban hospital located in Washington, DC. Mr. Hollings was also a senior partner at RequestHealth, LLC, a consulting practice focused on providing interim management services to hospitals in a chief financial officer transition. Mr. Hollings has also held chief financial officer roles at Stamford Health System (Stamford, CT), Howard University Hospital (Washington, DC), University of Massachusetts Medical Center (Worcester, MA) and MediVision, Inc. (Boston, MA). Mr. Hollings graduated from the University of Alabama-Birmingham and is a Certified Public Accountant.

EMHS Senior V.P., & Chief Transformation Officer: Richard W. Freeman, MD, MPH, ScD, FACP:

Richard Freeman, MD, a general internist, was appointed Senior Vice President and Chief Transformation Officer in July, 2011. He is responsible for guiding the transformation of EMHS from volume-based reimbursement and care delivery models to value-based models. Prior to joining EMHS, Dr. Freeman served concurrently as chief medical officer for two subsidiary multi-specialty group practices of Spectrum Health System in west Michigan. Dr. Freeman holds an undergraduate degree from Cornell University, graduate degrees in public health and epidemiology from the Johns Hopkins Bloomberg School of Public Health, and Doctor of Medicine from University of Maryland School of Medicine. His early career included service as Vice President for Medical Affairs, Johns Hopkins Bayview Medical Center; as President and COO of CareAdvantage, Inc., a medical management firm serving BlueCross BlueShield plans; and as Director in the Healthcare Division of Navigant Consulting, Inc.

EMHS Senior V.P., CMO and Chief Administrative Officer: Erik Steele, D.O., FAAFP:

Dr. Steele has held various positions at both EMMC and EMHS including EMMC as Patient Care Administrator, for Emergency, Trauma, Pulmonary, ICU, and Heart Center Services. In April 2002 he was appointed Vice President of Patient Care Services at EMMC, and in 2005 he became Vice President of Medical Affairs at Rosscare and Vice President and Chief Medical Officer at EMHS. In 2012 Dr. Steele was appointed Senior Vice President, Chief Administrative Officer and Chief Medical Officer (CMO). From December 2008 to September 2010 he served as the Interim President and CEO of Blue Hill Memorial Hospital, Blue Hill, Maine. Dr. Steele is a member of the Associate Clinical Faculty, University of New England, College of Osteopathic Medicine, Biddeford, Maine and Tufts University School of Medicine, Boston, Massachusetts. He also serves as a part-time faculty member of the EMMC Center for Family Medicine. As a practicing family physician, he also is on the courtesy staff and provides emergency medicine department coverage at several area hospitals. He holds a B.A. degree in History and Government from Bowdoin College, Brunswick, Maine and a medical degree from the University of New England: College of Family Medicine.

Dr. Steele has accepted a position with Summa Health in Akron, Ohio and will be leaving EMHS in May. A national search for a system physician executive will be conducted.

2. Mercy key personnel

Mercy Board Chair: Thomas Yoder, Jr.:

Mr. Yoder is a third generation construction professional and a graduate of Villanova University with a Bachelor of Science Degree in Civil Engineering. He entered the United States Navy where he served as Chief Engineer and Executive Officer on the USS Plainview AGEH-1, an experimental hydrofoil ship. After living in Texas, Mr. Yoder relocated to Portland Maine where he served as General Manager of Donalco Construction, a regional General Contractor. After three years in that position, he moved to Hannaford Bros. Co. where he served for 15 years in the position of Director of Construction Services. In that role he managed a department which served as the owner's representative for all of Hannaford's construction operations. In January of 2004, Mr. Yoder started Yoder Inc., a Maine corporation engaged in construction consulting and providing owner representation services to a diverse list of clients. Mr. Yoder is currently serving as Chairman of the Board of Trustees of Mercy Hospital and Board of Directors of Mercy Health System of Maine. He also served for six (6) years as Trustee for the Norlands Foundation Living History Center, in Livermore Falls, Maine. Upon retirement from the Norlands Foundation board, he was awarded a lifetime position as Honorary Board Member.

Mercy President and CEO: Eileen F. Skinner, FACHE:

Ms. Skinner has served as President and Chief Executive Officer of the Mercy Health System of Maine and Mercy Hospital since 2002. Over the course of the last decade, she has strategically repositioned Mercy to meet the rapidly-changing healthcare needs of the community. Accomplishments have included an expanded Mercy presence and reach throughout southern Maine, including: construction of a third campus and state-of-the art hospital building which required completion of an extensive Certificate of Need process; doubling of the network of Mercy Hospital primary care facilities throughout Cumberland County; and oversight of an expanded range of express care and specialty practices to ensure integrated, interdisciplinary and convenient access and delivery of care. Ms. Skinner has led the organization to Tier1 status with the State of Maine Employees Health Commission, an accolade awarded to Mercy Hospital as a low-cost, high-value provider for six (6) consecutive years.

As President and CEO of one Maine's largest employers, Ms. Skinner has taken an active role as a board member of the Maine Chamber of Commerce, the Portland Regional Community Chamber, and the Hanley Center for Healthcare Leadership; she is also a member of the City Manager's Portland Business Advisory Council. She has also chaired a Crime Prevention Task for the Portland Regional Community Chamber and is well-recognized throughout Maine as an advocate for the poor and disadvantaged as evidenced by awards such as the Salvation Army's "Others" Award. Ms. Skinner holds a BS degree in Medical Technology and a Master's Degree in Health Administration from Tulane University. She is a Fellow of the American College of Healthcare Executives.

Mercy Senior V.P. and CFO: Michael Hachey, CPA, FACHE:

Mr. Hachey has held key leadership roles since he joined Mercy in March 2003 and is currently the Senior Vice President and Chief Financial Officer of MHSM. His accomplishments include developing the financial feasibility plan for the first phase of the Fore River campus, implemented core clinical, revenue cycle, and financial systems and led the organization's development of MHSM's primary care and specialty care network of physicians. As Senior Vice President and Chief Financial Officer, Mr. Hachey provides senior leadership to financial, treasury management, information technology and physician practice functions. Prior to coming to MHSM, Mr. Hachey served as the Chief Financial

Officer of Miles Healthcare, Inc. and Franklin Memorial Hospital. He earned his Bachelor of Accounting in Accounting and Master of Business Administration at Thomas College, Waterville, Maine. He is a Certified Public Accountant, gaining his public accounting experience with Ernst & Young, a Fellow of the Healthcare Financial Management Association, and a Fellow of the American College of Healthcare Executives. Mr. Hachey serves as Chair of the Board of Synernet, Inc. and is on the Chief Financial Officer Council of the Maine Hospital Association.

Mercy V.P. of Medical Administration and CMO: Scott Rusk, M.D.:

Dr. Rusk most recently served as Director of Hospital Medicine and Case Management at Portsmouth Regional Hospital; he had been there for three years. Prior to this, he held similar roles at Eastern Maine Medical Center in Bangor, Maine from 1996 to 2007. He has extensive experience in hospital medicine, care management, quality, information technology, palliative care, and risk management. During this time, Dr. Rusk served on the Board of Trustees of Eastern Maine Medical Center. Dr. Rusk has a BA from Bowdoin College, MD from the Stanford University School of Medicine in California, and Residency in Internal Medicine at the University of California at Davis. He is Board Certified in Internal Medicine. Dr. Rusk's experience in southern California and as a hospitalist in New England, has uniquely qualified him in the areas of care management and coordination.

Mercy V.P. and Chief Operating Officer: Robert Nutter:

Mr. Nutter is the most tenured member of Mercy's Executive Management Team. He assumed the role of COO in 2011 following twelve years as Vice President of Human Resources & Support Services and Chief Human Resource Officer. Mr. Nutter led the completion, staffing, and opening of the Fore River Campus, developed 12 new service locations, redesigned employee benefit plans, and significantly improved organizational effectiveness and productivity. As COO, he provides management oversight for the development of high quality, cost effective and integrated clinical and operational programs within the hospital. Mr. Nutter is responsible for all operational areas including Surgical Services, Acute Hospital Services, Ancillary Services, Support Services, Materials Management, Administrative Services, and Human Resources. Prior to joining Mercy, Mr. Nutter held senior leadership roles with Cole-Haan (Yarmouth, Me) and Marriott International (Washington, D.C). Mr. Nutter holds a Bachelor of Science in Business Administration and Management from the University of Southern Maine.

3. Board of Directors

EMHS and Mercy are committed to community advised governance. Governing Boards have approved the affiliation. Directors include a broad range of skills and background. Complete Board listings are included as Attachment D.

E. Summary of Fit, Willing and Able

One of EMHS' positioning statement is "Together We're Stronger". These words are reflective of EMHS' history of successfully bringing hospitals and other organizations into its system. EMHS has demonstrated the available resources to improve the financial and quality results of current and new members. EMHS' established record in the pursuit of quality care and patient safety, its nationally recognized health information technology record, and being named as one of the 100 best integrated delivery networks by IMS further demonstrate its ability to facilitate this affiliation.

EMHS is fit, willing, and able to welcome Mercy as the newest EMHS member.

B. CONU Discussion

i. CON Standard

The relevant standard for inclusion in this section is 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.

If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.

ii. CON Analysis

EMHS, based in Brewer, Maine, is a nonprofit, tax-exempt corporation. EMHS is a vertically integrated healthcare system serving central, eastern, and northern Maine. EMHS includes more than 30 organizations, including seven hospitals. MHSM (Mercy), the co-applicant, is a Maine nonprofit, tax-exempt corporation and is the sole corporate member of Mercy and VNA. The sole corporate member of MHSM is CHE. CHE is a multi-institutional, Catholic health system co-sponsored by 13 religious congregations, including the Sisters of Mercy, Northeast Community, based in Rhode Island. CHE's corporate offices are located in Newtown Square, Pennsylvania. Mercy provides a broad array of both inpatient and outpatient diagnostic and therapeutic services including: medical, surgical, oncological, obstetrical, physical rehabilitation, imaging, laboratory, eating disorders, drug and alcohol detoxification and treatment services, and home care/hospice services.

EMHC largest hospital campus is located at Bangor, Maine. The 411 – bed Eastern Maine Medical Center facility represents 57% of EMHC current inpatient capacity. Bangor is 129 miles from Portland, Maine. The closest EMHC hospital, Inland Hospital, is a 48 bed facility located in Waterville, 74 miles from Mercy Hospital. This would represent a significant decrease in distance between system hospitals for Mercy, since the next closest CHE hospital is

in Springfield, Massachusetts, approximately 192 miles to the southwest. If Mercy is integrated into EMHS, Mercy Hospital would provide approximately 24% of the inpatient capacity for EMHS. Mercy would increase EMHS' inpatient capacity by 32%

In order to determine if the applicant is fit, willing and able CONU evaluated three measures of quality for Eastern Maine Medical Center (the largest hospital in the EMHS healthcare system) and for Mercy Hospital. These three measures of quality were:

- **Survey of patients' experiences:** How recently discharged patients responded to a national survey about their hospital experience. For example, how well a hospital's doctors and nurses communicate with patients and how well they manage their patients' pain.
- **Timely and effective care:** How often and how quickly each hospital gives recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children's asthma, and for surgical patients.
- **Readmissions, complications and deaths:**
  - How each hospital's rates of readmission and 30-day mortality (death) rates for certain conditions compare with the national rate.
  - How likely it is that patients will suffer from complications while in the hospital.
  - How often patients in the hospital get certain serious conditions, that might have been prevented if the hospital followed procedures based on best practices and scientific evidence.

These quality measures are available at http://www.hospitalcompare.hhs.gov. Data collected was from July 1, 2011 through June 30, 2012. (Data was downloaded from website – July 1, 2013.)

1.) Patient Survey Results:

Hospital Consumer Assessment of healthcare providers and Systems is a national survey that asks patients about their experiences during a recent hospital stay. The following chart summarizes results for Eastern Maine Medical Center and Mercy Hospital and compares them to the Maine and National averages.

Patient Survey Results	EMMC	Mercy	Maine Average	National Average
Patients who reported that their nurses "Always" communicated well.	77%	82%	82%	78%
Patients who reported that their doctors "Always" communicated well.	78%	84%	83%	81%

Patients who reported that they "Always" received help as soon as they wanted.	61%	71%	72%	67%
Patients who reported that their pain was "Always" well controlled.	67%	70%	74%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them.	61%	67%	68%	63%
Patients who reported that their room and bathroom were "Always" clean.	69%	73%	79%	73%
Patients who reported that the area around their room was "Always" quiet at night.	43%	70%	59%	60%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	87%	90%	88%	84%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	65%	82%	73%	70%
Patients who reported YES, they would definitely recommend the hospital.	73%	86%	76%	71%

The data shown in Exhibit 1: Patient Survey Results indicates that Mercy Hospital scores consistently at or above average. EMMC had several of the same indicators which were significantly lower than Maine and national averages and Mercy. This may be related to the age of the EMMC facility, since that facility is preparing to build a new tower that will allow the hospital to expand inpatient bed space. Mercy Hospital moved its inpatients to its Fore River Campus once the Fore River Campus opened about seven years ago.

2.) Timely and Effective Care:

These quality measures show how often or how quickly hospitals give recommended treatments know to get the best result for people with common conditions. We looked at available data pertaining to the most common conditions; heart attack care, pneumonia care, surgical care, emergency department, preventive care and children's asthma care.

Timely Heart Attack Care	**EMMC**	**Mercy**	**Maine Average**	**National Average**
Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	Not Available	Too few cases	44 Minutes	59 Minutes
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	Too few cases	Too few cases	6 Minutes	7 Minutes
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	Not Available	Too few cases	76%	59%
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival ***Higher** percentages are better*	Too few cases	Too few cases	99%	97%
Heart attack patients given fibrinolytic medication within 30 minutes of arrival ***Higher** percentages are better*	Too few cases	Not Available	67%	60%
Heart attack patients given PCI within 90 minutes of arrival ***Higher** percentages are better*	94%	Not Available	96%	95%
Effective Heart Attack Care				
Heart attack patients given aspirin at discharge ***Higher** percentages are better*	100%	100%	100%	99%
Heart attack patients given a prescription for a statin at discharge ***Higher** percentages are better*	100%	96%	98%	98%

Effective Heart Failure Care				
Heart failure patients given discharge instructions ***Higher** percentages are better*	96%	98%	96%	93%
Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function ***Higher** percentages are better*	100%	100%	100%	99%
Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) ***Higher** percentages are better*	100%	Too few cases	97%	96%
Effective Pneumonia Care				
Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics ***Higher** percentages are better*	96%	98%	98%	97%
Pneumonia patients given the most appropriate initial antibiotic(s) ***Higher** percentages are better*	98%	97%	98%	95%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) ***Higher** percentages are better*	93%	99%	96%	97%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection ***Higher** percentages are better*	99%	99%	99%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) ***Higher** percentages are better*	99%	98%	99%	97%

Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery ***Higher** percentages are better*	98%	99%	98%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic ***Higher** percentages are better*	93%	97%	96%	97%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery ***Higher** percentages are better*	100%	99%	98%	97%
Surgery patients who were given the right kind of antibiotic to help prevent infection ***Higher** percentages are better*	99%	99%	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery ***Higher** percentages are better*	97%	Not Available	98%	96%
Surgery patients whose urinary catheters were removed on the first or second day after surgery ***Higher** percentages are better*	98%	96%	97%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery ***Higher** percentages are better*	100%	100%	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries ***Higher** percentages are better*	99%	99%	99%	98%
Timely Emergency Department Care				

Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better*	408 Minutes	357 Minutes	282 Minutes	274 Minutes
Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better*	230 Minutes	128 Minutes	112 Minutes	96 Minutes
Average time patients spent in the emergency department before being sent home *A **lower** number of minutes is better*	193 Minutes	148 Minutes	119 Minutes	139 Minutes
Average time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better*	54 Minutes	24 Minutes	28 Minutes	29 Minutes
Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication *A **lower** number of minutes is better*	72 Minutes	54 Minutes	56 Minutes	60 Minutes
Percentage of patients who left the emergency department before being seen ***Lower** percentages are better*	3%	0%	Not Available	Not Available
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	Too few cases	Too few cases	38%	45%
Preventive Care				
Patients assessed and given influenza vaccination ***Higher** percentages are better*	72%	89%	92%	86%
Patients assessed and given pneumonia vaccination ***Higher** percentages are better*	87%	90%	92%	88%

Effective Childrens Asthma Care				
Children who received reliever medication while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available	100%
Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available	100%
Children and their caregivers who received a home management plan of care document while hospitalized for asthma ***Higher** percentages are better*	Not Available	Not Available	Not Available	86%

The results of this patient survey indicate that in most instances both EMMC and Mercy have results meeting and/or exceeding State and National averages in effective heart attack and heart failure care, pneumonia care and timely and effective surgical care. An area of weakness for both hospitals is timely Emergency Department care. Both hospitals have several instances of waiting times in excess of State and National averages. This may be in part because both hospitals are located in urban areas with a significant population density. This points out the need for less expensive alternatives to emergency department care. It was also noted that EMMC scored lower than State and National averages in preventive care.

3.) Readmissions, Complications and Deaths:

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

Measures	**EMMC**	**Mercy**
Rate of Readmission for Heart Attack Patients	ND	ND
Death Rate for Heart Attack Patients	ND	ND
Rate of Readmission for Heart Failure Patients	ND	ND
Death Rate for Heart Failure Patients	ND	ND
Rate of Readmission for Pneumonia Patients	ND	ND

Death Rate for Pneumonia Patients	ND	ND
Death Among Patients with serious treatable complications after Surgery	ND	ND

Note: B = Better than national rate, ND = no different than national rate, W = worse than national rate, NA = not available or too few cases to measure.

The results displayed above show that both Mercy and Eastern Maine Medical performed no better or worse than the national rate for readmissions, complications or death.

State Survey Results

The results of the most recent surveys for Eastern Maine Medical Center and Mercy Hospital are as follows:

"**Eastern Maine Medical Center** is in compliance with the State of Maine Rules for the Licensing of Hospitals. There were no deficiencies cited during the recent onsite State complaint investigations completed on March 26, 2013."

"**Mercy Hospital** was found to be in compliance with the hospital Regulations for the State of Maine. There were no deficiencies noted during the onsite visit conducted on April 1, 2013."

Approvals from Governing Bodies and Others

As part of the pre-release technical assistance meeting on August1, 2013. The CONU had requested documentation regarding the approval of the Vatican regarding the proposed transfer. A copy of this approval dated May 31, 2013 is now contained in the record.

iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to show that the applicant is fit, willing and able.

III. Economic Feasibility

A. *From Applicant*

Background

The Mercy financial data and related statistical information includes historical performance for calendar years 2010, 2011 and 2012, and pro forma information presented in the EMHS Fiscal Years 2014 through 2016. EMHS fiscal year begins October 1st and ends September 30th. Mercy's fiscal year will be changed from a calendar year to coincide with the EMHS fiscal period. Financial proformas and related detailed assumption narrative is included in Attachment F.

Over the past several years Mercy has incurred operating losses primarily resulting from the cost of operating two campuses, volume declines at the time of the economic recession, revenue cycle deficiencies and investment in their ambulatory strategy. Table 9C in Attachment F indicates income improvements of over $4 million from projected nine months 2013 through fiscal year 2014. Mercy will experience a $2.0 million reduction in shared service and corporate overhead charges associated with the transfer of ownership from CHE to EMHS. The financial projections show a transformation of Mercy operating performance. Beyond this improved financial performance and a subject of a future CON application, the planned consolidation of the Fore River and State Street campuses is projected to generate $7 million in annual cost savings upon completion; these savings related to facility consolidation are not included in the projections presented in this CON application.

Mercy's projected revenue enhancements are due to revenue cycle improvements resulting from a major consulting engagement and revenue gains stemming from maturing of employed physician practices. Management began implementing its ambulatory growth strategy in 2007, which led to the hiring of approximately 60 physicians and mid-level providers deployed over 11 practice sites in the Portland area. The physician practice sites are as follows: 1) Falmouth, 2) Yarmouth, 3) West Falmouth, 4) Biddeford, 5) Westbrook, 6) Gorham Crossing, 7) Standish, 8) Windham, 9) South Portland, and 10) Portland (2 sites). Mercy service locations are listed and described in Section II. During the ramp-up phase of this strategy, significant losses were incurred. Fiscal Year 2014 represents the hurdle year of this ambulatory strategy. Hospitalization volume is impacted by declines resulting from ongoing efforts by insurance companies, large employers, and accountable care organizations to reduce in-patient utilization and expand aligned provider networks. The growth in physician visits will drive outpatient visits shown on Table 14; inpatient growth is anticipated to be marginal.

As noted, the projections include over $4 million in estimated financial improvements beginning in Fiscal Year 2014. There are additional efficiency opportunities that are excluded from the accompanying projections which are likely to be achieved through the affiliation with EMHS. An affiliation with EMHS will enhance Mercy's ability to remain a low cost care provider while stabilizing its financial operations through shared common resources.

B. Management initiatives

Financial Assumptions are described in more details in Attachment F. The following key initiatives will bring about financial results:

- Staffing: Mercy leaders have conducted extensive analyses and implemented right-sized staffing models across its system. Even with inherent inefficiencies of operating on two major campuses, staff size is currently budgeted to address patient service demands.
- Revenue Cycle improvements: Mercy engaged Accretive Health, an expert consulting firm in the area of revenue cycle management, to co-manage the revenue cycle function. Engagement recommendations are being implemented in 2012-2014 with the full benefit of the improvements to be realized by 2015.
- Corporate service charge reductions: Catholic Health East currently charges Mercy approximately $7.2 million annually for services ranging from information technology support to business services and administrative overhead. Discussions with Mercy and EMHS leaders indicate that this charge will be reduced by $2 million in 2014. The EMHS shared services infrastructure will still be able to provide a full range of administrative services to Mercy.
- Volume growth in provider network: Mercy's employed primary care and specialty providers will have the capacity to provide additional inpatient and outpatient services. Volume changes will derive from improved primary care medical home access which will hold down emergency department visits and allow patients to be referred to regional specialists as necessary.

C. Consideration

The affiliation will result in EMHS becoming the sole corporate member of Mercy and assuming or discharging certain obligations of Mercy to CHE. This includes restructuring of Mercy's existing $73 million tax exempt debt obligations currently underwritten by CHE. In addition and subject to the approval of the Eastern Maine Healthcare Systems Board, and subject to other due diligence, EMHS will cause to invest no less than $115 million over 5 years for a range of purposes, including to consolidate operations at the Fore River Campus, improve operating performance, develop required care models for success under healthcare reform and finance integration of Mercy into EMHS.

D. CON Filing Fee.

The CON filing fee, as shown on Tab 24 in Attachment F, the financial forecast, was calculated based on the value of Mercy's net assets. The transaction agreement does not set forth a discrete purchase price.

E. Summary of Financial Feasibility

The attached financial projection in Attachment F and the discussion in this section reflect the financial feasibility of the proposed affiliation. Losses incurred by Mercy over the past few years will be turned around based on efficient use of shared services, lower corporate allocation costs, internally developed performance improvement efforts, revenue cycle efficiencies, physician practices service capacity, and participating in population health (accountable care) strategies.

B. CONU Discussion

i. CON Standard

The relevant standard for inclusion in this section are specific to the determination that the economic feasibility of the proposed services is demonstrated in terms of 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

- 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. If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this subparagraph if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards;

Because this is an application regarding the acquisition of control of a health facility, these additional standards apply.

- the applicant must demonstrate the economic feasibility of the project in light of its impact on the operating budget of the facility and the applicant;
- and the applicant's ability to operate the facility without increases in the facility's rates beyond those that would otherwise occur absent the acquisition.

If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements. This is allowable if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards

ii. CON Analysis

The financial review of Mercy Hospital provides for unique issues in determining whether the applicant (EMHS) can meet its obligations toward Mercy. This process usually begins with a review of Marcy hospital’s current operating conditions and then apply changes to basic assumptions that are related to the consummation of the project. In this case, Mercy has begun

operational changes that relate to "revenue cycle improvements of over $4 million from projected nine months 2013 through 2014. An additional $2 million dollars in savings are expected to occur resulting from the acquisition by EMHS. Mercy estimates that completion of consolidation of operations at the Fore River location will result in an additional $7 million in savings that are not included in the projections provided to CONU or part of this record.

In order to assess the financial stability of the applicants, the CONU used financial ratios to measure profitability, liquidity, capital structure and asset efficiency. Financial data from Mercy Hospital and Eastern Maine Medical Center are used in this analysis. CONU utilized Maine Health Data Organization (MHDO) data from 2007 through 2011. Please see MHDO hospital financial information Part II available on MHDO's website http://mhdo.maine.gov/imhdo/. National trend and forecast information was obtained from the 2012 Almanac of Hospital Financial and Operating Indicators. The 2012 Consolidated Financial Statements and Other Financial Information for Mercy Health System of Maine was provided to CONU as part of the response to issues discussed at the pre-release technical assistance meeting held of August 1, 2013. Where relevant the CONU will include in its commentary information regarding 2012. For comparison purposes, CONU has elected to include the financial ratios for EMMC, the largest hospital component of EMHS.

PROFITABILITY RATIOS

CONU used three profitability ratios to measure the applicant's ability to produce a profit (excess of revenue over expenses). Hospitals cannot be viable in the long term without an excess of revenues over expenditures. Cash flow would not be available to meet normal cash requirements needed to service debt and investment in fixed or current assets. Profitability has a large impact on most other ratios. For example, low profitability may adversely affect liquidity and sharply reduce the ability to pay off debt.

Operating margin: The operating margin is the most commonly used financial ratio to measure a hospitals financial performance. This ratio is calculated as follows:

Operating Income/Total Operating Revenue

Operating Margin	2007	2008	2009	2010	2011
EMMC	0.99%	3.30%	2.33%	1.64%	2.58%
Mercy	2.13%	-0.34%	-2.91%	-9.20%	-9.07%
All Maine Hospitals Median	2.37%	1.61%	2.08%	0.98%	2.34%
National Median	NAV	NAV	NAV	NAV	NAV

Net Operating Income (Loss): Net operating income is calculated by subtracting operating expense from operating revenue. This measure is used to look at how a hospital's net operating income performed in comparison with last years' figure and whether or not there is a positive or negative trend in the future.

Net Operating Income	2007	2008	2009	2010	2011
EMMC	$4,748,240	$17,107,378	$12,657,859	$9,185,814	$14,711,174
Mercy	$3,363,322	-$587,000	-$5,397,000	-$16,108,000	-$17,208,000
All Maine Hospitals Median	$1,354,376	$720,298	$1,419,993	$762,435	$1,549,111
National Median	NAV	NAV	NAV	NAV	NAV

Return on Equity: This ratio defines the amount of excess revenue over expenses and losses earned per dollar of equity investment. Most not-for-profit hospitals received their initial, start-up equity capital from religious, educational, or governmental entities, and today some hospitals continue to receive funding from these sources. However, since the 1970s, these sources have provided a much smaller proportion of hospital funding, forcing not-for-profit hospitals to rely more on excess revenue over expenses and outside contributions. Many analysts consider the Return on Equity measure a primary indication of profitability. A hospital may not be able to obtain equity capital in the future if it fails to maintain a satisfactory value for this ratio. This ratio was calculated as follows:

Excess of Revenue over Expenses/Fund Balance-Unrestricted

Return on Equity	2007	2008	2009	2010	2011
EMMC	3.72%	10.64%	4.99%	6.77%	7.85%
Mercy	7.56%	-14.69%	7.10%	-18.43%	-27.37%
All Maine Hospitals Median	9.16%	7.12%	5.01%	4.51%	8.28%
National Median	8.30%	4.60%	5.50%	6.20%	6.40%

Trends for Return on Equity:
Return on Equity saw continued improvement in 2010 nationally. Larger hospitals continue to out- perform smaller ones. Hospitals with a lower operating margin show lower overall values as lower total margin and less financial leverage combine to reduce Return on Equity.

Forecast:
Return on Equity values should show a slight increase in the short term. Continued improvement will only be possible if hospitals can realize increased asset efficiency, especially in the area of fixed assets.

Mercy Hospital continued to show significant operating losses of $13,722,000 in 2012. This marks five consecutive years of operating losses. The operating income of EMMC can and does offset the losses of Mercy.

LIQUIDITY RATIOS

CONU used three liquidity ratios to measure the applicant's ability to meet short-term obligations and maintain cash position. A poor liquidity ratio would indicate that the hospital is unable to pay current obligations as the come due.

Current Ratio: Current ratio is a liquidity ratio that measures a company's ability to pay short-term obligations. The ratio is mainly used to determine if the hospital is able to pay back its short-term liabilities (debt and payables with its short-term assets (cash, inventory, receivables). From an evaluation stand point, high values for the Current Ratio imply a high likelihood of being able to pay short term obligations. A ratio under 1 suggests that the hospital would be unable to pay off its obligations if they came due at that point. This ratio is calculated as follows:

Total Current Assets/Total Current Liabilities

Current Ratio	2007	2008	2009	2010	2011
EMMC	1.214	1.076	1.077	1.512	1.603
Mercy	1.563	1.214	1.413	1.117	1.349
All Maine Hospitals Median	1.880	1.490	1.650	1.680	1.600
National Median	2.130	2.050	2.110	2.190	2.100

Current Ratio Trends:
Northeast hospitals have values for the Current Ratio that has been consistently lower than those of other regions. This is a direct result of relatively weak operating profitability. Continued erosion of margins in this region may impair the short-term liquidity positions of the weakest hospitals and may force some defaults.

Forecast:
Little change in current ratios are expected over the next five years. Values will continue to fluctuate around 2.0.

Days Cash on Hand: Days cash on hand is a common measure that gives a snapshot of how many days of operating expenses a hospital could pay with its current cash available. High values for this ratio usually imply a greater ability to meet short term obligations and are viewed favorably by creditors. This ratio is calculated as follows:

Cash & Investments + Current Assets Whose Use is Limited/Total Advertising + Salaries & Benefits +Other Operating Expenses + Interest/365 days

Days Cash on Hand	2007	2008	2009	2010	2011
EMMC	5.3	5.6	8.6	12.7	15.6
Mercy	44.0	-0.5	22.6	-4.9	-0.5
All Maine Hospitals Median	26.7	15.9	33.3	32.5	26.2
National Median	26.8	24.6	34.7	26.7	25.4

Trends for Days Cash on Hand:
Values for Days Cash on Hand (Current) continue to increase because of hospitals caution with their cash positions. A reasonable norm for most hospitals would be 20 days of cash on hand for short-term working capital purposes.

Forecast:
Days Cash on hand should remain steady or slightly increase as hospitals solidify their cash positions. The majority of hospitals should not expect any difficulty in maintaining short-term liquidity positions.

Average Payment Period: This ratio provides a measure of the average time that elapses before current liabilities are paid. Creditors regard high values for this ratio as an indication of potential liquidity problems. Decreasing values are favorable. This ratio is calculated as follows:

Total Current Liabilities/Total Advertising + Salaries & Benefits +Other Operating Expenses + Interest/365

Average Payment Period	2007	2008	2009	2010	2011
EMMC	43.6	45.7	59.9	36.2	39.8
Mercy	67.6	73.5	60.2	87.8	84.2
All Maine Hospitals Median	50.8	54.3	59.9	60.5	62.8
National Median	49.8	51.2	50.5	48.6	50.2

Trends for Avg. Payment Period:
Median values in Average Payment Period continued to decrease in 2010. Northeast hospitals have the highest values for Average Payment Period, which is consistent with their relatively low values for the Current Ratio.

Forecast:
Overall Average Payment Period values should remain unchanged in the short term.

CAPITAL STRUCTURE RATIOS

CONU used three capital structure ratios in order to measure the applicant's capacity to pay for any debt. The hospital industry has radically increased its percentage of debt financing over the past two decades making this ratio vitally important to creditors who determine if a hospital is able to increase its debt financing. The amount of funding available to a hospital directly impacts its ability to grow.

Debt Service Coverage: This ratio measures the amount of cash flow available to meet annual interest and principal payments on debt. A DSCR of less than 1 would mean a negative cash flow. Increasing values are favorable. This ratio is calculated as follows:

Excess of Revenue over Expenses + Depreciation + Interest/Interest + Previous Years Current LTD

Debt Service Coverage	2007	2008	2009	2010	2011
EMMC	7.729	10.561	8.205	8.193	7.320
Mercy	9.553	-1.757	2.072	-0.238	-0.397
All Maine Hospitals Median	3.820	3.430	2.910	2.680	4.110
National Median	3.820	2.860	3.100	2.800	3.180

Trends for Debt Service Coverage:
Debt Service coverage fell again in 2010 after 2009's decrease. Some of the changes on a regional basis are more striking and variable indicating that local economic experience is more variable. The Northeast showed an increase while all other regions showed a decrease.

Forecast:
Debt Service Coverage should stabilize or increase somewhat over the next few years. Values are predicted to remain between 2.8 and 3.0.

Cash Flow to Total Debt: This coverage ratio compares a company's operating cash flow to its total debt. This ratio provides an indication of a hospitals ability to cover total debt with its yearly cash flow from operations. The retirement of debt principal is not a discretionary decision. It is a contractual obligation that has definite priority in the use of funds. Therefore, a decrease in the value of the Cash Flow to Total Debt ratio may indicate a future debt repayment problem. The higher the percentage ratio, the better the company's ability to carry its total debt. This ratio is calculated as follows:

Excess of Revenue over Expenses + Depreciation/Total Current Liabilities + Total Non-Current Liabilities

Cash Flow to Total Debt	2007	2008	2009	2010	2011
EMMC	24.97%	28.63%	15.21%	17.73%	17.58%
Mercy	12.89%	-3.86%	17.95%	-4.05%	-5.99%

All Maine Hospitals Median	22.54%	17.06%	15.00%	15.14%	20.51%
National Median	22.70%	15.70%	17.40%	19.50%	19.00%

Trends for Cash Flow to Total Debt:
Median Cash Flow to Total Debt continued to increase in 2010 although values still remain under 2007. Northeast hospitals continue to have the lowest median cash flow to total debt of any region. This results from both lower profitability and higher indebtedness as compared with other regions.

Forecast:
Cash Flow to Total Debt should continue to have modest gains during the next few years.

Fixed Asset Financing: This ratio defines the proportion of net fixed assets (gross fixed assets less accumulated depreciation) financed with long-term debt. This ratio is used by lenders to provide an index of the security of the loan. Decreasing values are favorable. This ratio is calculated as follows:

Long Term Debt/Net Plant, Property & Equipment

Fixed Asset Financing	2007	2008	2009	2010	2011
EMMC	27.51%	26.08%	18.89%	38.29%	38.42%
Mercy	88.51%	57.10%	59.34%	62.04%	62.90%
All Maine Hospitals Median	49.49%	52.37%	54.22%	47.59%	46.06%
National Median	52.50%	60.30%	49.80%	48.20%	50.80%

Trends in Fixed Asset Financing:
Median values for the Fixed Asset Financing Ratio continued to decrease in 2010 after a five year 2008 high.

Forecast:
Fixed Asset Financing Ratios are expected to remain stable during the next five years as hospitals curtail their growth in new capital expenditures and reduce their reliance on long-term debt.

ASSET EFFICIENCY RATIOS

CONU used two asset efficiency ratios. These ratios measure the relationship between revenue and assets.

Total asset turnover ratio: Provides an index of the number of revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from a limited resource base and are sometimes viewed as a positive indication of efficiency. This ratio is affected by the age of the plant being used by the hospital. Increasing values are favorable. This ratio is calculated as follows:

Total Operating Revenue + Total non-operating Revenue/Total Unrestricted Assets

Total Asset Turnover	2007	2008	2009	2010	2011
EMMC	1.520	1.601	1.437	1.379	1.325
Mercy	0.802	0.793	0.978	0.880	0.979
All Maine Hospitals Median	1.170	1.200	1.230	1.210	1.210
National Median	1.080	1.080	1.070	1.050	1.070

Trends in Total Asset Turnover:

Total Asset Turnover values have remained generally constant over the past five years with a slight decline in 2010.

Forecast:
Total Asset Turnover should improve over the next five years.

Fixed Asset Turnover Ratio: Measures the number of revenue dollars generated per dollar of fixed asset investment. High values for this ratio may imply good generation of revenue from a limited fixed asset base and are usually regarded as a positive indication of operating efficiency. This ratio is calculated as follows:

Total Operating Revenue/Net Plant, Property, & Equipment

Fixed Asset Turnover	2007	2008	2009	2010	2011
EMMC	4.550	4.777	3.731	3.223	3.401
Mercy	1.855	1.453	1.643	1.636	1.820
All Maine Hospitals Median	2.900	2.780	2.720	2.630	2.960
National Median	NAV	NAV	NAV	NAV	NAV

Trends in Fixed Asset Turnover:
Fixed Asset Turnover is relatively unchanged in 2010, declining slightly.

Forecast:
Fixed Asset Turnover ratios should remain stable during most of the next few years.

CONU Summary of Financial Ratios:

CONU used data from the Maine Health Data Organization for 2007 through 2011 and data from the 2012 Almanac of Hospital Financial and Operating Indicators in order to compare measures of profitability, liquidity, capital structure and asset efficiency of EMMC and Mercy Hospital with Maine and National medians.

Percentage of Time Hospital Meets or Exceeds Maine and National Medians

MAINE MEASURE	RATIO	EMMC	Mercy
Profitability	Operating Margin	80.00%	0.00%
Profitability	Net Operating Income	100.00%	20.00%
Profitability	Return on Equity	40.00%	20.00%
Liquidity	Current Ratio	20.00%	0.00%
Liquidity	Days Cash on Hand	0.00%	20.00%
Liquidity	Avg. Payment Period	20.00%	100.00%
Capital Structure	Debt Service Coverage	100.00%	20.00%
Capital Structure	Cash Flow to Total Debt	80.00%	20.00%
Capital Structure	Fixed Asset Financing	0.00%	100.00%
Asset Efficiency	Total Asset Turnover	100.00%	0.00%
Asset Efficiency	Fixed Asset Turnover	100.00%	0.00%

NATIONAL MEASURE	RATIO	EMMC	Mercy
Profitability	Operating Margin	NAV	NAV
Profitability	Net Operating Income	NAV	NAV
Profitability	Return on Equity	60.00%	20.00%
Liquidity	Current Ratio	0.00%	0.00%
Liquidity	Days Cash on Hand	0.00%	20.00%
Liquidity	Avg. Payment Period	20.00%	100.00%
Capital Structure	Debt Service Coverage	100.00%	20.00%
Capital Structure	Cash Flow to Total Debt	40.00%	20.00%
Capital Structure	Fixed Asset Financing	0.00%	80.00%
Asset Efficiency	Total Asset Turnover	100.00%	0.00%
Asset Efficiency	Fixed Asset Turnover	NAV	NAV

NAV = Data not available

Mercy Hospital

Mercy Hospital has incurred operating losses for several years. This is the result of operating two campuses (State Street and Fore River), volume declines due to the recession and efforts by insurance companies, large employers and ACO's to reduce inpatient utilization, revenue cycle deficiencies and an investment in an ambulatory strategy beginning in 2007. Mercy lags State and National averages in measures of profitability, liquidity, capital structure and asset efficiency. The 2012 financial results indicate that Mercy Hospital improved its net revenue received from private payers and reduced charity care as a percentage of service while increasing gross charges by 7% for the year. This amounts to about a $12,000,000 improvement in operating revenue. At the same time operating expenses decreased by nearly $1,000,000. Mercy reported significant revenue improvement in the 9 month period of 2013. Mercy's annualized results for 2013 and projected revenues and expenses for 2014 and 2015 are consistent with improvements included in the 2012 results. As a result it appears likely that given current conditions and volumes, Mercy Hospital would experience losses no greater than 1-3 million dollars. These losses would be partially offset by other assets and earnings of approximately $1 million. As demonstrated through using EMMC, EMHS has the financial capacity to support Mercy. Clearly, ongoing plans to consolidate operations would improve the financial forecast for Mercy Hospital.

iii. Conclusion

CONU recommends that the Commissioner determine that the applicant has demonstrated that the project is economically feasible.

IV. Public Need

A. From Applicant

Needs of the Community
Mercy Hospital is a vital healthcare resource to the people of Cumberland County and the surrounding region. Mercy employs 1,832 people representing 1,386 full time equivalents and is a major economic driver in the Portland region. The hospital actively participates in key district health efforts to coordinate the right care with public needs. As an EMHS member, Mercy will directly benefit from EMHS' participation in the OneMaine Health Collaborative which includes EMHS, MaineGeneral Health, and MaineHealth. It is the intent of EMHS to utilize the Collaborative to advance health services planning and integration, following the tenets of the Triple Aim, in Mercy's market area. In addition, working together, OneMaine engaged Muskie and University of New England in 2010 to conduct a Community Health Needs Assessment (CHNA) study with a resulting extensive report that documents the health status, barriers to care, and other demographic and social issues affecting people and organizations throughout Maine.

The CHNA report assesses health status, barriers to care, and other demographic and social issues affecting people and organizations throughout Maine. OneMaine's CHNA identified the following key issues for Cumberland County (which represents Mercy's primary service population) including:

- Risk factors:
    - High Rate of chronic heavy drinking and binge drinking
- Disease Incidence & Prevalence:
    - Highest incidence rate for HIV of any Maine county
- Hospital Admissions:
    - High hospital rate for major depressive disorder, senility/organic mental disorders, substance/alcohol abuse, drug-related psychosis, and HIV/AIDS
- Emergency Department Visits:
    - High schizophrenia ED admission rate
- High acute alcohol-related mental disorders and major depressive disorders

Mercy participates as an active member of The Cumberland District Public Health Council (CDPHC) which represents the 26 municipalities of Cumberland County. Funding for CDPHC is provided by Maine Medical Center (MMC), Mercy Hospital, Maine CDC (via Health Maine

Partnership grant), among others. The CDPHC's 2012 Annual Report outlines the following as their community health priorities and initiatives:

- Tobacco abuse
- Cardiovascular health
- Physical activity, nutrition, & obesity
- Access to care (with a targeted focus on the Lakes Region)
- Mental Health and Substance Abuse

Mercy will continue to collaborate with local healthcare organizations to address community needs. Current collaborations are set forth in Table 15 of this application.

The proposed affiliation will enhance Mercy's efforts to meet the needs of the Portland region. For example, Mercy's specialized substance abuse treatment services at the Mercy Recovery Center provide programs and therapies clearly needed by the community by providing inpatient and nonresidential care, partial hospitalization, and ambulatory treatment programs. Acadia Hospital in Bangor provides inpatient psychiatry, child psychiatry, as well as an additional chemical dependency skill in their Cognitive Behavioral Pain program to augment Mercy's services. The Affiliation will facilitate more effective collaboration and the sharing of best practices between Mercy and Acadia. For example, the Affiliation will facilitate Acadia's ability to share its innovative tele-psych program, clinical information technology, and integrating behavioral health with primary care medical homes with Mercy, and Mercy can share its addiction medicine care expertise with Acadia.

Rationale for Mercy to Seek a New System Affiliation

In today's challenging economic environment, consumers, employers, and government are looking for ways to improve healthcare access and outcomes (quality) while lowering the costs. Although Mercy is already recognized as a low cost, high quality provider in Maine (per published comparisons by the Maine Health Management Coalition), this desirable position will be difficult, if not impossible, to maintain as the cost of operations inevitably continue to rise (e.g., in salaries, physician recruitment, supplies, equipment, insurance, bad debt, charity care, etc.). Hospitals affiliate with health systems to take advantage of scale and scope. In this situation, CHE and Mercy determined together that Mercy would benefit from identifying an affiliation with a Maine-based healthcare system.

Mercy is a lower cost, high quality provider, with a history of consistently seeking out and implementing the best practices and searching for ways to reduce both fixed and variable costs. As part of its efforts to improve financial performance, Mercy worked with CHE to deliver services in an efficient manner. However, Mercy's leadership (with the agreement of CHE) concluded that the CHE system is generating certain unavoidable costs that are difficult to reduce or eliminate as long as that relationship is maintained. Moreover, Mercy is not able to

implement certain CHE cost saving initiatives in a manner paralleling other CHE member hospital systems that service more densely populated urban markets. For example, 1) quality systems and metrics for CHE covered a multi-state panorama, making straight line comparisons difficult. Therefore, this issue has caused Mercy to collect data beyond local needs and without meeting reporting requirements relevant to Maine (e.g., Maine DHHS, the QIO i.e. the Northeast Healthcare Quality Foundation, or the Maine Health Management Coalition.) 2) IT systems are largely run in Philadelphia generating travel costs, connectivity, and duplicative systems. At the same time, local priority projects e.g. an EMR, MaineCare/local payer formularies, and Maine Health Information Exchanges were lower priorities for a system with larger facilities in other states. 3) Mercy has had to manage Maine-specific programs on its own, since many laws, regulations, programs are state specific. In addition, CHE cannot provide the local synergy critical in supporting population health and ACO development given the disparate geographic distribution of its member hospital systems across the Atlantic seaboard (with the closest hospital CHE member to Mercy being located in Western Massachusetts). As will be set forth more specifically herein, it would be prohibitively expensive for Mercy to develop these population health and ACO initiatives on its own.

Figure 4: EMHS/Mercy Affiliation

Being part of EMHS, a Maine based, local system will create synergies, improve economies of scale, simplify the work and enhance Mercy's ability to focus on Maine-specific goals. By becoming part of the EMHS family, Mercy and the community it serves can benefit from

(1) cost savings related to scale,

(2) infrastructure necessary for population health management which will enable Mercy to offer local (connected to statewide) choice regarding an entire care system and **(**3)

complementary coordinated services such as behavioral and substance abuse services as discussed elsewhere in this application.

Mercy takes pride in its low cost, high quality value proposition to patients, employers and payers. Mercy recognizes the need to continue to be competitive as a member of EMHS in the communities it serves with respect to price, quality and service.

Rationale for EMHS to affiliate with Mercy

EMHS vision for 2020 is to be a national model for healthcare delivery. This includes transforming the full spectrum of care delivery systems with a defined goal of providing the "right care at the right time in the right place." As a strategic initiative, EMHS' goal is to reduce total cost for patients and payers by accepting accountability for costs and quality, including the patient's experience. Additionally, as the largest system in northern and eastern Maine, EMHS strives to serve as the backbone for sustainable, locally distributed care delivery as referring hospitals come under increasing economic pressure in the national healthcare reform market.

The EMHS response to these market dynamics is to develop a range of strategic partnership options for collaborating. Partnership models include clinical relationships, accountable care arrangements, medical transport, purchasing cooperation, comprehensive population health management, as well as a path to full corporate membership. For example, a significant number of the non-EMHS hospitals and Federally Qualified Health Centers are aligning with EMHS to participate in EMHS' value based population initiatives. Nearly every hospital in the EMHS region has one or more tele-medical support systems connected 24 hours a day and 7 days a week to EMHS. Most rural emergency departments have tele-trauma systems connected to the surgical trauma and pediatric intensivists at EMHS for real time consultation. Many of these rural hospitals maintain small intensive care units through video and biometric connections to the EMHS tele-ICU monitoring systems, "Critical Care Connections". Most of these rural hospitals are connected to EMHS Picture Archiving and Communication System ("PACS") radiology imaging system supporting state-of-the-art consultations. Nearly all of the rural hospitals and Federally Qualified Health Centers (FQHC) have remote access to EMHS inpatient electronic medical records so that they can review the status of patients transferred to an EMHS hospital.

EMHS' goal is to be a regional system for clinically integrated and distributed specialty care providers. As such, EMHS member organizations would collectively serve as the regional core for these clinically integrated and locally distributed service lines. EMHS ambulatory strategy will ensure that every community served will have access to specialty and primary care services that otherwise would not be available in communities with standalone small hospitals. Through

partnerships and/or by stepping in to ensure access to ambulatory services, EMHS is committed to improving the sustainability of healthcare.

The Mercy affiliation will allow EMHS to continue its commitment of collaboration with healthcare providers across Maine. Mercy has developed a very strong local care network that connects patients to needed services. Linking EMHS and Mercy will create a level of collaborations that is not possible without this affiliation. Mercy is joining EMHS as a full corporate member; this will allow for a more efficient combining of infrastructures into a single care delivery platform which capitalizes on shared learning and economies of scale. Together in one system, EMHS and Mercy can pool resources, share expertise, knowledge, and relationships necessary for effective care coordination across Maine.

EMHS recognizes Mercy as an excellent affiliation partner with a similar mission driven culture, a strong primary care network needed for population health management and a leadership team who will add to EMHS' expertise. EMHS works with member organizations to improve quality, service and cost effectiveness. Best practices are shared within the system and incorporated into standard system-wide processes.

Mercy will support EMHS' strategy to develop a stronger ambulatory care system with its strong and growing provider network. Mercy's 114 employed physicians and additional nurse practitioners, physician assistants, behavioral health experts, and other clinicians will be welcome participants in efforts towards value-based consumer directed plan designs and delivery models for commercial and government insured populations.

The proposed affiliation will strengthen EMHS' corporate infrastructure by dispersing administrative costs over a larger system thereby, reducing overhead costs for other EMHS members. This will result in more cost effective and streamlined services throughout the EMHS system.

As EMHS develops a care model that succeeds under risk sharing, population health payment models, Mercy's attributed patients will provide additional numbers needed to support the growing Pioneer ACO demonstration sites and the infrastructure needed to improve health.
Accountable Care and Population Health
EMHS is proud to be one of only 32 organizations across the United States invited to become a Pioneer Accountable Care Organization (ACO) through a demonstration project administered by the Centers for Medicare and Medicaid Innovation (CMMI). EMHS has been a participant in the Medicare Pioneer shared risk demonstration since January 1, 2012. During year 1, CMS limited

the program to PPS hospitals; in year 2, critical access hospitals and FQHCs were added to the model. In year 1, approximately half of the 32 Pioneer ACOs are achieving shared savings; EMHS has calculated 2.5%+ in savings. EMHS has enlisted Geisinger Health System of Pennsylvania to partner in implementing healthcare innovations that result in improved quality and value. Geisinger Health System and Geisinger Health Plan, the insurance component of the system, are viewed across the country as a model for ACO design and primary care excellence, and EMHS is confident that the partnership will yield positive results for Maine citizens.

Mercy will participate in EMHS' ACO. In addition to benefiting the residents of the Mercy Service Area, Mercy's participation broadens the base and benefits for those already participating in the ACO and living in northern, central, and eastern Maine. Mercy has a strong primary care network and ambulatory health information system, both of which are integral to success under population health payment. Mercy's primary care network provides services to over 27,000 active patients currently. These will be added to the 170,000 covered lives cared for by the existing accountable care network.

EMHS and Mercy recognize the value in adding covered lives to a shared accountable care strategy. Some reasons to partner in ACOs are:

Benefits of Increased Number of Covered Lives

There are substantial quality and financial incentives for increasing the number of assigned beneficiaries. The proposed affiliation will facilitate that outcome. While it is possible for Mercy to join the EMHS ACO without affiliating, affiliation has the substantial advantage of promoting a closer, more coordinated relationship between the parties and provides EMHS with the ability to resource the readiness and start-up of Mercy's ACO efforts.

Medicare Pioneer Demonstration: A Statewide Population Management Network

The Medicare Pioneer Program provides substantial public benefits. It requires ACOs to: (a) be accountable for Medicare beneficiaries, (b) improve the coordination of fee-for-service items and services, and (c) invest in infrastructure and redesigned care processes that promote high quality, efficient service delivery, and "demonstrate a dedication and focus toward patient centered care." Participating ACOs, like EMHS, will, in turn, have an opportunity to earn shared savings payments by reducing Medicare expenditure growth for their assigned beneficiaries below specified targets while at the same time meeting quality performance measures.

Accountable Care beyond Medicare

EMHS' ACO, Beacon Health LLC, has been developed to contract for risk based arrangements with employers, payers, and other governmental agencies, such as MaineCare. This unique organization with a strong management team is partnering not only with EMHS members but with other regional hospitals and Federally Qualified Health Centers to bring a focus on population health to communities throughout Maine.

Mercy Service Areas and Market Overview

For analysis purposes, the Mercy Primary Service Area (PSA) is defined to include sufficient contiguous zip codes to capture 80% of Mercy Hospital's admissions. These zip codes represent 25 cities and towns in the Portland Area. A Secondary Service Area (SSA) was defined to represent an additional 10% of Mercy's admissions. These zip codes include 34 towns adjacent to the PSA. See Figure 5. The Maine Health Data Organization 2011 hospital inpatient dataset was used to develop these definitions.

Figure 5: Mercy Primary and Secondary Service Areas

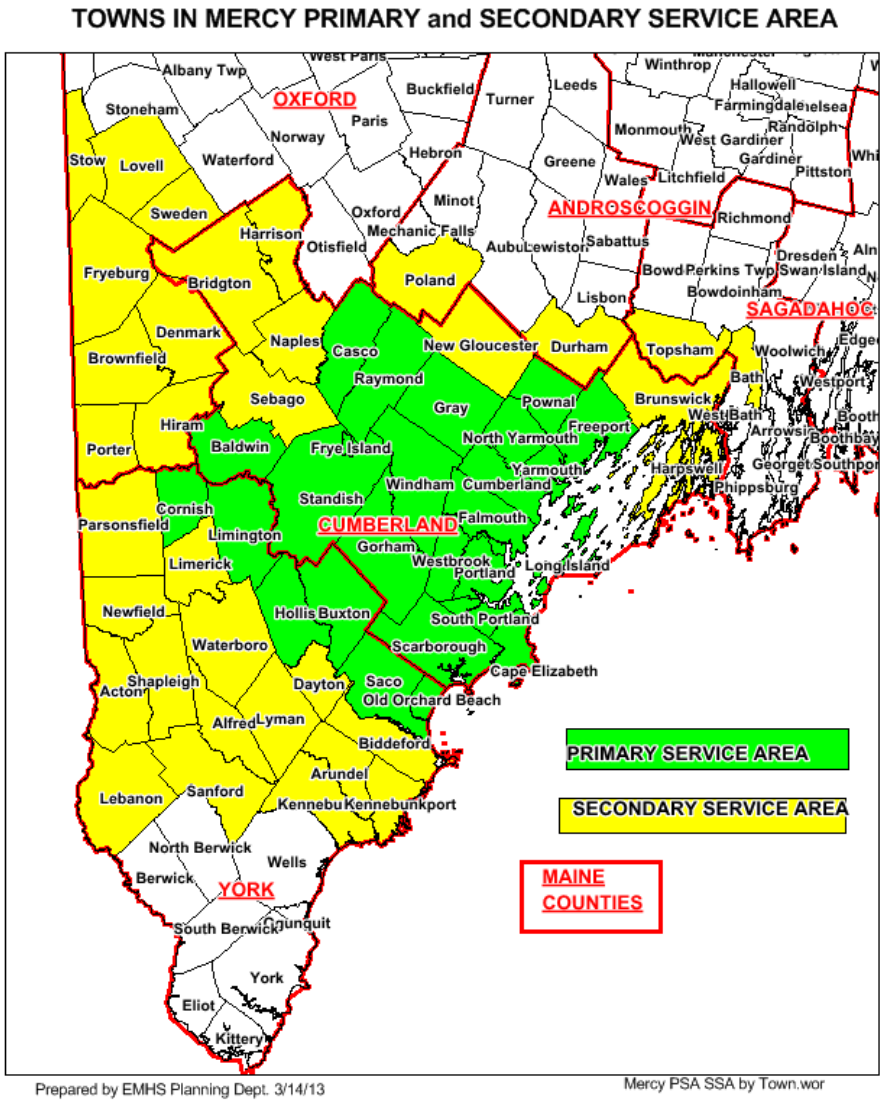


Table 4 provides more detail regarding the origin of Mercy's admissions.

Table 4: Mercy Hospital Patient Origin by Town: FY 2011 Admissions

Primary Service Area PSA)

City/Town	Admit	% Total	City/Town	Admit	% Total
Portland	2,173	28.3%	Gray	134	1.7%
South Portland	593	7.7%	Cumberland	110	1.4%
Westbrook	397	5.2%	Hollis	62	0.8%
Windham	365	4.8%	Limington	64	0.8%
Scarborough	227	3.0%	Casco	66	0.9%
Gorham	427	5.6%	Freeport	67	0.9%
Buxton	181	2.4%	Raymond	53	0.7%
Falmouth	143	1.9%	North Yarmouth	58	0.8%
Saco	148	1.9%	Cornish	20	0.3%
Standish	207	2.7%	Baldwin	28	0.4%
Old Orchard Beach	108	1.4%	Pownal	11	0.1%
Cape Elizabeth	119	1.6%	Long Island	2	0.0%
Yarmouth	151	2.0%	**PSA Total**	**5,914**	**77.0%**

Secondary Service Area (SSA)

City/Town	Admit	% Total	City/Town	Admit	% Total
Biddeford	155	2.0%	Porter	23	0.3%
Brunswick	68	0.9%	Hiram	15	0.2%
Sanford	88	1.1%	Harrison	6	0.1%
Kennebunk	62	0.8%	Arundel	10	0.1%
Bridgton	16	0.2%	Acton	5	0.1%
Naples	36	0.5%	Fryeburg	12	0.2%
Sebago	25	0.3%	Harpswell	16	0.2%
New Gloucester	32	0.4%	Dayton	8	0.1%
Waterboro	49	0.6%	Lyman	11	0.1%
Bath	32	0.4%	Newfield	11	0.1%
Kennebunkport	18	0.2%	Shapleigh	6	0.1%
Topsham	19	0.2%	Denmark	6	0.1%
Limerick	24	0.3%	Brownfield	7	0.1%
Durham	17	0.2%	Lebanon	12	0.2%
Parsonsfield	27	0.4%	Lovell	1	0.0%
Alfred	19	0.2%	Stow	1	0.0%
Poland	12	0.2%	Sweden	0	0.0%
			SSA Total	**849**	**11.1%**

Other Admit	**914**	**11.9%**	**Mercy Total**	**7,677**	**100%**

Compiled from EMHS copy of MHDO database.

Socioeconomic and Market Share Information for the Service Area

Population and Age Characteristics

Mercy Hospital serves the Greater Portland region. As noted in Table 5 below, population in the southern regions of the state are expected to grow even as population remains flat in the State overall. Consistent with other areas in the State, the population of residents age 65+ is expected to grow most rapidly over the next five years while the numbers of younger residents are expected to decline.

Table 5: Mercy Hospital Service Area Population Trends to 2018

Geographic Areas	2000 Census	2013 Estimated	% change 2000-2013	2018 Projected	% change 2013-2018
Mercy Primary Service Area					
Age 0-17	59,092	56,835	-3.8%	55,120	-3.0%
Age 18-44	114,702	107,977	-5.9%	103,655	-4.0%
Age 45-64	55,186	78,482	42.2%	81,011	3.2%
Age 65 and over	28,325	34,517	21.9%	40,000	15.9%
Total Primary	**257,305**	**277,811**	**8.0%**	**279,786**	**0.7%**
Median Age	37.4	41.1	9.9%	42.5	3.4%
Mercy Secondary Service Area					
Age 0-17	42,681	37,553	-12.0%	36,615	-2.5%
Age 18-44	63,846	56,986	-10.7%	56,235	-1.3%
Age 45-64	40,983	55,708	35.9%	53,864	-3.3%
Age 65 and over	23,486	30,621	30.4%	35,311	15.3%
Total Secondary	**170,996**	**180,868**	**5.8%**	**182,025**	**0.6%**
Median Age	37.7	43.1	14.3%	44.1	2.3%
Total PSA + SSA	**428,301**	**458,679**	**7.1%**	**461,811**	**0.7%**
Maine					
Age 0-17	301,240	268,614	-10.8%	260,420	-3.1%
Age 18-44	474,487	423,204	-10.8%	412,133	-2.6%
Age 45-64	315,803	408,193	29.3%	392,156	-3.9%
Age 65 and over	183,387	227,353	24.0%	258,777	13.8%
Total Maine	1,274,917	1,327,364	4.1%	1,323,486	-0.3%

Source: Claritas, Inc.

Cumberland County continues to have the lowest unemployment rate in Maine. The Maine Bureau of Labor reported the February unemployment rate for Cumberland County was 6.3% and 8.2% for Maine (not seasonally adjusted).

As shown in Table 6, the area served by Mercy has a higher 2013 estimated household income than the average Maine household. The service area is projected to continue to have a relatively higher household income through 2018 than Maine as a whole.

Table 6: Mercy Hospital Service Area Income Trends to 2018

Geographic Areas	2000 Census	2013 Estimated	% change 2000-2013	2018 Projected	% change 2013-2018
Mercy Primary Service Area					
Population	257,305	277,811	8.0%	279,786	0.7%
Households	101,869	111,922	9.9%	113,346	1.3%
Average household income	$ 57,154	$ 73,710	29.0%	$ 80,511	9.2%
Median household income	$ 44,822	$ 56,577	26.2%	$ 60,516	7.0%
% Households with income < $15,000	13.79%	11.13%		10.09%	
Mercy Secondary Service Area					
Population	170,996	180,868	5.8%	182,025	0.6%
Households	67,487	74,540	10.5%	75,474	1.3%
Average household income	$ 49,850	$ 63,101	26.6%	$ 65,884	4.4%
Median household income	$ 40,877	$ 51,159	25.2%	$ 52,910	3.4%
% Households with income < $15,000	14.53%	12.07%		11.52%	
Maine					
Population	1,274,917	1,327,364	4.1%	1,323,486	-0.3%
Households	518,196	560,006	8.1%	561,734	0.3%
Average household income	$ 47,358	$ 60,539	27.8%	$ 64,433	6.4%
Median household income	$ 37,602	$ 46,680	24.1%	$ 48,648	4.2%
% Households with income < $15,000	17.84%	13.94%		13.00%	-6.7%
United States					
Average household income	$ 56,644	$ 69,637	22.9%	$ 71,917	3.3%
Median household income	$ 42,728	$ 49,297	15.4%	$ 49,815	1.1%
% Households with income < $15,000	15.85%	13.81%		13.70%	

Source: Claritas, Inc.

The service area for Mercy will not change with this affiliation. Non-Mercy Providers in the service areas will see little if any impact from this affiliation.

As shown in Tables 9 and 10 below, Mercy has a 23% historical inpatient market share of the PSA and 5% of the SSA.

Table 9: Mercy Primary Service Area Admissions and Historical Market Share

Mercy Primary Service Area (1)	Admissions		Market Share	
	2010	**2011**	**2010**	**2011**
Mercy Hospital	5,924	5,600	23.2%	22.5%
Maine Medical Center	14,452	13,985	56.5%	56.2%
EMHS Hospitals (2)	90	90	0.4%	0.4%
MaineHealth, excluding MMC (3)	3,985	4,093	15.6%	16.4%
Others	1,121	1,130	4.4%	4.5%
Total Admissions	**25,572**	**24,898**	**100%**	**100%**
EMHS w/Mercy	6,014	5,690	23.5%	22.9%
MaineHealth	18,437	18,078	72.1%	72.6%

(1) See region in Figure 5 map above.

(2) Includes EMHS hospitals: Eastern Maine Medical Center, Acadia Hospital, Charles A. Dean, Blue Hill Memorial Hospital, Inland Hospital, The Aroostook Medical Center, Sebasticook Valley Health

(3) Includes MaineHealth members with exception of MMC, including Miles Memorial, Pen Bay Medical Center, St. Andrews Hospital, Southern Maine Medical Center, Waldo County General Hospital, HealthSouth and Spring Harbor.

Source: MHDO Inpatient Database

Table 10: Mercy Secondary Service Area Admissions and Market Share

Mercy Secondary Service Area (1)	Admissions FY2010	Admissions FY2011	Market Share FY2010	Market Share FY2011
Mercy Hospital	887	844	5.1%	4.9%
Maine Medical Center	4,028	3,977	23.2%	23.0%
EMHS Hospitals (2)	95	114	0.5%	0.7%
MaineHealth, excluding MMC (3)	6.220	6,249	35.8%	36.1%
Others	6,123	6,107	35.3%	35.3%
Total Admissions	**17,353**	**17,291**	**100%**	**100%**
EMHS w/Mercy	982	958	5.7%	5.5%
MaineHealth	10,248	10,226	59.1%	59.1%

(1) See region in Figure 5 map above.

(2) Includes EMHS hospitals: Eastern Maine Medical Center, Acadia Hospital, Charles A. Dean, Blue Hill Memorial Hospital, Inland Hospital, The Aroostook Medical Center, Sebasticook Valley Health

(3) Includes MaineHealth members with exception of MMC, including Miles Memorial, Pen Bay Medical Center, St. Andrews Hospital, Southern Maine Medical Center, Waldo County General Hospital, HealthSouth and Spring Harbor.

Source: MHDO Inpt Database

Table 11: Hospitals in Mercy Service Area with distance from Mercy Hospital

Mercy Service Area	Hospital	Location	Distance from Mercy Fore River Campus (Miles)
Primary	Maine Medical Center	Portland	0.7
Primary	New England Rehab Hospital	Portland	1.7
Primary	Spring Harbor Hospital	Portland	4.0
Secondary	Southern Maine Medical Center	Biddeford	18
Secondary	Parkview Adventist Medical Center	Brunswick	26.1
Secondary	Mid Coast Hospital	Brunswick	26.4
Secondary	Goodall Hospital	Sanford	32.5
Secondary	Bridgton Hospital	Bridgton	39.8

The EMHS and Mercy affiliation is anticipated to have little impact on the market share of Hospital Service Areas between Bangor and Portland as shown in Table 12:

Table 12: Historical Market Share of Selected Hospital Service Areas- FY2011

ADULT PED ADMISSIONS and MARKET SHARE for SELECTED HOSPITAL SERVICE AREAS							
Hospital Service Area	**Total Admissions**	**EMHS w/o Mercy**		**Mercy**		**EMHS w/Mercy**	
		Admits	**% Share**	**Admits**	**% Share**	**Admits**	**% Share**
Waterville	7,880	1,794	22.8%	36	0.5%	1,830	23.2%
Augusta	7,069	178	2.5%	90	1.3%	268	3.8%
Farmington	3,708	54	1.5%	40	1.1%	94	2.5%
Rockland	6,008	215	3.6%	48	0.8%	263	4.4%
Portland	24,355	77	0.3%	5,832	23.9%	5,909	24.3%
Maine Total	145,278	25,986	17.9%	7,677	5.3%	33,663	23.2%
Source: compiled from Maine Health Data Organization hospital inpatient database							

Mercy provides much more than just inpatient services. Forecasts of patient volume in developing the financial forecasting study reflect little change in Mercy's inpatient volume with little change, up or down, compared to ED, outpatient surgery and other outpatient visits, which are projected to growing steadily.

The following table sets forth a summary of historical utilization data for Mercy Hospital for calendar years 2010 through 2012. As shown, Mercy provides significant range and volume of services to Portland region residents.

Table 13: Mercy Historical Inpatient and Outpatient Volume

	CY 2010	CY 2011	CY 2012
Inpatient Routine Services Statistics			
Available Beds (Adult/Ped)	157	148	148
Adult & Pediatric Days	30,484	29,390	26,502
Adult & Pediatric Admissions	7,881	7,714	7,517
Average Length of Stay	3.9	3.8	3.5
Births	961	787	866
Nursery Days	2,145	1,838	2,032
Medicare Case Mix Index	1.42	1.49	1.56
Ancillary Statistics – Inpt. and Outpt.	**CY 2010**	**CY 2011**	**CY 2012**
Visits:			
Emergency Department	28,617	28,124	27,020
OB Specialty Clinics	1,004	740	99
Physician Practices (2)	158,552	181,951	223,548
Rehab Therapies	94,800	100,598	108,349
Procedures and Tests			
Endoscopy	1,815	1,304	1,006
Surgery cases	8,255	9,159	9,017
Laboratory Tests	538,377	610,484	583,002
Imaging procedures:			
Diagnostic	52,163	54,285	52,162
Interventional	2,666	2,893	3,167
Nuclear Medicine	1,532	1,414	1,387
Ultrasound	13,611	13,851	13,593
MRI	4,214	3,381	3,340
CT Scan	13,245	9,884	9,278
Total Imaging	87,431	85,708	82,927
Cardiac Catheterization Lab	1,887	606	550

Source: Mercy Hospital internal data

Volume Projections

The projected volume used as a basis of the financial forecasts included in Attachment F are based on analysis of Mercy's service area demographics and do not assume changes in market share due to the proposed affiliation. Due to population based health management initiatives and

increased membership in ACOs in the region, inpatient use rates by age group are projected to decline. This decrease will be offset by the maturing of physician practices that have recently become part of Mercy. This will result in a small increase in inpatient admissions to Mercy averaging 1% per year through 2018. Mercy is also projecting small increases outpatient services including emergency department visits, outpatient surgery and other outpatient visits. These are reflected in Table 14 below. The increase in the proportion of the population over age 65 will increase the proportion of Medicare patients. This change in payor mix is included in Attachment G

Maine Medical Center and Mercy provide many similar services and also have services unique to their missions, expertise and experience. Maine Medical Center is a statewide referral center for burns, kidney transplants, pediatric cardiac surgery and other subspecialties. Mercy's Recovery Center provides substance abuse services unique to the Portland region. Mercy is not anticipating adding new services as a result of the proposed affiliation.

Table 14: Mercy Inpatient and Outpatient Volume Projections

	Budgeted	Forecasted				
Inpatient Admissions	2013	2014	2015	2016	2017	2018
Cardiac Services	460	470	475	483	490	496
Gastroenterology	401	455	485	512	566	585
General Medicine	454	446	436	422	398	386
Gerneral Surgery	414	461	487	510	528	539
Gynecology	78	80	81	82	82	83
Mental Health	2,049	2,050	2,057	2,072	2,097	2,117
Obstetrics	925	938	946	954	964	973
Orthopedics	1,075	1,099	1,111	1,119	1,132	1,143
Other Surgery	79	99	137	159	173	186
Pulmononlogy	429	431	434	439	446	451
Spine	292	336	371	408	439	451
Urology	140	143	145	146	147	148
Thoracic	200	271	299	307	315	328
All other	521	406	318	235	135	52
Total Admissions	7,517	7,685	7,783	7,847	7,914	7,938
Emergency Room Visits	27,268	27,370	27,507	27,644	27,782	27,921
Other Visits/Registrations	390,100	403,980	406,284	405,973	406,611	406,559
Total Outpatient Surgeries	7,181	7,514	7,744	7,905	8,071	8,229
Physician Visits	245,141	256,470	261,270	261,918	262,329	262,296
VNA Visits	73,334	74,430	75,919	77,437	78,986	80,565
Yearly Percent Change		2014	2015	2016	2017	2018
Total Admissions		2.2%	1.3%	0.8%	0.9%	0.3%
Emergency Room Visits		0.4%	0.5%	0.5%	0.5%	0.5%
Other Visits/Registrations		3.6%	0.6%	-0.1%	0.2%	0.0%
Total Outpatient Surgeries		4.6%	3.1%	2.1%	2.1%	2.0%
Physician Visits		4.6%	1.9%	0.2%	0.2%	0.0%
VNA Visits		1.5%	2.0%	2.0%	2.0%	2.0%

EMHS Member Hospital Service Area in Relation to Mercy Service Area

EMHS traditionally serves northern, eastern, and central Maine with no market overlap of Mercy's service area.

The affiliation will not adversely affect competition or have any significant effect on other providers in Greater Portland. The affiliation may draw some Portland region patients to Mercy based on the EMHS brand enhancement or as a result of participating in the ACO. The primary purpose of the Affiliation is to lower costs and improve quality and access to care.

Maine Medical Center's defined service area is larger than Mercy's. For many services MMC defines its total service area as the State of Maine. Some services are more local; 80% of MMC's emergency visits are from the Portland Hospital Service Area. As discussed in MMC's

2007 CON application for emergency department expansion, both Mercy's and MMC's Emergency Departments are needed to serve the needs of the residents of the Portland region.

Summary of Public Need

The needs of the community will be met in many ways from the Affiliation. EMHS will strengthen Mercy's current role as a community based care provider (thus keeping costs low, preserving local choice, and enhancing the patient centered medical home model in primary care); this support includes access to affordable capital to eventually complete Mercy's Fore River facility and results in lower costs of operation. Access to EMHS ACO infrastructure will create a population health based system and a care delivery choice for consumers.

The Affiliation will ensure that Mercy remains a high quality, low cost provider. Mercy will benefit from the cost savings related to economies of scale and continue to be a low cost provider to the community. The projected savings are included in the financial analysis module included within this application.

The Mercy service area will not change as a result of the Affiliation. Mercy's 23% market share of inpatient admissions from its Primary Service Area and 5% share of its Secondary Service Area will not change materially.

Participation in EMHS quality improvement programs will allow Mercy to work with its new colleagues on continuous improvement, care integration and benchmarked results among EMHS hospitals.

In summary, the affiliation will improve quality outcomes, address identified community needs, engage Mercy providers in the accountable care transformation of service delivery and payment models while maintaining consumer choice in the Portland region.

B. CONU Discussion

i. CON Standard

The relevant standard 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:

- 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;
- Whether the project will have a positive impact on the health status indicators of the population to be served;
- Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
- Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

ii. **CON Analysis**

In order to determine if there is a public need for the proposed transfer of ownership CONU analyzed the strategic vision of both EMHS and Mercy.

EMHS:

EMHS is a participant in the OneMaine Health Collaborative which includes EMHS, MaineGeneral Health and MaineHealth. The purpose of the OneMaine Health Collaborative is to advance health services planning and integration following the tenets of the Triple Aim which is described below.

Both the healthcare industry and consumers recognize that healthcare costs are growing at an unsustainable pace. Healthcare costs in the U.S. are higher than other countries and result in poorer overall population health. The Institute for Healthcare Improvement (IHI) developed the "Triple Aim" approach which has three crucial objectives:

1. Improve the health of the defined population

2. Enhance the patient care experience (including quality, access and reliability).
3. Reduce, or at least control, the per capita cost of care.

Some methods of accomplishing the Triple Aim include:

1. A focus on individuals and families
2. Redesign of primary care services and structures
3. Population health management
4. A cost-control platform
5. System integration and execution

The OneMaine Health Collaborative sponsored a report entitled Community Health Needs Assessment 2010 . The report identifies health status, barriers to care, and other demographic and social issues affecting Maine healthcare consumers. Among the relevant findings:

Access to care as measured by several health use indicators is a significant issue in most of the state. Maine residents as a whole and in many counties have high rates of emergency department (ED) and preventable hospitalizations. The 2010 CHNA data provides a disturbing view of high ED and hospital use by patients with symptoms and conditions that could be prevented or controlled with care provided in primary care settings.

Access to, and availability of, high quality primary care, especially for those with chronic health conditions, is a continuing challenge in Maine. This is an issue in many Maine counties and may be due to inadequate availability of providers, lack of health insurance, or lack of patient self- management, among other patient, health system or population issues.

Care for Chronic Conditions: Approximately 90 million Americans are living with at least one chronic disease which contributes to over 70% of deaths in the U.S. each year. Despite the relatively low cost and proven effectiveness of treatments for these common and preventable – but potentially deadly – conditions, many Americans are not getting better. Changes need to address core competencies around how to deliver patient centered care; how to partner with patients, providers and the community; and how to improve medication management and adherence. Use of community care teams that include patients in treatment decisions, and continued quality improvement using evidenced based guidelines, coupled with changes in reimbursement policies may be required.

Substance Abuse and Mental health Services: Mental health problems affect a large portion of Maine's population, and are frequently seen in populations with physical health issues and substance abuse (SA) problems. In order to address these issues a broad based, collaborative prevention programs at the community level need to be implemented. Primary care providers (PCPs) and ED providers need education programs related to substance abuse diagnosis, treatment tools, and protocols. Strategies should be implemented to coordinate the delivery of substance abuse services at the local level. Access to expanded referral and consultative resources for PCP's needs to be provided.

EMHS envisions transforming the full spectrum of care delivery systems with a defined goal of providing the "right care at the right time in the right place". EMHS has a goal of reducing total cost for patients and payers and being a leader and driving force in establishing sustainable, locally distributed care delivery.

Patient Centered Medical Home (PCMH)

This care model transforms the organization and delivery of primary care . The medical home has five characteristics:

1. Comprehensive Care – The PCMH is accountable for meeting a large majority of each patients health care needs.

2. Coordinated Care – care across the health care spectrum is carefully coordinated

3. Patient Focused – provides primary health care that is relationship-focused with an orientation toward the whole person.

4. Accessible Services – delivers accessible services with shorter waiting times for urgent needs.

5. Quality and Safety – demonstrates a commitment to quality and quality improvement

Mercy

Mercy's mission is to provide high quality and low cost healthcare. Mercy has implemented a community based care model with the goal of improving access to care. During the past five years Mercy has expanded its ambulatory services into the community. Primary care practices exist in Portland, Falmouth, Gorham, Standish, Westbrook, West Falmouth, Windham and Yarmouth.

Four of these locations have express care services. Opening these services has allowed consumers to receive quality care close to home. Mercy also has a number of multi-specialty physician practices providing both inpatient and outpatient care in several communities in greater Portland. Mercy participates in key district health efforts to coordinate the right care with public need. (Mercy is an active member of the Cumberland District Public Health Council which represents the 26 municipalities of Cumberland County). Please refer to Table 15 of this application for a detailed description of Mercy's collaborations.

Mercy provides a broad range and volume of health care services including inpatient and outpatient diagnostic and therapeutic services including: medical, surgical, oncological, obstetrical, physical rehabilitation, imaging, laboratory, eating disorders, drug and alcohol detoxification and treatments services, and home care/hospice services. Mercy has three hospital

campuses with a total of 230 beds. Mercy's 2011 occupancy rate of 85.6% was significantly higher than the national average rate of 66%. Mercy's primary service area includes the 25 cities and towns in the Portland area. Mercy currently has a 23% market share of inpatient services in the Portland area and is one of the State's largest employers.

Both EMHS and Mercy recognize the importance of easily accessible primary care located in local communities to address specific health problems identified in the Cumberland District Public Health Council 2012 annual report and the Community Health Needs Assessment 2010. Having access to care is critical to reducing high rates of emergency department usage and preventable hospitalizations. Mercy has a strong local care network connecting patients to needed services. Joining EMHS will create an opportunity for collaboration that is not possible without this affiliation. EMHS and Mercy can pool resources in order to coordinate care across the State of Maine. This affiliation will improve quality outcomes, address identified community needs and will have a positive impact on the health status indicators of the both Mercy's and EMHS's primary service areas. Mercy Hospital's service area will continue to be the Greater Portland region. Expansion of their primary care services has increased access to all residents of this area. Mercy's service area and its 23% historical inpatient market share is not expected to change due to this affiliation. This affiliation will allow Mercy to work with EMHS to achieve continued improvement, care integration and benchmarked results. This will provide demonstrable improvements in quality and outcome measures for Maine residents.

Both Mercy and EMHS have demonstrated a commitment to identifying and addressing the health needs in the service area. The ongoing commitment to bring in additional medical practitioners has been demonstrated financially. The impact of health from the additional primary and secondary services available will not be demonstrable for some time. Medical research and the ACA indicate that greater access to care improves patient health. Of one concern in the financial review however was the prediction of lower free care expenditures. The applicant and Mercy Hospital were asked to address this issue in light of the standard of review in this section. This part of the standard is whether the services affected by the project will be accessible to all residents of the area proposed to be served. In their response to concerns discussed at the per-release technical assistance meeting, the applicant expressed that while their free-care policies were similar there was an expectation that at some time in the future that Mercy Hospital would eventually conform with the EMHS charity care guidelines. This however does not alleviate the responsibilities of Mercy Hospital under EMTALA or state mandated free-care. The applicant in a response to the pre-release technical assistance meeting argued that Free Care policies are not part of the consideration or purview of CON. In light of the requirement to review the accessibility of services for all members of the community it can be argued that the ability or impetus to change the free care policy at Mercy hospital may restrict access to the services in the CON. Accordingly, CONU recommends that the following condition be included:

For the three years following commencement of the CON, Mercy hospital will need to notify the Division of Licensing and Regulatory Services of any proposed change to the Free Care policy or Charity Care policy of the Hospital no less than 90 days before the proposed change is to go into effect.

iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to show that there is a public need for the proposed project in conjunction with the recommended condition..

V. Orderly and Economic Development

A. From Applicant

Benefits of Mercy and EMHS Affiliation
As the result of an extensive strategic planning process, Mercy determined to affiliate with EMHS in order to facilitate improved access to capital, gain information technology expertise, and create the scale needed to be successful under population health and value-based payment systems. Initially, Mercy's strategic partnership initiative identified five primary goals in pursuing an affiliation in order to position Mercy for longer term success in a dynamically changing healthcare environment:

- Establishing infrastructure for delivering accountable care
- Right–sizing care delivery network/continuum
- Growing covered patient population
- Increasing scale to improve operating efficiency
- Gaining access to capital

Mercy concluded that, properly structured, forming a strategic partnership would enable Mercy to:

- Achieve greater scale, consolidate activities, and improve operational efficiencies
- Improve cost management of specialty care
- Offer a value network product
- 0Engage in risk sharing for value based pricing for covered population
- Develop medical homes
- Form a clinically integrated network (CIN)
- Enhance primary care network
- Develop accountable care competencies with respect to:
    - Infrastructure
    - Fully integrated clinical IT
    - Care management

Mercy conducted an extensive, highly competitive process, reviewing possible affiliation candidates. Mercy chose to partner with EMHS because EMHS was the choice that best enabled Mercy to achieve the goals identified during its strategic planning process. Additionally, there is a cultural congruity between both organizations' commitment to designing the healthcare of the

future – keeping populations healthy, rather than focusing primarily on the treatment of patients after they become ill. EMHS supports the continuation of Mercy's mission, its identity as a Catholic healthcare system and its commitment to charity care. Both organizations share a strong commitment to treating all patients with compassion and respect.

EMHS and the community it serves will also benefit from the Affiliation. EMHS will benefit from its new relationship with Mercy, with its strong provider network, resulting in economics of scale, and the opportunity to establish a statewide accountable care organization for multiple payers.

All of the benefits and savings related to the Affiliation have not yet been quantified; however, the following positive results are expected. Expected benefits of the affiliation include quality improvements, efficiencies, and cost savings including, but not limited to:

- Supply Chain savings: EMHS is part of several group purchasing organizations. By adding Mercy to the network, additional savings are anticipated for all of the current members as well as Mercy.
- Administrative function integration: The EMHS home offices support member organizations by providing a range of administrative services, including patient billing, information technology, accounting, planning, human resource and employee benefits, compliance and others. By adding Mercy, EMHS will be able to be more efficient with administrative overhead to be spread among all members.
- Health information technology – EMHS is a national leader in health information technology. Sharing best practices with Mercy is expected to not only improve clinical outcomes (see note below) but reduce duplicate tests and re-admissions as the shared clinical data becomes available to providers statewide.
- Clinical quality – EMHS has long-standing committees comprised of physician, clinical and others who develop care path protocols which are integrated into the electronic medical record systems. These committees also determine evidence based care which is incorporated into system wide clinical policies. For example, patients at risk of stroke or infections are screened upon admission; in the outpatient setting, all patients diagnosed with chronic diseases are identified for standardized treatment services. As Medicare and other payers continue to move towards payment for outcomes, EMHS and Mercy will implement evidence based care to more Maine residents.
- Population Management and Contracting – EMHS is one of 32 health systems participating in the CMS Pioneer risk sharing demonstration. To succeed in

health population payment systems, an infrastructure is being developed to manage multiple contracts with employers, and governmental and commercial payers. This includes contracting, legal, analytical and population health expertise. Mercy has a strong primary care network, as do the EMHS member hospitals. Adding Mercy's covered lives to EMHS' Accountable Care Organization (ACO) will spread the infrastructure investment and allow the System and Maine to move more quickly to a patient centered medical home payment system.

- Service line development – Having a hospital in Portland will build on EMHS' efforts to develop integrated service lines with a goal of excellent and consistent care at all EMHS care sites. For example, Mercy's substance abuse program will coordinate care with Acadia Hospital's behavioral health continuum.
- Workforce development – Having a larger employee base will support a broader range of training and engagement opportunities. Although Mercy is involved in providing a wide range of training opportunities with local colleges and schools, it would be advantageous to view these opportunities across all of EMHS (with Mercy as a member) and provide coordination to students and generate efficiencies at the program oversight level.

The EMHS-Mercy relationship is based on the principle that patients will continue to go to the local provider and hospital of their choice, and in their own communities. Mercy and EMHS are both leaders in adapting care for the twenty-first century. Mercy is recognized for patient safety, and renowned for shifting its focus to primary care years before healthcare reform made that a priority. EMHS is a leader in managing the health of the communities it serves and using leading edge health information technology to improve the quality and safety of care. Both systems are known for providing high-quality, safe care in all settings – inpatient, community clinic, and home.

B. Mercy Collaborations

The residents of Cumberland County and the surrounding region will continue to benefit from a choice in healthcare providers. Competing health systems often find ways to work together for the benefit of patients, as the hospitals in Portland have done for many years.

Tables 15 and 16 outline selected collaborative activities among Portland based providers.

Table 15: Portland Area Collaborations

Collaboration	Description
Portland CBSA Wage Index Review	Facilitated by the MHA, MMC and Mercy jointly engage Core Finance Team of Indianapolis, IN to provide consultative services

	surrounding the hospitals' wage index submission. York, Goodall and SMMC also participate.
Synernet, Inc.	Synernet is a cooperative, which is 50% owned by MaineHealth and 50% owned by non-MaineHealth members (St. Joseph's Hospital, Franklin Memorial Hospital, Northern Maine Medical Center, Redington-Fairview General Hospital, Mount Desert Island Hospital and Mercy Hospital). Mike Hachey, Mercy's Sr. VP & CFO serves as Board Chair of Synernet, Inc. Mercy outsources the following services to Synernet: - Transcription - Clinical Engineering - Credentialing and verification - Provider paneling with managed care organizations - Coding on an as needed basis
Synernet – Coding Services	Mercy utilizes Synernet coders on an as-needed basis.
MaineHealth Vital Network	Mercy is a participant in Maine Health's eICU solution, which provides remote physician and nurse oversight of ICU patients during non-business hours utilizing the Visicu system.
MMC- Physicians	Shared call coverage(ENT)
MMC- NICU	Mercy has a collaborative relationship with MMC for assessment and transport of infants with high risks or impending deliveries of high risk mothers
Maine Health- data analysis	Agreement for data aggregation/analysis re patient quality metrics following AMI- STEMI
Diabetes	Mercy's diabetes practice was trained on the use of Microsystems by MaineHealth Staff. They occasionally have "tune-up" sessions with the consultant—the last one being last year (2012).
Care Partners	Care Partners coordinates the provision of donated healthcare services for low-income, uninsured residents in four Maine counties (Cumberland, Lincoln, Waldo and Kennebec). The program, a partnership between MaineHealth, physicians, hospitals and other healthcare providers, helps community members who don't qualify for public or private healthcare coverage programs get comprehensive, medically necessary healthcare. Mercy Hospital and Mercy Primary and Specialty Practices are members of Care Partners and accept referrals.
Gary's House	Families of MMC patients routinely stay at Gary's House. MMC has been a strong supporter of the program through contributions.
CHF Management of Home Patients	The VNA is working collaboratively with a group at MMC to share diuretic protocols of the home CHF patients.

Cardiology	• Mended Hearts is a MMC based volunteer program in which Mercy employed Dr. Jon John Eddinger is engaged, currently as a collaborative between both organizations • Maine Medical Center Heart Failure Team- program collaboration (through Mercy, VNA and HomeHealth, VNS) • Mercy's Dr. Craig Brett is joining a new Maine collaborative group reviewing cardiology quality metrics; the group is led by MMC cardiologist, Dr. James Powers
Oncology and Radiation Therapy	• One of Mercy's most significant interactions/collaborations with MMC is in Radiation Therapy. • The providers are Spectrum employees and all the Radiation Services are through Maine Medical Center (all locations Bath, Portland, and Scarborough), so there is close collaboration on care coordination. • The Radiation Oncology Physicians attend General Tumor Board, MDC Breast Rounds, and the new Thoracic Tumor Board, and they are a required member of the Hospital Cancer Committee for the CoC. • Mercy collaborates on shared patients that might be enrolled in a clinical trial within Maine Medical Center. • Mercy collaborates on outreach activities in the community on Cancer Awareness and Education.
Outreach Education Council	• Coordinated by MMC, Maine hospitals (including Mercy) pay a "membership fee" to attend education sessions focused toward RN's at a greatly discounted rate.

Table 16: Collaborations between Portland Providers

Local/Statewide Committee/Task Force involvement where Mercy and MH collaborate	
	• Maine Hospital Association • Maine Medical Association • Maine Health Management Coalition • Quality Counts • American Heart Association (Mercy's Dr. Jon Eddinger sits on the Board) • United Way • International Association Healthcare Security & Safety (collaborate on Hospital Security Related Issues and share trends). • Maine Healthcare Engineers Society (collaborate on Hospital

	Facility Related Issues). • Southern Maine Regional Resource Center (statewide Emergency Management Collaborative.)
Maine Health Palliative Care workgroup	• A Maine Health Palliative Care workgroup exists for information sharing and education in which Mercy may participate.
Home Care & Hospice Alliance of Maine Board of Directors	• A collaboration with HHVN – MaineHealth affiliate and other home care and hospice providers (much like MHA)
Defending Childhood Initiative	MMC and Mercy collaborate in a work group that addresses trauma for immigrant children. Defending Childhood is a new Department of Justice initiative focused on addressing children's exposure to violence. The goals of the initiative are to prevent children's exposure to violence as victims and witnesses, mitigate the negative effects experienced by children exposed to violence, and develop knowledge about and increase awareness of this issue. Portland, ME is a demonstration site and Mercy and MMC representatives serve on the advisory board to develop and implement comprehensive community-based strategies to prevent and reduce the impact of children's exposure to violence in their homes, schools, and communities.
West End Neighborhood Association (WENA)	This is a very active neighborhood association. Mercy and MMC joined together on the 2010 CBDG grant, both Mercy and MMC send representatives to the meetings.
Cumberland County Substance Abuse and Mental Health Workgroup	Mercy and MMC representatives serve on this taskforce.
Portland's Homelessness Task Force	Mercy and MMC reps served on Portland's Homelessness Task Force. The draft report was sent to committee by the City Council for revision and will return with recommendations in 2013.
Mayor's Healthcare Task Force	Convened by Mayor Brennan to prepare for the implementation of ACA, Mercy and MaineHealth are represented at the meetings.
MEHAF Advancing Payment Reform	MMC and Mercy are involved in this work group as both are participating in the grant. The effort is to mitigate the increasing cost of healthcare in Maine through innovative delivery system and payment reform strategies that preserve access, improve quality, and offer better value.
Greater Portland Refugee and Immigrant Collaborative	Mercy and MMC have representatives on the collaborative, which is designed to meet the distinct healthcare needs of the Refugee and Immigrant Community
National Children's Study Community Advisory Council	The group is organized to help them make inroads into the community, review messaging for community and help promote the program. Mercy and Maine Medical Center participate.

Cumberland District Public Health Council	• Representative district-wide body of local public health stakeholders working toward collaborative public health planning and coordination. • Mercy worked with MMC on the One Maine Health Community Needs Assessment to host stakeholder groups in the community to identify areas to collaborate in the future. Mercy worked collaboratively with MaineHealth representatives on a number of flu immunization initiatives.

A local board will continue to be involved in the oversight of Mercy after it becomes a member of EMHS. Both organizations believe in strong local governance that ensures the voices of the community are at the table when decisions are made about their healthcare needs.

MHSM has had a successful partnership with CHE. Becoming part of EMHS will bring many of the same strengths associated with being part of a larger health system, but with the additional benefit that Mercy will be part of a Maine-based health system which will enable the realization of greater synergies and cost savings. Combining the two systems allows for the sharing of strengths to further enhance quality improvement and safety initiatives for all patients.

C. Alternatives

During its strategic planning process Mercy considered a complete array of alternatives before concluding that the EMHS affiliation presented the best possible alternative for Mercy and the communities it serves. Mercy's strategic partnership process began in the spring of 2011. In the summer of 2011, Mercy designed a three-phase approach to the strategic partnership process, including:

- Phase I – overall, global assessment of strategic alternatives and long term financial and strategic planning including validation of goals and review of competencies and identifying resource gaps;
- Phase II – identification of potential strategic partners; and
- Phase III – finalizing and executing on the strategic partnership transaction identified in Phase II

In the fall of 2011, MHSM retained consultants from Sg2 to review Commercial and Medicare Advantage Markets. There was an assessment of MHSM's market position and the emerging market forces driving the need for change in healthcare providers generally and Mercy specifically. Under the guidance of a strategic partnership advisory committee appointed by the MHSM Board, in December 2011, Mercy retained Chartis and Kaufman Hall to assist with analysis of various partnership models and long term financial and strategic planning.

This process included an analysis of MHSM's ability to continue to effectively service its market and address the dynamic changes occurring in healthcare. The Phase I recommendation was that, under its existing relationship with CHE, Mercy lacked the scale and capital resources to most effectively serve its market and needed to establish a strategic partnership with a party or parties with access to accountable care infrastructure, comprehensive scale, and better access to capital resources. It was determined that the market implications for Mercy's success in the future hinged upon the ability to achieve sufficient scale, develop strength in hospital-physician alignment, and enhance its readiness for value-based purchasing models. It was determined that, without a strategic partner to address these crucial needs, Mercy would continue to experience declining market share and shrinkage of its inpatient business.

In Phase II of its strategic partnership process, MHSM retained Merrill Lynch to comprehensively solicit proposals for strategic partnership. Both through Merrill Lynch and directly, MHSM approached 32 parties in total, and ultimately received 7 expressions of interests in establishing a strategic partnership or affiliation.

Mercy analyzed each of these proposals and ultimately determined that the EMHS affiliation presented the best possible alternative in achieving Mercy's stated strategic goals. This analysis included review of each alternative through a set of evaluation criteria including (1) financial, operational and strategic considerations, (2) governance and mission objectives, and (3) the interests of key constituencies. Based on these criteria, it became clear that affiliation with a Maine-based healthcare system presented a much better alternative than partnering with out-of-state organizations. MHSM's experience with CHE informed its decision that access to more remote resources developed for communities outside of Maine did not necessarily translate well into application to MHSM's Maine-based market.

Alternatively, EMHS presented a perfect fit with Mercy. The receipt of Hart-Scott-Rodino early termination referenced above confirmed the affiliation with EMHS has no negative effect upon competition in the relevant market and is in fact expected to maintain Mercy's position as a healthy, viable provider within its market over the long term. Additionally, EMHS brings to Mercy all of the financial, operational and strategic resources that were identified in MHSM's strategic planning process. The discussions between the two organizations revealed a close alignment regarding governance and mission, as well as a willingness to perpetuate Mercy's Catholic identity. Ultimately, this affiliation presented the best alternative for key constituencies including medical staff, employees, volunteers, payers, employers and healthcare consumers.

Summary of Alternatives Considered

- **Affiliate with a different national system**

MHSM considered partnering with a national chain. It determined that the same geographic issues that exist with its CHE affiliation would exist with a national chain. Accordingly, MHSM concluded that affiliating with a Maine-based healthcare system would be more efficient and cost-effective in meeting the needs of the population it serves. Moreover, MHSM was unable to identify a national system partner whose mission and vision fit with its values and focus on Maine-based goals.

- **Affiliate with a Portland area system**
  MHSM determined that it would be very difficult, if not impossible to affiliate with a directly competing Portland-based healthcare system because of the obvious antitrust hurdles such an affiliation would face. MHSM also determined that participating in an ACO that included a directly competing healthcare system would involve additional, costly, antitrust compliance and regulatory constraints.
- **Affiliate with a non-Portland based Maine system**
  After much analysis and deliberation, MHSM determined that the proposed affiliation: (1) best met its strategic partnership goals; (2) was consistent with its mission; and, (3) allowed it to maintain its Catholic identity.

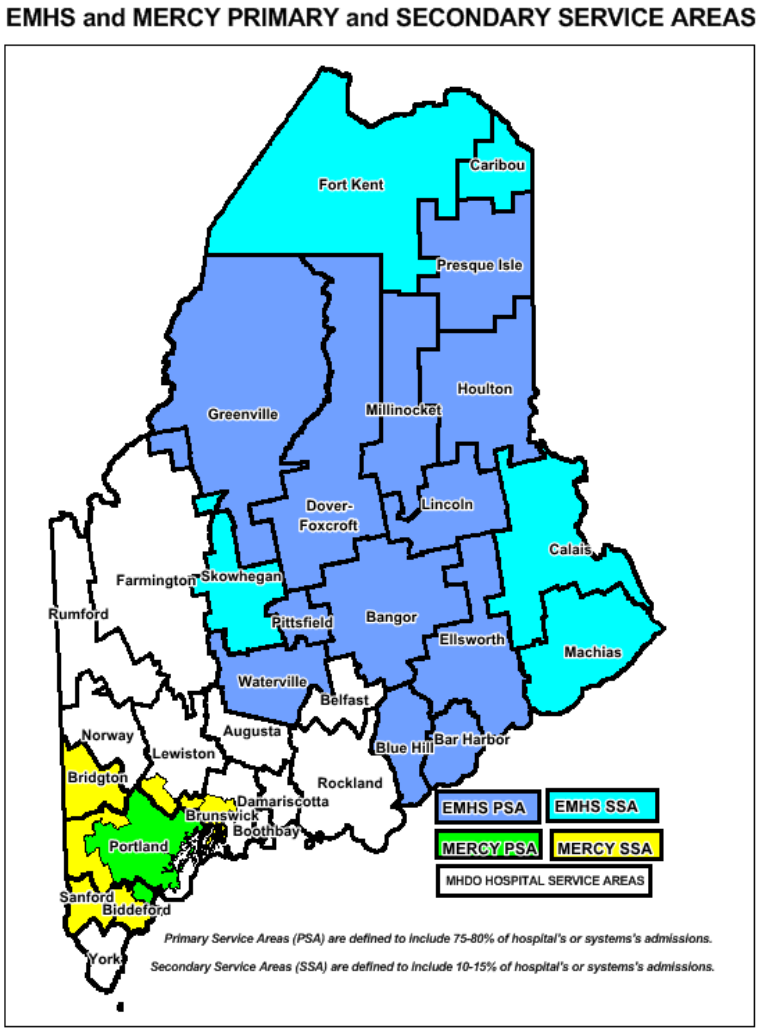
Minimal overlap between Service Regions

Both EMHS and CHE filed premerger notifications with the Federal Trade Commission required under the Hart-Scott-Rodino Act (HSR). Once the filings were made, the parties were precluded from proceeding with the proposed affiliation until the expiration or early termination of a statutory thirty (30) day waiting period. During the waiting period, the Federal Trade Commission (FTC) reviewed the proposed affiliation. As part of its review, the FTC had several options: extend the waiting period by requesting additional information from the parties; notify the parties that it intended to oppose the proposed merger; allow the waiting period to expire without taking any action; or notify the parties of early termination of the waiting period.

With proposed mergers that pose little or no anti-competitive concerns, such as the affiliation of Mercy with EMHS, the parties may request early termination of the statutory waiting period. Requests for early termination are only granted if the FTC has completed its review and opted not to take any enforcement action during the waiting period. EMHS and CHE requested early termination, which was granted on February 25, 2013. (Attachment F). Accordingly, the parties have obtained federal antitrust clearance to proceed with the proposed affiliation immediately upon receiving a CON and completing due diligence.

Figure 5 below illustrates the lack of overlap of the two systems' service areas. The northernmost boundary of Mercy's secondary service area is Topsham, which is 49 miles from EMHS' Inland Hospital in Waterville.

Figure 5: EMHS and Mercy Primary and Secondary Service Markets



EMHS' current service area is defined using the Maine Health Data Organization's (MHDO's) definitions of Hospital Service Areas (HSA's). The Primary Service Area includes the HSA's that contain the seven (7) EMHS hospitals and selected adjacent HSAs that contribute a high number of EMHS' patients. In 2011 these areas accounted for 80% of EMHS' admissions. EMHS' Secondary Service Area (SSA) includes an additional six (6) HSA's that contributed another 12.8% of EMHS' 2011 admissions. This service area definition methodology is consistent with that used for Mercy as described in Section IV.

Payer mix assumptions

Attachment G includes the revenue assumptions by payer mix incorporated into the projected financial statements in Attachment F. Payer mix is anticipated to change recognizing the commencement of the insurance exchanges, or marketplaces, designed by the Affordable Care Act. Patients who are self-pay currently will have the opportunity to move to the Exchange

payer mix classification. Medicare and Medicaid will continue to comprise 40% of net revenue. The assumptions surrounding price increases and reimbursement increases are consistent with existing managed care contracts and are not impacted by the Project. The reimbursement assumptions take into consideration Federal health payment reform.

Summary of Orderly and Economic Development

The proposed affiliation is consistent with the orderly and economic develop of Maine's healthcare system as demonstrated by:

- Costs will be lowered through shared administrative services and other initiatives.
- No providers in the region will be adversely affected.
- After extensive review of potential national systems, Mercy is certain an affiliation with Maine-based EMHS is the alternative that most effectively reduces costs and provides enhanced access to services as effectively as Mercy's affiliation with EMHS.
- EMHS has demonstrated success in assisting Maine hospitals through its previous affiliations and cooperative initiatives.
- EMHS provides Mercy with access to capital, to group purchasing, and to a statewide accountable care network.

B. CONU Discussion

i. CON Standard

The relevant standard 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:

- 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.

ii. CON Analysis

The services proposed to be provided in this project are not able to be provided by other facilities in a capacity significant enough to question the need for the facility. Total health care expenditures are not expected to increase as a result of this transaction. The need for these services is definite and measurable. Current utilization levels of these services make the continuation and availability of these services a necessary component of health care.

State funds should not be materially impacted by this transaction. There should not be any increased utilization of these services because of this proposed transaction.

Total projected 3rd year incremental operating costs are projected to show no additional costs due to this affiliation. Any increase in MaineCare funds will be due to inflation or changes in volume unrelated to this project through the 3rd year of operation (2016).

An immediate cost savings resulting from this affiliation will be a $2,000,000 reduction in shared service and corporate overhead charges associated with the transfer of ownership from CHE to EMHS. Catholic Health East currently charges Mercy approximately $7.2 million annually for services ranging from information technology support to business services and administrative overhead. The EMHS shared services infrastructure will still be able to provide a full range of

administrative services to Mercy. Sharing administrative services and other initiatives will reduce costs. EMHS will restructure Mercy's existing $73,000,000 tax exempt debt obligations currently underwritten by CHE. The applicant did not include the impact of a $115,000,000, five year investment for capital expenditures, integration costs, electronic medical records, accountable care organization infrastructure development, campus consolidation design and construction, provider network development and other improvements in the financial forecasts.

It is prudent and customary for transactions like the one contemplated here to include a reporting condition in order for CONU to monitor the financial effect of the transaction. Accordingly, CONU recommends that the following condition be included in any approval:

The applicant is to report costs savings attributable to the merger for three years.

Anti – Trust Determination

Hart-Scott-Rodino

The Hart-Scott-Rodino Act established the federal premerger notification program, which provides the FTC and the Department of Justice with information about large mergers and acquisitions before they occur. The parties to certain proposed transactions must submit premerger notification to the FTC and DOJ. Premerger notification involves completing an HSR Form, also called a "Notification and Report Form for Certain Mergers and Acquisitions," with information about each company's business. The parties may not close their deal until the waiting period outlined in the HSR Act has passed, or the government has granted early termination of the waiting period.

The Federal Trade Commission has already completed its review and has given the parties clearance to proceed with the transaction.

Since EMHS and Mercy operate in separate and distinct service areas the impact on competing providers within Mercy's primary and secondary service areas will be minimal.

Mercy explored other alternatives to affiliating with EMHS. 1). Affiliating with a national chain would result in the same issues that currently exist with CHE, namely a lack of local synergy which hampers supporting population health and ACO development and certain unavoidable costs that are difficult to reduce or eliminate (duplicative IT systems, travel cost, data collection requirements, etc.). 2). Affiliating with a directly competing Portland based system would lead to costly antitrust issues and regulatory restraints. Based on an assessment of Mercy's market position completed by Sg2 Mercy "lacked the scale and capital resources to most effectively serve its market and needed to establish a strategic partnership with a party or parties with access to accountable care infrastructure, comprehensive scale, and better access to capital resources. It was determined that the market implications for Mercy's success in the future hinged upon the ability to achieve sufficient scale, develop strength in hospital-physician alignment, and enhance

its readiness for value-based purchasing models. It was determined that, without a strategic partner to address these crucial needs, Mercy would continue to experience declining market share and shrinkage of its inpatient business." Based on this information it is unlikely that more effective, more accessible or less costly alternative technologies or methods of service delivery will become available.

iii. Conclusion

CONU recommends that the Commissioner find that the applicant 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 subject to including the recommended condition.

VI. Outcomes and Community Impact

A. From Applicant

Quality Improvement

EMHS has an established record in the pursuit of quality care. Its clinical leaders for years have focused on "Zero Defects" in clinical care delivery. EMHS' vision is to become a nationally recognized healthcare delivery system in America. Mercy also focuses significant efforts on achieving quality outcomes. EMHS quality programs will link Mercy to quality and performance improvement initiatives including the following: improving care transitions; medication safety; and infection reduction. By transitioning from CHE clinical IT systems (which are designed and implemented to meet the New York, New Jersey, and Pennsylvania quality and compliance reporting rules and regulations), Mercy can hard wire reporting systems that not only meet the needs of required state and federal intermediary reporting, but include local payer initiatives such as the Maine State Medical Home Pilot, the Maine State Employees health plan, and regional payers (e.g. Maine Community Health Options). Mercy's current affiliation with an out-of-state parent makes current comparison to other Maine hospitals less available and requires duplicative data collection and analysis as CHE systems do not allow for the flexibility or infrastructure to support these locally progressive quality improvement programs.

EMHS and Mercy are committed to assuring patients, payers and providers of their commitment to provide the highest quality and safety in all aspects of care. Both systems share a commitment to enhancing patient and family experiences with the use of evidence based design, quality monitoring systems and other resources. Both organizations strive for improved healthcare for individuals, improving the health of populations and reducing the per capita cost of care.

This affiliation will enhance the effort of EMHS in addressing critical issues related to population health. Efforts to reduce chronic disease will be enhanced to be a cohesive state-wide approach. Mercy will participate in these initiatives, among others:

- Patient Centered Medical Homes - EMHS has a mature network of Tier 3 PCMHs. Their expertise in care coordination will assist Mercy in further enhancing these services in southern Maine. Additionally, EMHS has a full spectrum of behavioral health services which have been integrated into these practices.
- Maine Care Value Based Purchasing (VBP) initiative - EMHS has provided feedback to Maine DHHS as MaineCare considers a risk sharing approach with providers. Mercy and EMHS will work together on a statewide approach.
- Bangor Beacon Community - Three years ago, EMHS was awarded $12.8 million as one of 17 grantees of the Federal Office of the National Coordinator. Funds supported the

development of exemplary healthcare communities with strong health information technology ties, chronic care managers, and community wide collaboration. Positive learning and results are being shared among all EMHS members in the systems' primary service regions, and will be shared with Mercy's Portland team.

- Chronic conditions such as Diabetes, Heart Disease, COPD, Obesity and Smoking will be able to be addressed through these efforts.

The boards of EMHS and Mercy review quality performance measures at least quarterly. These metrics include:

- National Quality Forum Measures.
- CMS Core Measures.
- Patient Satisfaction Data.
- Other publically reported data.
- VNA publically reported data.

Mercy will participate in all EMHS sponsored clinical integration programs. Examples include:

- CMS and Joint Commission data submissions regarding process and outcomes of care.
- EMHS Zero Defect Monitoring Program
- Patient satisfaction data.
- Participation in the Annual Leapfrog Group patient safety survey.
- Active participation in Maine Health Management Coalition that includes data displayed on their site: *Get Better Maine*.
- Statewide Hand Hygiene Monitoring Program

Results of these activities are published on public sites. Mercy will publish results in the same manner and to the same extent as other hospital members of EMHS. Attachment I includes examples of quality measures and outcomes for EMHS, Mercy, and the Bangor Beacon Community.

The Affiliation will support the public's demand for access, choice and cost efficient care in Mercy's primary and secondary service areas. Mercy will become part of a fully aligned healthcare system, focused on Maine-based clinical and quality improvement initiatives and programs. This will allow Mercy to shift resources, standardize process improvement and simplify reporting structures. The combined resources of the quality and clinical teams of MHSM and EMHS will enable the creation and implementation of care plans across Maine to the benefit of patients, employers and payers.

B. Region's capacity for services

The proposed affiliation will not result in a change in the services Mercy or EMHS offer in the region. This proposal will not change existing capacity or affect other providers in the Mercy's Primary or Secondary Service Area. The methodology for defining these service areas was

reviewed in Section IV. As discussed in other sections of this application, with Mercy's participation in the EMHS ACO access to care will be increased.

B. CONU Discussion

i. CON Standard

The relevant standard 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

Mercy's clinical outcomes will be enhanced from participation in EMHS's population health status improvement initiatives, clinical integration and quality improvements initiatives and programs. Both EMHS and Mercy review quality measures quarterly. In order to ensure that anticipated improvements in quality and outcome measures occur, CONU recommends that EMHS and Mercy report improvements in quality and outcome measures for a period of three years from the affiliation date.

The applicants provided a significant amount of demographic and statistical information regarding both EMHS and Mercy primary and secondary service areas and the services provided in these areas. As stated in previous sections there is no overlap in service areas between EMHS and Mercy. Mercy's affiliation with EMHS will result in no new health services being added in the area. As a result the project will not negatively affect the quality of care delivered by existing service providers.

iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that this project will ensure high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

VII. Service Utilization

A. From Applicant

The region will benefit from the affiliation. Access to services will expand due to a growing physician practice networking and statewide service line integration.

A. Summary of Service Utilization

The historical and projected utilization of Mercy is reviewed in Section IV. Table 14 shows anticipated volume changes which are incorporated into the financial projections in Attachment F. A summary of key assumptions is as follows:

- Inpatient volume will grow slowly at approximately 1% per year, recognizing upward pressures of an aging population coupled with downward pressures from population health management strategies and increased capacity to treat patients in outpatient settings
- Emergency department visits will remain relatively flat, anticipating ability to treat patients in lower cost, less acute settings
- Outpatient visits will grow modestly as patients get care in lower cost settings dealing with chronic disease management and primary and secondary prevention programs

B. CONU Discussion

i. CON Standard

The relevant standard 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 as established in Title 24-A, section 6951, when the principles adopted by the Maine Quality Forum are directly applicable to the application.

ii. CON Analysis

This application involves the affiliation of Mercy with EMHS and does not result in the addition of new health services or the expansion of existing services. This affiliation will improve quality outcomes, address identified community needs, encourage clinical integration and improve the health status of the population in Mercy's service area. As discussed earlier in the application the joint Mercy/EMHS focus on community centered primary care will decrease inappropriate and unnecessary hospitalizations and Emergency Department utilization. This will have a positive impact on patient care.

iii. Conclusion

CONU recommends that the Commissioner find that the applicant 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.

VIII. Timeline

A. From Applicant

EMHS and Mercy will comply with notification timelines required by CON regulations. Key dates to date are as follows:

- January 24, 2013: Letter of intent/reviewability sent.
- February 6, 2013: Technical Assistance meeting with Healthcare Oversight staff and representatives of Mercy and EMHS.
- April 16, 2013: Application filed and declared complete

B. CON Discussion

Letter of Intent Received	01/25/2013
Subject to Con Letter Issued	01/29/2013
Technical Assistance Meeting held	02/06/2013
Application Filed	04/17/2013
Application Certified Complete	04/17/2013
Public Information Meeting	Waived
Public Hearing	05/07/2013
Close of Public Record	06/07/2013
PR TA Meeting	08/01/2013

IX. CON 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 subject to the conditions below:

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 is 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 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 ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; and

F. 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.

Conditions:

- The applicant is to report costs savings attributable to the merger for three years.

- For the three years following commencement of the CON, Mercy hospital will need to notify the Division of Licensing and Regulatory Services of any proposed change to the Free Care policy or Charity Care policy of the Hospital no less than 90 days before the proposed change is to go into effect.