SunBridge Healthcare, LLC 17112414-LE

Sunbridge Healthcare, LLC Staff Report Questions
February 8, 2018

1. **What is the evidence base supporting the implementation of a 'hybrid model' of care at Merrimack Valley Center?**

   The Applicant recognizes that the future Skilled Nursing Facility marketplace will be different from the present models and will be dramatically different than the SNF environment of the 1970's. While Merrimack Valley Center is a "replacement" SNF, it is being designed and built to address the priority service and care needs of future patient panel members.

   The Applicant predicates the Merrimack Valley design on a number of core assumptions about the future marketplace:

   - The average length of stay for patients will be measured in days, not weeks.
   - The Proposed Project must be planned so as to serve patients with complex clinical needs, including those currently served in higher cost acute care settings.
   - In terms of sheer volume, Merrimack Valley Center must be prepared to provide quality care to as many as 1,000 seniors each year given the shorter lengths of stay and the imperative of assisting patients transition to home or alternative community settings.
   - The physical design of Merrimack Valley Center and its programs must be able to accommodate a changing array of clinical therapies and services for seniors transitioning and recovering from a medical crisis, surgery or setback.

   Nationally, Genesis Healthcare has been planning for this new SNF marketplace with several initiatives reflective of what the Applicant terms "upstream" models. In effect, that means preparing the staff, incorporating technological expertise and updating the physical plant to accommodate the more clinically complex patient seeking shorter post hospital recovery lengths of stay and fewer post-discharge setbacks.

   In 2012 PowerBack Rehabilitation Centers were introduced. More recently, collaborative arrangements have been established in Pennsylvania and Florida with LTACs for Genesis Healthcare to accept their clinically complex patients, complicated and extensive wounds, LVADs, extensive pulmonary care needs and other significant diagnoses and comorbidities. Merrimack Valley Center is the Applicant's innovative entry into the Massachusetts Health Care Market, different from those models described above as the clinically complex care provided here is consistent with the needs of this patient panel and supported by programmatic partner LGH/Circle Health ACO.

   Use of the term hybrid may have been somewhat misleading. To explain, the definition the Applicant is applying is "the mixture of two things, resulting in something that has a little bit of both." As has been noted, these are replacement SNF beds maintaining all the practices of sub-acute and long-term care recognized for years by all payer sources as the appropriate and proven treatment for the patient panel. Adding to and complimenting these services will be the

introduction of care for some of the most clinically complex cardiac patients in the Greater Lowell Area. A significant part of a cardiac management program developed in concert with LGH/Circle Health ACO will be the 12 bed telemetry unit. The use of telemetry has been used successfully in hospital units since the 1960's with demand for greater monitoring capability growing each year. The establishment of a SNF telemetry unit would be unique to the region and potentially could become a national model.

So, the Merrimack Valley Center is made up of the quality patient centered care offered to traditional short-term stay and long-term residents PLUS the introduction of very high level post-acute care to some of the most clinically complex patients in the Patient Panel, patients currently served in a higher cost acute care setting. This blend will result in the innovative or new profile of the SNF, therefore the term hybrid is believed appropriate.

a. How does the 'hybrid' model address the specific needs of the patient panel in ways that traditional short term care and long term care models do not?

The Proposed Project addresses the needs of the patient panel by providing quality and appropriate services in a non-acute care, amenity rich environment. Currently, the sort of monitoring and cardiac management available to members of the patient panel exist only in the hospital. Consequently, patients have costly extended acute care stays, exposure to hospital acquired infections and complications and risk re-admission upon discharge. The innovative and clinically complex nature of the 'hybrid' model will address these very specific needs with predicted favorable outcomes.

b. Define the 'gap' in healthcare continuum identified by LGH/Circle Health that was used to determine need for the proposed facility.

During the conceptual phase of design for the Merrimack Valley Center, discussions with programmatic partner LGH/Circle ACO were initiated to design an innovative program that would meet the needs of both the local community and the hospital. The Applicant's goal was to develop a clinical capabilities that would have a meaningful impact on patient outcomes.

Empirical hospital data, future projections and community health needs assessment supported the need for a high level cardiac management and rehabilitation program, basically, an extension of services provided in the acute care setting. Here was the 'gap.' Currently, that capacity does not exist have to remain in the acute care setting.

c. How will the 'hybrid' model improve health outcomes for the patient panel?

With the high level of skill and monitoring proposed for Merrimack Valley Center, LGH/Circle ACO will have a less costly, yet appropriate setting of care for their patients. Establishing this clinically complex supportive service at Merrimack Valley Center is expected to reduce hospital lengths of stay, reduced hospital admissions and readmissions, redirect from the ER and provide solid connection with care transitions to home.

To produce the desired outcomes mentioned above and, most importantly, to have a meaningful impact on the health and well-being of the patient panel, complications during the recovery process must be avoided. Of course, this is true for all post-acute patients, but those suitable for the 'hybrid' model, clinically complex, frail patients, may be at

higher risk of complication depending on their diagnosis. Managing the patients with numerous diagnoses and comorbidities is challenging, but essential to the production of positive health outcomes.

As far as cardiac patients the Applicant would be looking to avoid further heart failure with early recognition of symptoms. Patients requiring telemetry would be monitored for changes in their heart rhythms and associated complications. Post-operative patients regardless of operation type have similar risks for complications including pneumonia, DVT, pulmonary emboli, infection, etc.

Patients with heart failure often experience shortness of breath, fluid retention, and low physical endurance. Often trips to the ER result in IV meds to diuresis the patient who is in a state of fluid retention, many are admitted to the hospital for this treatment, but the expectation here is that at Merrimack Valley Center these patients could be safely treated in the trained skilled nursing care environment.

i. What measures will you use to assess impact?

The Applicant uses a number of internal analytics, external metrics and publically reported quality measures to track and measure performance relative to patient outcomes. All of these measures will be employed at Merrimack Valley Center. Among them are:

1. Hospital Lengths of Stay
2. Hospitalizations
3. Re-hospitalizations
4. Emergency Room redirection
5. 5-Star performance
6. Discharge Customer Satisfaction Surveys

d. Which outcomes will improve for clinically complex patients?

Improving outcomes for the clinically complex patient has been touched upon in several ways, but probably the most important are reduced hospital lengths of stay and the attendant possible exposure to nosocomial infection as well as reducing hospital readmission rates.

2. What impacts on care will result from the transformations in clinical education?

As was noted in Question F1.a.ii **Need by Patient Panel**, the 2016 Comprehensive Health Needs Assessment released by the Greater Lowell Health Alliance concluded that the elderly were a population at risk for a variety of reasons. Significantly, one factor that puts the area seniors at risk is the insufficient number of PCP's and other healthcare professionals with geriatric experience to treat this population.

The Interprofessional Education (IPE) component of this Project takes this problem 'head on.' In an interview made public on February 8, 2018 in the ***Boston Business Journal***, UMass Lowell's Zuckerberg College of Health Sciences Dean Shortie McKinney states, "…all students will serve rotations through the center, with an emphasis on so-called 'interprofessional learning,' in which different types of care providers besides physicians – including nurses, nutritionists and clinical lab professionals – collaborate to address each patient's needs." Commenting further on the Proposed Project she says, "…it will expand our opportunity to provide clinical experiences for

students. The (IPE) team environment fits with the way Genesis is planning and designing the new building."

More and more health care education has been moving to Interprofessional Education ("IPE") which has been lauded by the Institute of Medicine and the World Health Organization. It is increasingly becoming the future of clinical education. Here, students from two or more health professions work together during all or part of their professional training. This real world experience creates highly prepared professionals that will impact care by improving the quality of patient care, lowering health care costs, decreasing lengths of stay and reducing medical errors.

Also, and very important in this case is the fact that historically, UMASS trained clinicians have remained in the Greater Lowell market. With the expansion of the local workforce with geriatric experienced team professionals, the positive impact on patient panel care is greatly enhanced. As Dean McKinney says, "it will help transform clinical education." Transforming clinical education translates directly into transforming patient clinical care in the Greater Lowell area.

3. Where will the Inter-professional Education (IPE) model take place in the facility?

IPE will occur throughout Merrimack Valley Center, notably bedside in patient rooms which have been designed specifically to accommodate patient, family, licensed clinician and student conferences. There will be all private rooms to facilitate the educational component and these are consistent with the Applicant's patient centered care respecting privacy and patient preferences. Also, IPE will be present in Physical Therapy areas and other treatment spaces. Given the Team nature of the IPE experience, it is a truly constantly ongoing educational process "within walls and without walls."

a. What patients will be exposed to this level of care and for how long?

All patients will be part of the IPE process. Students will have opportunities to work with short-term patients from admission to discharge, following them through all stages of recovery whether these are the most clinically complex or a more typical short-term stay patient. Long-term care patients will be exposed to IPE care as well. This will provide the students in rotation a variety of experiences in both short-term and long-term care in the skilled setting.

4. What impacts will the projected change in payer mix have on access to care?

The change in payer mix will have no effect on access to care. The Applicant has a longstanding commitment to health access equity providing services to underserved populations. In fact, the Applicant rejected an alternative proposed model that would have consisted of 100% short stay patients for this very reason. Essentially, the Applicant will accept patients NOT on their payer source, but rather on whether the Applicant has the ability to provide the care required and to meet the patient's needs. While a valid payer source is sought, acceptance decisions are not made on that criterion.

The vast majority of Merrimack Valley Center patients whether affluent or poor will access care via reliance on their Medicare based health insurance. Medicare payment/care models are changing annually, and will continue to evolve in the years ahead. The Applicant must be able to accommodate Medicare changes whether they pertain to bundled payment, expansion of ACO models, new versions of care continuums or payment for quality outcomes. The Applicant must

not only be able to provide high quality services during the patient stay, but also help themmake safe transitions to home or other community based setting.

5. **Explain cost reductions associated with the anticipated reductions in acute care lengths of stay.**

   Cost reduction and safe management of patient needs have been paramount for years as health care costs have spiraled out of control. Cost containment is one of the Commonwealth's Health Priorities which the Applicant believes is addressed with this Proposed Project.

   Typically, a day in an acute care setting could cost the payer $2,000 more or less depending on the services accompanying the spell of illness. As has been noted in the data regarding telemetry beds, the cost here adds $200 per day more to the hospital total. Interim care at an LTAC costs could approach $1,000 per day. In contrast, Skilled Nursing facility care costs $500 per day.

   The evidence is clear regarding setting of care costs, clinically complex care in a SNF is a fraction of that in higher settings.

6. **How will the telemetry unit result in cost savings with the additional cost per day of telemetry beds, as well as staff and technology needs?**

   Admittedly, it would be reasonable to assume that the addition of this highly technical hardware and training would add to the cost associated with the cardiac management services. As is further detailed here in Question 8, the Applicant plans to purchase the same telemetry equipment used by LGH/Circle ACO. The estimated cost of this equipment is $45,000. This cost is included in the aggregate numbers appearing in Factor 4.a.ii. All of this data and its backup was reviewed by the Independent C.P.A. Bernard Donohue and as part of his Analysis was found to be both reasonable and feasible relative to the capacity of the Applicant. Staff costs and operating expenses were reviewed as well with a similar conclusion that the costs were reasonable.

   a. **What are the proposed improvements to care and outcomes from telemetry?**

      The proposed improvement to care is to take a proven technology that has been in use in hospitals since the 1960's and replicate the service in a state-of-the-art Skilled Nursing Facility, reducing costs, the patient's hospital length of stay and possible readmission, plus enhancing the privacy and patient centered care desired by 21st century patients..

      As for outcomes, telemetry has been extraordinarily successful in preventing subsequent or further heart failure by early recognition of symptoms. According to Dr. Marwan M. Mohammad in an article published in September 2016, "cardiac telemetry, now a widely available technology, was first introduced for the detection of life threatening arrhythmias. Its utility has since expanded to include ischemia surveillance as well as QT-interval monitoring." Even as the American Heart Association has tried to limit use and prevent hospital bottlenecks, there is ongoing discussion of expanding patient guidelines to include those with sepsis, alcohol withdrawal and COPD. As the number of potential telemetry patients increases, added pressure will be put on hospitals and capable and innovative SNFs like Merrimack Valley Center will become even more in demand.

7. **How will the proposed transaction improve navigation supports for seniors (an identified need reported in the CHNA)?**

The Proposed Project will improve navigation supports for seniors by bringing together in an even more seamless relationship, two of the major health care organizations in Greater Lowell. Working in concert they will create care paths for patients that will benefit from the navigation, transition and integration resources of both entities.

Question F2.c **Delivery System Transformation** discusses the importance of the integration of social services and community-based expertise into patient care coordination. The Applicant has detailed the Genesis Transition of Care program that stresses effective management of transitions of care within and between settings on the continuum. From admission to discharge Applicant staff focus on an inter-professional process for patients navigating the continuum of care. In order to successfully achieve the set goals, the Applicant works with a variety of health care and community-based resources including the following:

Organization Name	Organization Contact Information	Services Provided
Circle Home VNA & Hospice	847 Rogers Street, #201 Lowell, Ma 01852 Tel: (978) 459-9343	Skilled home care services and hospice
Commonwealth Nursing Services	847 Rogers Street Lowell, Ma 01852 Tel: (978) 459-7771	Homemaker services
Personal Touch	15 Tyngsboro Road, Unit 4B N. Chelmsford, Ma 01863 Tel: (978) 251-0170	Home care and homemaker services
Home Instead Senior Care	139 Billerica Road Chelmsford, Ma 01863 Tel: (978) 256-5950	Homemaker services
Visiting Angels	111 Chelmsford Street Chelmsford, Ma 01824 Tel: (978) 244-0200	Homemaker, companionship, personal care services
Alternative Home Health Care, LLC	2314 Main Street Tewksbury, Ma 01876 Tel: (978) 657-7444	Skilled home care services

Amedisys Home Health Care	1 Parker Street, Suite 2A Lawrence, Ma 01843 Tel: (978) 685-2818	Skilled home care services
Home Health VNA	360 Merrimack Street, Building 9 Lawrence, Ma 01843 Tel: (978) 552-4000	Skilled home care services
Nashoba Nursing Services and Hospice	2 Shaker Road, Suite D225 Shirley, Ma 01464 Tel: 1-800-698-3307	Skilled home care and hospice services
Nizhoni Health Systems	5 Middlesex Avenue, Suite 404 Somerville, Ma 02145 Tel: 1-800-915-3211	Skilled home care services specializing in mental health needs
Northeast Independent Living Program	20 Ballard Road Lawrence, Ma 01843 Tel: (978) 687-4288	Options counseling, community support services, deaf & hard of hearing services, long term support services, nursing home transitions, personal care assistance program, home modifications
Road Runner Lowell Regional Transit Authority	113 Thorndike Street Lowell, Ma 01852 Tel: (978) 459-0152	Transportation services
Home Away From Home	150 Industrial Avenue East Lowell, Ma 01852 Tel: (978) 453-4663	Adult day health services
Community Family, Inc.	236 Broadway Street Lowell, Ma 01854 Tel: (978) 458-4844	Adult day health services
Active Life Adult Day Health, Inc	664 Lakeview Avenue Lowell, Ma 01850 Tel: (978) 322-0092	Adult day health services

Blaire House of Tewksbury Adult Day Health Center	10 Erlin Terrace Tewksbury, Ma 01876 Tel: (978) 851-3121	Adult day health services
All Care Adult Day Health Program at North Village	20 Sheila Avenue Chelmsford, Ma 01863 Tel: (978) 251-0367	Adult day health services
Castle Hill Adult Day Health	225 Stedman Street #31 Lowell, Ma 01851 Tel: (978) 323-7811	Adult day health services
Lowell Elder Care	345 Chelmsford Street Lowell, Ma 01851 Tel: (978) 596-1111	Adult day health services
New England Community Care Adult Day Health	81 Bridge Street, Suite A Lowell, Ma 01852 Tel: (978) 441-0000	Adult day health services
All Care Resources	200 Sutton Street North Andover, Ma 01845 Tel: (781) 598-7066	Skilled homecare, companionship, adult foster care, hospice services
Intercity Home Care	100 Merrimack Street, Suite 201 Lowell, Ma 01852 Tel: (978) 937-0170	Companionship and homemaker services
Dracut Council on Aging	951 Mammoth Road Dracut, Ma 01826 Tel: (978) 957-2611	Council on aging / senior center services
Lowell Council on Aging	276 Broadway Street Lowell, Ma 01854 Tel: (978) 674-1172	Council on aging/senior center services

Lowell General Hospital Palliative Care	295 Varnum Avenue Lowell, Ma 01854 Tel: (978) 942-2064	Outpatient consultation for palliative care services.
Lowell Community Health Center	161 Jackson Street Lowell, Ma 01851 Tel: (978) 441-1700	Adult medicine services, physician services, HIV services, chronic health conditions management, health education and prevention services.
Lowell Transitional Living Center	205 Middlesex Street Lowell, Ma 01852 (978) 458-9888	Homelessness, shelter and housing services, meals program, case management services.
Element Care/Lowell PACE	166 Central Street Lowell, Ma 01852 (978) 513-7300	PACE program
Department of Mental Health	365 East Street Tewksbury, Ma 01876 Tel: (978) 863-5000	Mental health services for qualified individuals.
Vinfin	950 Cambridge Street Cambridge, Ma 02141 Tel: (617) 441-1800	Mental health services, intellectual and developmental disability services, brain injury services.
HKD Treatment Options	21 George Street Lowell, Ma 01852 Tel: (978) 710-9877	Alcohol and drug addiction treatment services
Elder Services of the Merrimack Valley	280 Merrimack Street Lawrence, Ma 01843 Tel: (978) 683-7747	Information and referral services, alternatives to nursing home care information, behavioral health services, care transitions program, family caregiver support program, financial resource program, healthy living programs, home care, housing options, nutrition programs (Meals on Wheels), managed care options.

The Applicant's clinical programmatic partner Lowell General Hospital is similarly concerned about care coordination, integration and follow-up with patients at risk. They, too, work with a myriad of community based organizations who help guide patients through the health system maze. Taking their interest a step further they have been awarded a $1 million Community Hospital Acceleration, Revitalization and Transformation Investment Program Grant (CHART) by the Massachusetts Health Policy Commission. According to an article in the *Lowell Sun*, "the patients targeted are the most vulnerable: elderly, chronically ill people who have no direct support at home." This is consistent with the population identified at risk by the Greater Lowell Health Alliance Needs Assessment.

Commenting on the CHART Program, The Lowell General Hospital Director of Continuity of Care noted, "The program offers 'reassurance that there will be follow-up on patients after discharge, which we never really had before." A CHART patient said, "On a scale of 1 to 10, my social worker is a 20…This program helps me a lot."

8. What systems will facilitate integration and coordination of care between Merrimack Valley Center and LGH/Circle Health ACO?

The Applicant has shared a unique relationship with Lowell General Hospital/Circle Health ACO in its joint collaborative efforts to improve data connectivity and interoperability. When CMS first introduced its Electronic Health Record (EHR) Incentive Programs (commonly known as "Meaningful Use"), Lowell General Hospital reached out to the Applicant to assist them in meeting their CMS Attestation requirements for electronically transmitting Continuity of Care Documents (CCD's) across the care continuum. As one of the largest providers in this local market, the Applicant was able to provide the volume needed to successfully implement a process that facilitates the seamless transmission of Patient Health Information (PHI) utilizing CMS approved encrypted messages. This important change in how the hospital transmits its CCD's allowed the Applicant's Centers to obtain Patient Health Information in advance of an acute-to-SNF transfer, whereby allowing Center care teams to better prepare to meet the needs of an inbound patient. These enhanced electronic processes have helped Applicant organizations to: increase operational efficiencies; decrease reporting lag times; reduce transcriptions errors; and eliminate workflow redundancies. All of which have led to improved patient outcomes, lower re-hospitalization rates within first 72 hours, and have helped to reduce the cost of delivering high quality health care.

The Applicant continues to evolve its interoperability platform with the development of automated ADT data feeds that send & receive secured PHI between providers as needed to improve the care transition process for our mutual patient population. The proposed Dracut facility will continue to advance this relationship with secured bi-directional (push/pull) transmission of patient health information via a virtual Health Information Exchange (HIE) that will be created to allow access to providers supporting the care needs of our patients.

In addition to the integration of systems mentioned above, the Applicant took great pains to insure the seamlessness of the telemetry monitoring with LGH/Circle Health ACO by proposing to utilize equipment at Merrimack Valley Center that was already operative at the hospital. The Development team conducted meetings with hospital IT personnel, met with the vendor that provided the LGH telemetry equipment and has built the purchase of identical equipment into the proposed budget. With the hardware and monitoring equipment being the same, the highly skilled staff needed at Merrimack Valley Center will be trained just as their counterparts at LGH/Circle Health.

Discussions, meetings and planning for Merrimack Valley Center have been ongoing since 2015 with clinical partner LGH/Circle Health ACO relative to patient selection, care paths and policies and procedures. As noted above, technologically the systems will be completely integrated. Further, significant conceptual agreement has been reached and it is the clear intention of the parties to develop the specific patient protocols with the Applicant, LGH/Circle Health ACO and the cardiologists as the Proposed Project moves toward completion.

At this time in 2018, the Applicant can describe current thinking and efforts in planning for an operational future that is a number of years away. The systems and programs described here are examples of the intent to pursue innovation and excellence. The process of developing integration and coordination systems will be ongoing, the plan will continue to evolve. Accordingly, the Merrimack Valley Center is designed with flexibility and innovation in mind.

9. How will the facility impact the quality of care and quality of life for long-term patients?

The quality of care for long-term patient will be enhanced by the completion of the Proposed Project. Academic studies and literature all point to the beneficial effect both psychosocially and clinically that a private room and new state-of-the-art physical plant has on the patient, their families and staff. Socially, privacy, especially with visitors, control over one's environment, empowerment and the dignity derived from patient centered care all rank high in patient and family satisfaction surveys. Clinically, reduced risk of exposure to nosocomial infection and better sleep patterns all lead to positive quality outcomes for the long-term patients.

In addition, this particular site in Dracut enhances the patient/family resident experience as it offers proximity to interstate highways, public transportation and sufficient parking to accommodate visitors. Contiguous to the Proposed Project will the new LGH Outpatient Building offering immediately accessible services as needed to the long-term care patient.

a. How will the impact be measured?

As mention in Question F1.b.ii **Public Health Value/Outcome Oriented**, there are many measures which the Applicant uses to measure the impact of care for long-term patients.

7. Hospitalizations
8. Re-hospitalizations
9. Reducing Anti-psychotic Use
10. Minimizing Skin Integrity
11. Infection Prevention and Control
12. 5-Star performance

Complementing the clinical care measurements and protocols listed above is the administration of annual Family and Resident Satisfaction Surveys.

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SunBridge Healthcare, LLC Building Component Description
February 27, 2018

Overview

The Proposed Project located at 55 Loon Hill Road, Dracut, MA 01826 will be comprised of 120 licensed beds in a four story building encompassing 78,621 gross square feet on 3.5 acres in Dracut. Three 40-bed nursing units will consist of all private rooms, 40 of which will be long-term care beds and 80 will be short-term stay beds including a 12-bed telemetry unit. For greater detail regarding the size of individual spaces refer to the Application Question F4.a.i. **Capital Costs Chart**, what follows is a component summary.

First Floor

- Lobby/Corridor/Elevators
- Central Dining Room
- General Activity Room
- Beauty Parlor
- Public Restrooms
- Physical and Occupational Therapy Rooms with a Therapy Courtyard
- Administration – Clinical Director/Director of Nursing, CED Office/Administrator, Admissions Office, Clinical Reimbursement, HR Office, Conference Room, open Workstations, Staff Toilet and Medical Records
- Kitchen, Laundry, Loading Dock, Staff Dining and a Service Elevator
- Outdoor Recreational Spaces, Separate Ambulance Entrance and Parking Area at grade under a portion of the building

Second Floor Long-Term Care Unit

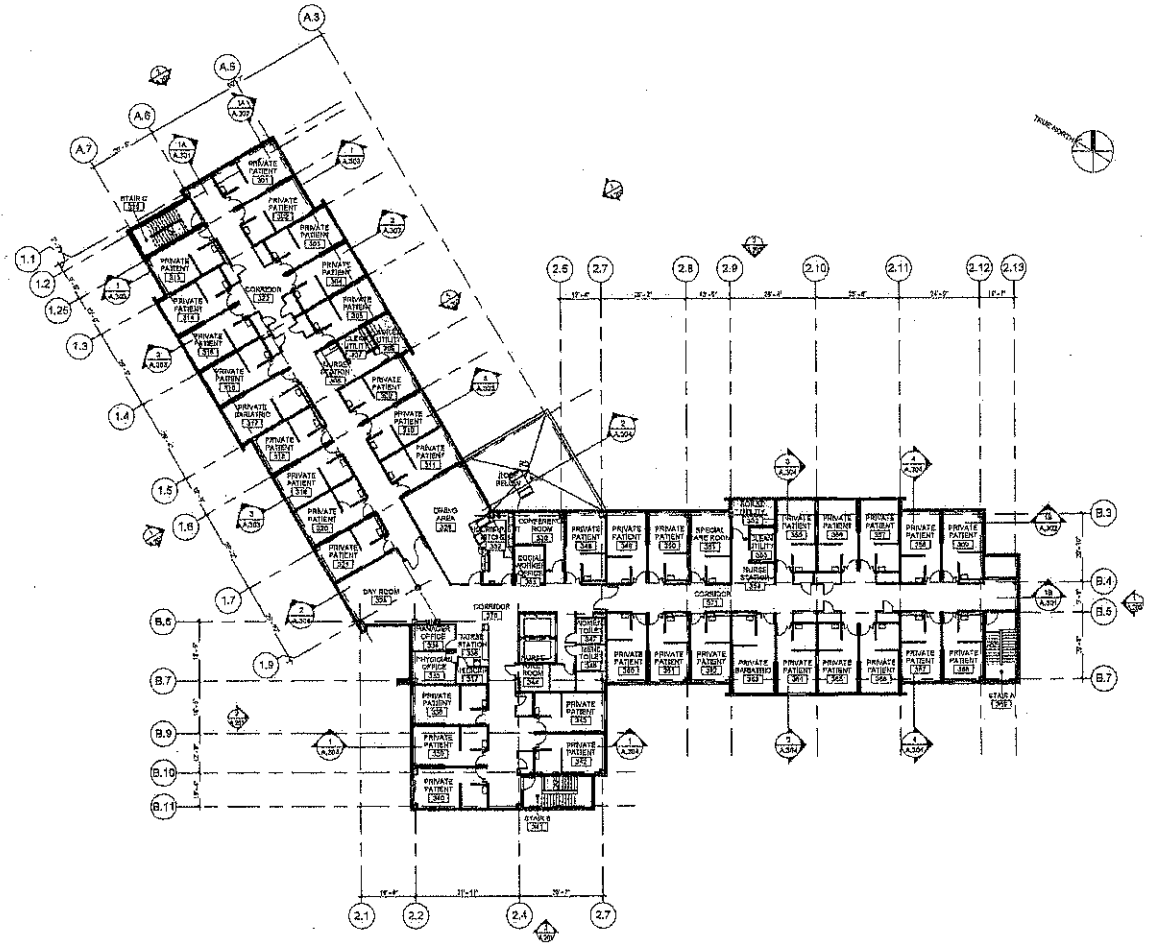
- 40 Private Patient Rooms with private bathrooms that include a shower. Two (2) are Bariatric Rooms and one (1) is a Special Care Room.
- Three (3) Nurses Stations, Dining Room, two (2) Day Rooms, Nourishment Kitchen, Bathing Room, Medicine Room, Clean and Soiled Utility Rooms and Offices for Unit Manager, Physicians and Social Worker.

Third and Fourth Floors, Short-Term Care Units

- 40 Private Patient Rooms on each of these floors with private bathrooms that include a shower. Per floor: Two (2) are Bariatric and one (1) is a Special Care Room.
- Twelve (12) of the Patient Rooms will be dedicated Telemetry Rooms. They will be situated on either the third or fourth floor. Six (6) of the Telemetry Rooms will be at the beginning of the "A" Wing and the remaining six (6) are at the beginning of the "B"

Wing, closest to the main Nurses Station and elevators. *The overall Third Floor Plan is attached here to better illustrate the "A" and "B" Wing orientation.*

- Per Floor: Three (3) Nurses Stations, Dining Room, Nourishment Kitchen, Medicine Room, Clean and Soiled Utility Rooms, Conference Room and Offices for the Unit Manager, Physicians and Social Worker.



1 THIRD FLOOR PLAN - OVERALL
SCALE: 1/16" = 1'-0"

Notes:

Key Plan:

Architect's Stamp:

Project:
Genesis HealthCare - Dracut

68 Loon Hill Rd.
Dracut, MA 01826

Client:
Genesis HealthCare

Loon Hill Road, Dracut, MA

Project #: 17070
Scale: 1/16" = 1'-0"

Issue:	Date:
Construction Documents	11/14/2017
Progress	

Revisions:	Date:

Drawing Title:
THIRD FLOOR OVERALL PLAN

Sheet Number:
A.103

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