Hospital of Saint Raphael

A member of the Saint Raphael Healthcare System

1450 Chapel Street
New Haven, Connecticut 06511
(203) 789-3000

May 20, 2004

Cristine Vogel
Commissioner
State of Connecticut
Office of Health Care Access
410 Capital Avenue
Hartford, Connecticut 06134-0308

RE: Letter of Intent
Redesign and Renovation of the Verdi-4-North (V4N) Inpatient Nursing Unit

Dear Commissioner Vogel:

This document should serve as a Letter of Intent to file a Certificate-of-Need application for the redesign and renovation of the Hospital's 30-bed Verdi-4-North inpatient nursing unit. Enclosed for your review is OHCA Form 2030 that describes this proposed project.

We believe that this project is critical to our ability to continue to meet the health care needs of our surgical and medical patients. We look forward to working with you, and with the analysts and staff of the Office of Health Care Access during this review process.

Please do not hesitate to contact me at (203) 789-5961, should you have any questions, or should you need any additional information.

Sincerely,

Jeffrey B. Hughes
Director
Planning & Business Development

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	**Hospital of Saint Raphael**	**N/A**
Doing Business As	**Hospital of Saint Raphael**	
Name of Parent Corporation	**Saint Raphael Healthcare System, Inc.**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**1450 Chapel Street New Haven, CT 06511**	
Applicant type (e.g., profit/non-profit)	**Non-profit**	
Contact person, including title or position	**Jeffrey B. Hughes Director, Planning & Business Development**	
Contact person's street mailing address	**1450 Chapel Street New Haven, CT 06511**	
Contact person's phone #, fax # and e-mail address	**(203) 789-5961 – Phone (203) 789-3653 – Fax jhughes@srhs.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Redesign and Renovation of the Verdi-4-North (V4N) Inpatient Nursing Unit

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):
1450 Chapel Street, New Haven, CT 06511

d. List all the municipalities this project is intended to serve:
(See Attachment #1)

e. Estimated starting date for the project: ***September 1, 2004***

f. Type of project: **4** **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

No changes in the number of beds are anticipated as a result of this project.

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: **$ 3,000,000**

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$ 2,700,000
Medical Equipment (Purchase)	200,000
Imaging Equipment (Purchase)	100,000
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$ 3,000,000**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$ 3,000,000**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☒ Applicant's Equity ☒ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

Please see Attachment 2

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

List of Attachments

1. ***List of Service Area Towns***
2. ***Project Description***

Attachment 1

List of Service Area Towns

Attachment 1

Hospital of Saint Raphael
Project Service Area

Ansonia
Bethany
Branford
Cheshire
Clinton
Derby
East Haven
Guilford
Hamden
Madison
Meriden
Milford
New Haven
North Branford
North Haven
Orange
Oxford
Seymour
Shelton
Wallingford
West Haven
Woodbridge

Attachment 2

Project Description

Attachment 2

Hospital of Saint Raphael
Redesign and Renovation of the Verdi-4-North (V4N) Inpatient Nursing Unit

Project Description

The purpose of this project is to redesign and renovate the Hospital's 30-bed Verdi-4-North ("V4N") inpatient nursing unit. The justification for this renovation project is the need to ensure the quality of patient care through improved infrastructure, updated medical technology, and enhanced operational design.

The V4N inpatient Nursing Unit, located on the 4th floor of the Verdi Building, is primarily used for the care and treatment of orthopedic patients. The V4N unit has not been updated since its original construction in the late 1970's.

This project represents a necessary upgrade and renovation of one aspect of our core inpatient business. The V4N inpatient nursing unit principally serves the residents of our 22-town Greater New Haven service area who are in need of post-operative orthopedic medical care. Medicare on the V4N nursing unit is provided by physicians, nurses, physician assistants, and nurses aides.

Yale-New Haven Hospital, Griffin Hospital (Derby), Midstate Medical Center (Meriden), and Milford Hospital, provide similar services within our defined service area. Because this request is for renovation and upgrade of an existing inpatient unit, this proposed project is not expected to adversely impact any other provider in the State of Connecticut.

The Hospital of Saint Raphael is seeking approval to upgrade vital services to our existing patient population. The need for these services has already been established, and the proposed project will enable the Hospital to continue to meet current demand.

The expected payor mix for this service is expected to mirror the overall payor mix of the Hospital which is:

Commercial	33.0 %
Medicare	54.9 %
Medicaid	5.9 %
Self Pay / Other	6.2 %
TOTAL	100.0 %