Connecticut Children's
MEDICAL CENTER

Christine A. Vogel, Commissioner
Office of Health Care Access, MS# 13HCA
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134-0308

11 July, 2007

Dear Commissioner Vogel:

Re: Consolidation of Pediatric Inpatient Beds in Waterbury

Enclosed is a CON Letter of Intent Form 2030 for the above named project. As you can see from the submission, there are three applicants for this project – Waterbury Hospital, Saint Mary's Hospital and Connecticut Children's Medical Center. All of us believe that this proposal will provide more efficient and better-coordinated pediatric inpatient care for children in the Greater Waterbury area.

We look forward to your request for a full Certificate of Need application.

I will be the contact for this proposal. Please call me (860-545-9339) or email (Lbanco@ccmckids.org) if you have any questions or need further information.

Regards,

Leonard Banco MD

Leonard Banco, MD
Vice President,
Regional Development

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 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 this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	Saint Mary's Hospital	Waterbury Hospital
Doing Business As	Saint Mary's Hospital	Waterbury Hospital
Name of Parent Corporation	Saint Mary's Health System	Greater Waterbury Health Network
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	56 Franklin Street Waterbury, CT 06706	64 Robbins Street Waterbury, CT 06721
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	NP
Does the Applicant have Tax Exempt Status?	**Yes** No	**Yes** No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Michael Novak VP, Graduate Medical Education & Professional Services	Colleen Scott Vice President, Finance
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Same	Same

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 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 this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant Three	
Full legal name	Connecticut Children's Medical Center	
Doing Business As	Connecticut Children's Medical Center	
Name of Parent Corporation	Connecticut Children's Medical Center Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	282 Washington Street Hartford, CT 06106	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	**Yes** No	
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Leonard Banco, MD Vice President, Regional Development	
Contact Person's Mailing Address, if PO Box, include a street mailing address for	Same	

Certified Mail		
Contact Person's Telephone Number	860-545-9339	
Contact Person's Fax Number	860-545-8558	
Contact Person's e-mail Address	Lbanco@ccmckids.org	

Contact Person's Telephone Number	203-709-3508	203-573-7280
Contact Person's Fax Number	203-709-8689	203-573-7325
Contact Person's e-mail Address	mnovak@stmh.org	cscott@wtbyhosp.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Consolidation of Pediatric Inpatient beds in Waterbury

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 $ 3,000,000
- ☐ Equipment Acquisition
  - ☐ New
  - ☐ Replacement
  - ☐ Major Medical (> $3,000,000)
  - ☐ Imaging
  - ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

Saint Mary's Hospital, 56 Franklin Street, Waterbury, 06706; Waterbury Hospital, 64 Robbins Street Waterbury, 06721

d. List each town this project is intended to serve: Primarily Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Prospect, Southbury, Thomaston, Waterbury, Watertown, Woodbury, Wolcott and other towns to a lesser degree.

e. Estimated starting date for the project: Mid 2008

f. Type of project: 5, 33

(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 or (Decrease)	Proposed Total Licensed
CCMC Total Pedi Med/Surg.	127 92	135 103	12 12	147 115
WH Total WH Pediatric	246 10	357	0 (10 pedi staffed)	357
SMH Total SMH Pediatric	209 12	347	0 (12 pedi staffed)	347

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 600,000

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	$100,000
Major Medical Equipment Purchases	-0-
Non-Medical Equipment Purchases*	$100,000
Land/Building Purchases	-0-
Construction/Renovation	$ 400,000
Other (Non-Construction) Specify:	

Total Capital Expenditure	**$ 600,000**
Medical Equipment – Fair Market Value of Leases	-0-
Major Medical Equipment – Fair Market Value of Leases	-0-
Non-Medical Equipment – Fair Market Value of Leases*	-0-
Fair Market Value of Space – Capital Leases Only	-0-
Total Capital Cost	**-0-**
Total Project Cost	**$ 600,000**
Capitalized Financing Costs (Informational Purpose Only)	

- Provide an itemized list of all non-medical equipment to be purchased and leased.

Side chairs
Side tables
Parent Sleep chairs/sofas
TVs/DVD players
Beds
Laptop PCs
Refrigerator
Distraction Machine (for pain/anxiety control)
Assorted shelving, playroom materials.

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☐ Yes

If you checked "Yes" above, please check the appropriate box below:

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
DNA				

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

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

☒ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable. **See Attachment**

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and who is the target population to be served.

4. Identify any unmet need and describe how this project will fulfill that need.

5. Are there any similar existing service providers in the proposed geographic area?

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

AFFIDAVIT

To be completed by each Applicant

Applicant: **Saint Mary's Hospital**

Project Title: Consolidation of Pediatric Inpatient beds in Waterbury

I, **Robert P. Ritz, CEO** of **Saint Mary's Hospital**, being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that **Saint Mary's Hospital** complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

July 5, 2007
Date

Subscribed and sworn to before me on July 5, 2007

Lynne H. Kilbourn
Notary Public/~~Commissioner of Superior Court~~

My commission expires: October 31, 2007

LYNNE H. KILBOURN
NOTARY PUBLIC
MY COMMISSION EXPIRES OCT. 31, 2007

RECEIVED
2007 JUL 13 A 11:41

AFFIDAVIT

To be completed by each Applicant

Applicant: Waterbury Hospital

Project Title: Consolidation of Pediatric Inpatient beds in Waterbury

I, Colleen Scott (Name), CFO (Position – CEO or CFO)

of Waterbury Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Waterbury Hospital (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

6/27/07
Date

Subscribed and sworn to before me on June 27, 2007

Kelly L Keating
Notary Public/Commissioner of Superior Court

My commission expires: August 31, 2009

AFFIDAVIT

To be completed by each Applicant

Applicant: CONNECTICUT CHILDREN"S MEDICAL CENTER

Project Title: Consolidation of Pediatric Inpatient beds in Waterbury

I, Martin J. Gavin, (Name), President and CEO (Position – CEO or CFO)

of Conn. Children's Medical Center being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Conn. Children's Medical Center (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Martin J Gavin
Signature

6/29/07
Date

RECEIVED
2007 JUL 13 A 11:42
OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on June 29, 2007

R J Phillips
Notary Public/~~Commissioner of Superior Court~~
Rebecca J. Phillips

My commission expires: 10/31/2011

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. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. **List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.** Waterbury Hospital and Saint Mary's Hospital both provide pediatric inpatient medical/surgical services to children under 17 years of age on inpatient units identified as "pediatric" at each facility. Each inpatient unit is staffed by attending physicians, advanced practice registered nurses, physician assistants and registered nurses, as well as other support staff as required. Connecticut Children's Medical Center is a freestanding children's hospital in Hartford which provides a full array of inpatient services for children <19 years of age. It provides care to children from the greater Hartford region as well as to children from around the rest of the state. At present, patients beyond the scope of expertise provided at Waterbury or Saint Mary's Hospital are often transferred to Connecticut Children's. Waterbury Hospital and Connecticut Children's Medical Center have had, since 1999, a formal affiliation agreement that defines the nature of their working relationship.

2. **List the types of services are being proposed and what DPH licensure categories will be sought, if applicable**. The three hospitals are proposing to consolidate inpatient pediatrics in Waterbury into a single inpatient unit to be owned and operated by Connecticut Children's Medical Center and located at Saint Mary's Hospital. Waterbury Hospital and Saint Mary's Hospital will close their existing pediatric units and eliminate their current staffed pediatric bed capacity. Connecticut Children's Medical Center will request an increase of 12 licensed beds, to be designated for a satellite location at Saint Mary's Hospital. As a result of this consolidation, there will be unified pediatric leadership and capacity to serve the Greater Waterbury region. There will also be integration with services currently being provided by Connecticut Children's and its physicians in Hartford and in other parts of the state. This proposal will not affect currently existing services for newborns or pediatric patients seeking services in the emergency department at either Saint Mary's Hospital or Waterbury Hospital. Connecticut Children's Medical Center will execute an agreement with both hospitals to provide the appropriate services and functions to support the new satellite.

3. **Identify the current population served and who is the target population to be served**. The pediatric population in the towns comprising the primary service area served by the two Waterbury hospitals is 52,627. Pediatric patients from 33 other towns were admitted to the two hospitals in FY2005. It is anticipated that the target population to be served by the consolidated pediatric service will be the same as at present.

4. **Identify any unmet need and describe how this project will fulfill that need.** It has become burdensome to sustain the cost of maintaining staffed beds at both hospitals. It is also challenging to recruit, train and maintain the skills of nursing, professional and support staff. By merging the volume at both current sites under the aegis of a comprehensive children's hospital, there are several patient care advantages

    - Improved access to a network of pediatric specialists for children in the greater Waterbury area.
    - Enhanced ability to hire and retain staff who have specific skills and proficiency in the care of children.
    - Opportunities to rotate pediatric staff between a secondary and tertiary care environment to enhance clinical education and maintenance of skills.
    - Children's Hospital leadership will strengthen the ability to provide continuing education for community pediatricians and family practitioners
    - A partnership between Connecticut Children's, Saint Mary's and Waterbury Hospitals will increase the ability to provide innovative community programs for pediatric health promotion and safety.

5. **Are there any similar existing service providers in the proposed geographic area?** There are no other inpatient pediatric units in the primary service area. Charlotte Hungerford Hospital has a small pediatric inpatient unit (209 admissions) north of Waterbury, in Torrington. Neither Bradley Hospital (Southington) nor Griffin Hospital (Derby) have inpatient pediatric beds. Danbury Hospital has an inpatient pediatric unit with 500 admissions in FY2006, but serves a different geographic service area for pediatrics.

6. **Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut**. This proposal will make the system of care for children more cost efficient. Use of resources will be enhanced and those resources will be better integrated across the region. Since Connecticut Children's Medical Center opened in 1996, it has been committed to raising the standard of pediatric care across the state and to providing appropriate care as close to where children live as possible. This has resulted in affiliation agreements with 10 hospitals across the state, and the establishment by CCMC's affiliate specialty physicians of 14 practice sites.

7. **Who will be responsible for providing the service?** This effort will be a collaboration between the three applicant institutions, with Connecticut

Children's owning the inpatient service, employing the staff and contracting for appropriate support services from the host hospital.

8. **Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?**

It is anticipated that the payer mix of the consolidated pediatric entity in Waterbury will be similar to those of the pediatric inpatient units of Saint Mary's Hospital and Waterbury Hospital presently. No patient will be denied service due to his/her ability to pay for those services.

Current Payer Mix (Medicaid + top 3 commercial payers)

	Saint Mary's	Waterbury	CT Children's
Medicaid/Med. Mgd. Care	55.6%	44.8%	46.7%
Commercial:			
Blue Cross	15.2%	23.2%	22.2%
Connecticare	3.9%	7.6%	7.0%
Aetna	--	--	6.0%
HealthNet	--	4.8%	--
Cigna	5.2%	--	--
Other	18.5%	15.6%	15.4%
Self Pay	1.6%	4.1%	2.7%

STATE OF CONNECTICUT

Pg 16/18

Department of Public Health

LICENSE

License No. 0055

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Saint Mary's Hospital, Inc. of Waterbury, CT, d/b/a Saint Mary's Hospital, Inc. is hereby licensed to maintain and operate a General Hospital.

Saint Mary's Hospital, Inc. is located at 56 Franklin Street, Waterbury, CT 06702

The maximum number of beds shall not exceed at any time:

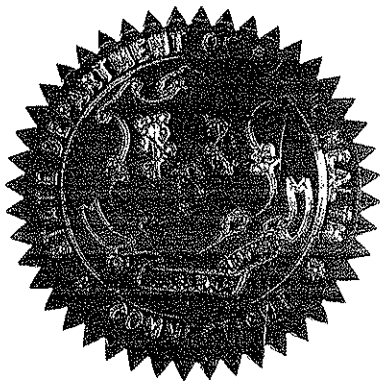
32 Bassinets
347 General Hospital beds

This license expires **December 31, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2007.

Satellites

St. Mary's Dept. of Behavioral Health Care Services, 100 Jefferson Square, Waterbury, CT



J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT

Pg 17/18

Department of Public Health

LICENSE

License No. 0060

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Waterbury Hospital of Waterbury, CT, d/b/a The Waterbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Waterbury Hospital is located at 64 Robbins Street, Waterbury, CT 06721

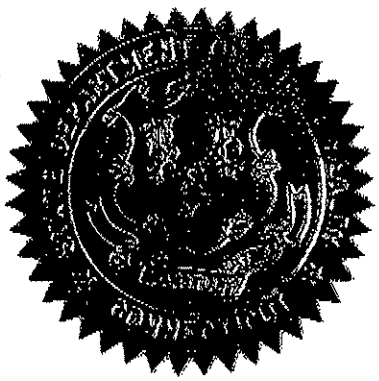
The maximum number of beds shall not exceed at any time:

357 General Hospital beds
36 Bassinets

This license expires **September 30, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2005.

License revised to reflect:
*Removed satellites effective 7/25/06



J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT

Pg 18/18

Department of Public Health

LICENSE

License No. 2-CH

Children's Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Connecticut Children's Medical Center of Hartford, CT, d/b/a Connecticut Children's Medical Center is hereby licensed to maintain and operate a Children's Hospital.

Connecticut Children's Medical Center is located at 282 Washington Street, Hartford, CT 06106

The maximum number of beds shall not exceed at any time:

103 Licensed Bed
32 Bassinet

This license expires **December 31, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006.

License revised to reflect:
*Corrected bed capacity

Satellites

Neo-Natal Intensive Care Unit, North Building, Hartford Hospital

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 18, 2007

Leonard Banco, M.D.
Vice President, Strategy & Regional Development
Connecticut Children's Medical Center
282 Washington Street
Hartford, CT 06106

Re: Letter of Intent, Docket Number 07-31003
CCMC, Waterbury Hospital & Saint Mary's Hospital
Consolidation of inpatient pediatric programs into a single inpatient unit to be owned and operated by CCMC and located at Saint Mary's Hospital
Notice of Letter of Intent

Dear Dr. Banco:

On July 13, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of CCMC, Waterbury Hospital & Saint Mary's Hospital ("Applicants") for the consolidation of inpatient pediatric programs into a single inpatient unit to be owned and operated by CCMC, at a total capital expenditure of $600,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Waterbury Republican American* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

Copy: Colleen Scott, Vice President of Finance, Waterbury Hospital
Michael Novak, Vice President, Graduate Medical Education, St. Mary's Hospital

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 18, 2007

Requisition # HCA08-009
FAX: (203) 754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, July 23, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Laurie Greci** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

Waterbury Republican American
Docket Number 07-31003

Letter of Intent
July 18, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	CCMC, Waterbury Hospital and Saint Mary's Hospital
Town:	Waterbury
Docket Number:	07-31003
Proposal:	Consolidate inpatient pediatric programs into a single inpatient unit to be owned and operated by CCMC and located at Saint Mary's Hospital
Capital Expenditure:	$600,000

The Applicant may file its Certificate of Need application between September 11, 2007 and November 10, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2367
RECIPIENT ADDRESS	912037540644
DESTINATION ID	
ST. TIME	07/18 14:55
TIME USE	00'18
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 18, 2007

Requisition # HCA08-009
FAX: (203) 754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, July 23, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Laurie Greci** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 24, 2007

Leonard Banco M.D. M.D.
Vice President, Strategy & Regional Development
Connecticut Children's Medical Center
282 Washington St.
Hartford, CT 06106

RE: Certificate of Need Application Forms, Docket Number 07-31003-CON
Connecticut Children's Medical Center, Saint Mary's Hospital, and Waterbury Hospital
Consolidation of Inpatient Pediatric Services in Waterbury

Dear Dr. Banco:

Enclosed are the application forms for the Certificate of Need ("CON") proposal for the consolidation of inpatient pediatric services in Waterbury, with an associated capital expenditure of $600,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between September 11, 2007, and November 10, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

Copy: Michael Novak, Vice President, Graduate Medical Education, St. Mary's Hospital
Colleen Scott, Vice President of Finance, Waterbury Hospital

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than September 11, 2007, and may be submitted no later than November 10, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-31003-CON

Applicants' Names: Connecticut Children's Medical Center
Saint Mary's Hospital Corporation
Waterbury Hospital

Contact Person: Leonard Banco M.D.
Contact Title: Vice President, Strategy & Regional Development
Connecticut Children's Medical Center
Contact Address: 282 Washington St.
Hartford, CT 06106

Project Location: Waterbury

Project Name: Connecticut Chidlren's Medical Center, Waterbury Hospital, and Saint Mary's Hospital - Consolidation of Inpatient Pediatric Programs into a Single Inpatient Unit Owned and Operated by CCMC and Located at SMH

Type of Proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $600,000

1. Expansion of Existing or New Service

What services are currently offered at the Applicants' facilities that the proposed expansion or new service will augment or replace? Please list.

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicants' Long Range Plan

Is this application consistent with the long-range plan of each hospital?

☐ Yes ☐ No If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The units of service for the past three fiscal years and the current fiscal year- to-date by service area town *for each Applicant.*
   d) The units of service for the past three fiscal years and the current fiscal year- to-date by service type f*or each Applicant.*
   e) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
   f) Scheduling backlogs in service area.
   g) Travel distance from the proposed site to service area towns.
   h) Hours of operation of existing and the proposed service.

ii) Identify the existing providers of the proposed service in the proposed service area (primary and secondary) using the following table format:

Description of Service	Provider Name, Address and Zip Code	Number of Licensed Beds	Number of Staffed Beds

iii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural
☐ Geographic
☐ Other (Identify)
☐ Transportation
☐ Economic
☐ None.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies
☐ Public information reports
☐ Other (Identify)
☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:
☐ Needs assessments
☐ Market share analysis

D. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies
☐ Public information reports
☐ Needs assessments
☐ Market share analysis

☐ Other (Identify)
☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

- ☐ American College of Cardiology
- ☐ National Association of Child Bearing Centers
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ American College of Radiology
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Substance Abuse Society and Mental Health Services Administration
- ☐ Other, Specify:

B. Describe in detail how the Applicants plan to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Applicants' Chief Executive Officers (CEO) and Chief Financial Officers (CFO), Medical Directors, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.
Note: *For physicians, please provide a list of hospitals where the physicians have admitting privileges.*

D. Provide a copy of the most recent inspection reports and/or certificate for your facility:

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

Note: Above referenced acronyms are defined below. [1]

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospitals (Applicants), Physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action that has been formulated to address the above action against the Hospitals (Applicants), Physician(s) working at the Hospital and/or any staff related to the proposal.

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[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

G. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has each Applicant undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Affiliations, Mergers, Acquisitions and Changes in Ownership

A. Provide a copy of the written agreement or memorandum of understanding among the Applicants related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

B. Identify the following items for each Applicant:

i) Geographical service area.
ii) Physician referral patterns.

C. Provide for each Applicant the following information related to the proposal:

i) Board of Directors or governing body resolutions approving the proposal.
ii) Changes in facility licensed beds, health care services, service areas, locations and management.
iii) Medicare provider number.
iv) Identify if a new cost center will be established or if an existing cost center will be utilized.
v) Identify the cost centers that will be terminated.

9. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.)
☐ Partnership
☐ Joint Venture
☐ Other (Specify):
☐ Limited Liability Company (LLC)
☐ Professional Corporation (PC)

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application for each Applicant.

iii) Provide a copy of the most recently completed internal monthly financial statements for each Applicant.

iv) Identify the entity that will be billing for the proposed service.

10. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

11. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	
CON Proposed debt financing	
Interest rate	%
Monthly payment	
Term	Years
Debt service reserve fund	

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

13. Revenue, Expense, and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format **for each Applicant and discuss each significant change in the payer mix.**

Total Facility Description	FY _____ (Current) Payer Mix	FY____ (Year 1) Projected Payer Mix	FY ____ (Year 2) Projected Payer Mix	FY _____ (Year 3) Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Do the Applicants have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project for each Applicant. **See attached, Financial Attachment I (a separate form has been enclosed for each Applicant).** ***Note:*** *Actual results for the fiscal year reported in the first column must agree with the Applicants' audited financial statements.*

ii) Provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, Financial Attachment II.**

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). ***Note:*** *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective for each Applicant.

vii) Provide a copy of any "turn-around" plan that the Applicants may have in place concerning the Applicants' current financial position.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

13. C (i). Please provide one year of actual results and three years of projections of Connecticut Children's Medical Center's revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs										
***Volume Statistics:**										

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

13. C (i). Please provide one year of actual results and three years of projections of Saint Mary's Hospital's revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs										
Volume Statistics:										

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

13. C (i). Please provide one year of actual results and three years of projections of Waterbury Hospital's revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs										
***Volume Statistics:**										

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

13. C. ii Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description									
Type of Unit Description:									
# of Months in Operation									
FY _____ (Year _)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by Payer Category:								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0