DANBURY HOSPITAL
A Higher Level of Care

Frank J. Kelly
President and Chief Executive Officer

June 19, 2008

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

Dear Commissioner Vogel,

Please find enclosed a CON Determination Form 2020 regarding the **Termination of Partial Hospital Program and Transfer Patients to an Already Established Intensive Outpatient Program**.

I respectfully submit this Determination Letter for your consideration. Should you have any questions regarding this request, please don't hesitate to contact me or Andrea Rynn, Community and Government Relations Manager. Ms. Rynn can be reached at 203-739-7919 or via e-mail at andrea.rynn@danhosp.org.

Sincerely,

Frank J. Kelly
President and CEO
Danbury Health Systems

Encl. Form 2020
Attachment "A" Project Description – Termination of Partial Hospital Program and Transfer Patients to an Already Established Intensive Outpatient Program Project Summary

cc: Charles Herrick, M.D./Danbury hospital
Joseph Shea/Danbury Hospital
Andrea Rynn/Danbury Hospital

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	**The Danbury Hospital**	
Doing Business As	**The Danbury Hospital**	
Name of Parent Corporation	**Danbury Health Systems, Inc.**	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	**24 Hospital Ave. Danbury, CT 06810**	
What is the Petitioner's Status: P for profit and NP for Nonprofit	**NP**	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	**Andrea Rynn Director, Public and Government Relations**	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**24 Hospital Avenue Danbury, CT 06810**	
Contact Person's Telephone Number	**203-739-7919**	
Contact Person's Fax Number	**203-739-1689**	
Contact Person's e-mail Address	**andrea.rynn@ danhosp.org**	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: **Termination of Partial Hospital Program and Transfer Patients to an Already Established Intensive Outpatient Program**

b. Location of proposal, identifying Street Address, Town and Zip Code:
24 Hospital Ave. Danbury, CT 06810

c. List each town this project is intended to serve:
Bethel, Brookfield, Danbury, New Fairfield, Newtown, Redding and Ridgefield

d. Estimated starting date for the project:
Upon approval

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☒	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):_____			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **No cost associated**

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	**N/A**
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space –Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☐ Petitioner's Equity	☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	☐ Other (specify): **N/A**

SECTION IV. PROPOSAL DESCRIPTION – See Attachment "A"

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 elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?
3. Identify the current population served and the target population to be served.
4. Identify the entity that will be providing the service(s).
5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.
6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service.
7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.
8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.
9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.
10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.
11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

SECTION V. USE OF CON DETERMINATION FORM AS A LETTER OF INTENT

If the Petitioner's proposal requires a Certificate of Need, please check one of the following:

☒ OHCA may consider the form, and the information provided, as the Petitioner's Letter of Intent Form 2030 requesting initiation of the Certificate of Need process. OHCA will provide the Petitioner a CON application for the proposal.

☐ The Petitioner will submit a separate Letter of Intent Form 2030 to request the initiation of the Certificate of Need process.

SECTION VI. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: **The Danbury Hospital, Inc.**

Project Title: **Terminate Partial Hospital Program and Transfer Patients to an Already Established Intensive Outpatient Program**

I, **Frank J. Kelly, President and CEO,** of **The Danbury Hospital**, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that **The Danbury 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 _____ Date 6/20/08

Subscribed and sworn to before me on June 20, 2008

_____
Notary Public/Commissioner of Superior Court

My commission expires: 9/30/09

RECEIVED
2008 JUN 24 A 10:57
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Attachment "A" Project Description

Summary

The Danbury Hospital has offered partial hospital and intensive outpatient psychiatric care for a number of years including a Partial Hospitalization Program. The patient population for this program is adults from our primary service area, with psychiatric disorders, who are recently discharged from inpatient hospitalization or whose symptoms have exacerbated and come to these programs to avoid an inpatient hospitalization. Referrals for these programs come from the Danbury Hospital inpatient unit and from other inpatient facilities. In addition, community outpatient providers such as psychiatrists, psychologists, social workers and therapists refer patients from the community to these programs.

At the present time, our average daily census for partial hospital patients is about 5 patients. To maintain this designation as a Partial Hospitalization Program takes significant staff time, which could be better spent re-allocated to an intensive outpatient level of care for these same patients. The regulatory compliance documentation and paperwork for a Partial Hospital Program are an arduous and consuming expenditure of staff resources. The documentation required for an Intensive Outpatient Program level of care, which is very similar to a Partial Hospital Program level of care, requires significantly less staff time.

We propose "transferring" these few Partial Hospital Program patients to an Intensive Outpatient Program level of care. The sole difference in actual care will be that instead of offering patients 41/2 hours of care, five days a week, we will be offering them 31/2 hours of care, five days a week. The same clinicians currently in the Partial Hospital will provide care in the Intensive Outpatient Program. There will be absolutely no change in the care provided, no change in patients, etc., aside from the daily 1-hour reduction to the program. Any time and costs saved would be redirected to patient care.

We intend to continue to offer full outpatient psychiatric care, including what is commonly referred to as "intensive" outpatient care (please note that all outpatient care is in effect the same service). We expect to treat the same number of patients as currently enrolled. We anticipate a slight increase in the number of days of care that patients are approved for by the insurance companies. Billing and Payers for this service would remain unchanged; Payers being Medicare, Medicaid, managed care, commercial, and self-pay.

This proposed change is consistent with efforts by both Department of Mental Health and Addiction Services submitted budget proposal to eliminate the Partial Hospitalization benefit from the SAGA schedule and insurance company's efforts to contain costs.

At present, our Department of Public Health license identifies our Community Center for Behavioral Health at 152 West Street Danbury, as providing "Adu-Php". Our program at this site would remain unchanged with the exception of our Partial Hospital Program, which as explained would transition to an Intensive Outpatient Program.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 3, 2008

Andrea Rynn
Director, Public and Government Relations
The Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Determination Report Number: 08-31194-DTR
The Danbury Hospital
Termination of Partial Hospitalization Program and Transfer of Patients to Intensive Outpatient Program in Danbury

Dear Ms. Rynn:

On June 24, 2008, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the termination of a Partial Hospitalization Program and transfer of patients to an Intensive Outpatient Program in Danbury, with no associated capital expenditure. OHCA has reviewed the information contained in your request and makes the following findings:

1. The Danbury Hospital ("Hospital") is a general hospital located at 24 Hospital Avenue, Danbury.

2. The Hospital currently provides outpatient psychiatric care, including a Partial Hospitalization Program ("PHP") and Intensive Outpatient Program ("IOP"), at its Community Center for Behavioral Health at 152 West Street, Danbury.

3. The Hospital proposes to terminate the PHP due to the amount of staff time that must be dedicated to regulatory compliance documentation and paperwork

4. The Hospital indicated that it would transfer its existing PHP patients to the IOP level of care.

5. The Hospital stated that the only difference in actual care associated with the proposal would be that instead of offering patients 4 ½ hours of care, five days a week under the PHP, the Hospital would offer patients 3 ½ hours of care, five days a week under the IOP.

6. The target population for the PHP is adults from the Hospital's primary service area, with psychiatric disorders, who are recently discharged from inpatient hospitalization or whose symptoms have exacerbated and who come to the program to avoid an inpatient hospitalization. The target population will not change with the proposal and the Hospital anticipates treating the same number of patients as currently enrolled.

7. There is no expenditure associated with the proposal.

8. Pursuant to Section 19a-638 (a) (3) of the C.G.S., each health care facility which intends to terminate a health service offered by such facility shall submit to OHCA a request to undertake such termination.

Based on the above findings, OHCA has determined that the termination of a Partial Hospitalization Program and transfer of patients to an Intensive Outpatient Program in Danbury, with no associated capital expenditure, represents the termination of a service. Consequently, the proposal requires Certificate of Need approval, pursuant to Section 19a-638 of the Connecticut General Statutes.

OHCA considers the submission of information received on June 24, 2008, as the Letter of Intent for this matter. Therefore, the Hospital, may file a completed CON application with OHCA between August 23, 2008 and October 22, 2008. The CON application is being mailed to your attention separately.

If you have any questions concerning this letter, please contact Kimberly Martone, Certificate of Need Supervisor, at (860) 418-7029.

Sincerely,

Cristine A. Vogel
Commissioner

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

CAV: agf

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 7, 2008

Andrea Rynn
Director, Public and Government Relations
The Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application Forms, Docket Number 08-31194-DTR
The Danbury Hospital
Termination of Partial Hospitalization Program and Transfer of Patients to Intensive Outpatient Program in Danbury

Dear Ms. Rynn:

Enclosed are the application forms for The Danbury Hospital's Certificate of Need ("CON") proposal for the Termination of a Partial Hospitalization Program in Danbury with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 23, 2008, and October 22, 2008.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefiled testimony, late file submissions, and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

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

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosure

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 August 23, 2008, and may be submitted no later than Octpber 22, 2008. The Analyst assigned to your application is Alexis Fedorjaczenko. She may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	08-31194-CON
Applicant(s) Name:	The Danbury Hosptial
Contact Person:	Andrea Rynn
Contact Title:	Director, Public and Givernment Relations The Danbury Hospital
Contact Address:	24 Hospital Ave. Danbury, CT 06810
Project Location:	Danbury
Project Name:	Termination of Partial Hospitalization Program and Transfer of Patients to Intensive Outpatient Program in Danbury
Type proposal:	Section 19a-638, C.G.S.

Est. Capital Expenditure: $ 0

1. Expansion of Existing or New Service

What services are currently offered at your facility? Please list.

Augment: _____

Replace: _____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

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

4. Clear Public Need

A. Regarding this termination of Partial Hospitalization Program ("PHP") services in Danbury, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of PHP services. Identify the process undertaken by the Applicant in making the decision to terminate (e.g. was patient feedback solicited, board authorization received, an analysis conducted of transportation issues for patients who will need to travel to other sites for services, etc).

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program at this site? Please explain.

iii) Is the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

iv) Will this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Danbury location. Identify what the hours of operation are for the service location.

ii) List the service area towns. Provide a rationale for choosing the selected towns.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Danbury service location.

iv) Discuss any scheduling backlogs that exist at the Danbury service location.

v) Are there any waiting lists in place at the Danbury service location? If so, identify the number of patients on the waiting list.

vi) Describe the pattern of referrals to the Danbury service location that currently exist.

C. Regarding the impact on the patient and provider community of the termination of services at the Danbury service location, provide the following information:

a. Explain the procedures that the Applicant will follow in terminating these services and transferring patients to other programs.

b. Describe the other programs that patients will be transferred or referred to, and compare the services offered under these programs to those offered in the PHP.

c. Provide the information as outlined in the following table concerning the existing providers services in the Danbury service area:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

d. Has your facility contacted any other providers in the Danbury service area to see if they are willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.

e. What will be the effect of the termination of the Danbury service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

f. Will this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

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

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

_____

_____

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

5. Quality Measures

A. Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Hartford Hospital in Cheshire.

B. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, 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.

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

☐	DPH	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

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

6. Improvements to Productivity and Containment of Costs

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

[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.

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify) _____

7. Miscellaneous

A. Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

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

B. 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.

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Verify that this termination of services has not resulted in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the Cheshire service location:

i) Please submit one of the following;

(a.) an Audited or Unaudited Balance Sheet.

(b.) an Income Statement or Statement of Operations for the two most recently completed fiscal years.

***Note*:** These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Provide a discussion of any incremental gains or losses from operations that will be a direct result of the termination of the services

B) Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on actual patient payor mix in the following reporting format:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

***Includes managed care activity.**

D. Provide the following for the financial and statistical projections for the Cheshire service location:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** Please note that

the actual results for the fiscal year reported in the first column must agree with the Applicant's financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment II**.

iii) Provide 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.).

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.

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: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** 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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*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.

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 _____	(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								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 7, 2008

Andrea Rynn
Community/Government Relations
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

Re: Letter of Intent, Docket Number: 08-31194
Danbury Health Systems, Inc.
Termination of Partial Hospitalization Program and Transfer of Patients to Intensive Outpatient Program

Dear Ms. Rynn,

On June 24, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of ("Applicant") for the termination of partial hospitalization program and transfer of patients to intensive outpatient program in Danbury, at no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The News Times* 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 Martone

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 7, 2008

Requisition # HCA09-005
Acct# 129573
Fax: (203) 792-4211

The News Times
333 Main Street
Danbury, CT 06810

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 **Friday, July 11, 2008.**

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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AF:lmg

c: Sandy Salus, OHCA

The News Times
Docket Number 08-31194

Letter of Intent
July 7, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Danbury Health Systems, Inc.
Town:	Danbury
Docket Number:	08-31194-LOI
Proposal:	Termination of partial hospitalization program and transfer of patients to intensive outpatient program
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between August 23, 2008 and October 22, 2008. 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	3721
RECIPIENT ADDRESS	912037924211
DESTINATION ID	
ST. TIME	07/07 13:54
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 7, 2008

Requisition # HCA09-005
Acct# 129573
Fax: (203) 792-4211

The News Times
333 Main Street
Danbury, CT 06810

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 **Friday, July 11, 2008.**

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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone