WATERBURY HOSPITAL
HEALTH • CENTER
caring makes a world of difference

July 23, 2008

Cristine A. Vogel, Commissioner
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
P.O. Box 340408, MS# 13HCA
Hartford, CT 06134-0308

RE: CON Determination Form 2020
Waterbury Hospital Sleep Lab - Southbury

Dear Commissioner Vogel,

Enclosed please find an original and five (5) copies of our determination filing for the above.

Thank you for your consideration on this project and should you have any further questions and/or concerns please do not hesitate to contact me at 203.573.7280.

Sincerely,

Colleen Scott, CPA
Vice President of Finance

CP

Enclosures (6)

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	WATERBURY HOSPITAL	
Doing Business As		
Name of Parent Corporation	GREATER WATERBURY HEALTH NETWORK	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	64 Robbins Street Waterbury, CT 06708	
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.	COLLEEN SCOTT VICE PRESIDENT OF FINANCE	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	64 Robbins Street Waterbury, CT 06708	
Contact Person's Telephone Number Fax Contact Person's e-mail Address	203.573.7280 203.573-7325 cscott@wtbyhosp.org	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: Waterbury Hospital Sleep Lab – Southbury.

b. Location of proposal, identifying Street Address, Town and Zip Code: Heritage Resort & Conference Center, 522 Heritage Road, Southbury, CT 06488.

c. List each town this project is intended to serve: Southbury, Woodbury, Oxford.

d. Estimated starting date for the project: February, 2009.

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: $69,010.

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	$51,491
Non-Medical Equipment Purchases*	$10,699
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify: low voltage & phone wiring, signage	$ 6,820
Total Capital Expenditure	**$69,010**
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	**$69,010**
Total Project Cost	**$69,010**
Capitalized Financing Costs (Informational Purpose Only)	

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

RESPONSE: See Attachment A for an itemized list of all non-medical equipment.

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
EEG/PSG Monitoring System	Compumedics	E- Series EEG/PSG 44 System	One 2-Bed System	$51,491

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

RESPONSE: See the vendor quotation submitted as Attachment B.

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): _____

SECTION IV. PROPOSAL 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 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.

PROPOSAL DESCRIPTON

1. **Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.**
Waterbury Hospital operates a 6 bed sleep laboratory in the town of Middlebury at 1625 Straits Turnpike. The volume in the Sleep Lab has increased each year over the last several years. Fiscal year 2007 volume was 1,280 cases with the current fiscal year on track to realize a volume of 1,400 cases (October to May FY 2008 = 935 cases). Services of the Sleep Lab include diagnostic and therapeutic nocturnal polysomnography and multiple sleep latency studies. The Sleep Lab also offers clinical services such as positive airway pressure desensitization, treatment of narcolepsy, hypersomnia, circadian rhythm disorders, insomnia, pre-operative sleep testing and Actigraphy. Accredited by the American Academy of Sleep Medicine and led by a medical director fellowship trained in sleep medicine, the Waterbury Hospital Sleep Lab offers high quality sleep studies to area patients. The proposed project will offer patients living in the Southbury region a local facility in which to receive care for common sleep disorders such as insomnia, sleepwalking, snoring and obstructive sleep apnea. It will also provide the space necessary to accommodate a growing service line. See Attachment C for the Hospital's Department of Public Health License.

2. **Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?**
No additional licensure will be required. The proposed project is a 2 bed Sleep Lab located in the town of Southbury that will offer all of the services listed above, with the exception of multiple sleep latency studies and Actigraphy. Located within the Heritage Resort and Conference Center ("Heritage") the proposed program will offer area residents a convenient and comfortable setting to receive their sleep study. It will be overseen by Waterbury Hospital Sleep Lab Medical Director and Waterbury Hospital's Director of Outpatient Services. Accreditation in the American Academy of Sleep Medicine will be extended to the proposed site.

   Waterbury Hospital will be leasing 3 adjoining guest rooms on an upper floor of the resort in a quiet section of the building. All rooms will connect via interior doors so that once inside the "suite" the technician need not use the hallway to travel between rooms. The two "outer" rooms will be bedrooms for the patients obtaining a sleep study. The "middle" room will be established as the technician's workspace. The Heritage will lease the rooms fully furnished (less furniture in the technician space as noted above) with utilities, local phone, wifi, cleaning and linen services included in the lease fee.

   Patients will come to the Heritage and be directed by the hotel's front desk staff to the Sleep Lab. Upon arrival at the Sleep Lab, the polysomnographic technician will greet the patient and begin the sleep study acquisition process. The equipment set up will be identical to that found in today's Middlebury Sleep Lab including the necessary video and bedside monitoring. The data acquired during a sleep study is done so electronically through specialized software and an EEG/PSG Monitoring System. The study is interpreted by the medical doctor at a later time after the patient has completed their testing. Given the electronic nature of the data, similar data acquisition processes followed today at the Middlebury facility, will be followed at the Southbury site. Scoring and interpretation of the study will be done at the medical director's main office in Middlebury.

   Patient consultation visits often take place with the Sleep Lab medical doctor. These patient visits occur in advance of (or post) the overnight-stay sleep study and need not be 'same day'. Such visits will take place in one of two medical office locations at the convenience of the patient. One location is at the Southbury Medical Office Building on Old Waterbury Road, in available medical office space that has been leased by Waterbury Hospital for several years. The other location is at

the Middlebury Sleep Lab offices. Both of these locations are established and no additional costs will be incurred.

Patients will be afforded the opportunity to utilize the Heritage's many resort amenities from normal hotel check-in time on the day of the study, up to the time of their exam, and again until check-out time the following day.

3. **Identify the current population served and the target population to be served.**
   Approximately 90% of the patients currently served by the Waterbury Hospital Sleep Lab reside in the 12 town primary market of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Thomaston, Waterbury, Watertown, Wolcott and Woodbury. The target population for the proposed project includes the towns of Southbury, Woodbury and Oxford.

4. **Identify the entity that will be providing the service(s).**
   Waterbury Hospital will be providing the service.

5. **Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.**
   Waterbury Hospital will be responsible for the billing of the service.

6. **Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service.**
   Waterbury Hospital will be leasing the physical space.

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.**
   Not applicable.

8. **Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.**
   Not applicable.

9. **Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.**
   See Attachment D for the two organizational charts; one for Waterbury Hospital and one for the Greater Waterbury Health Network.

10. **Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.**
    Not applicable.

11. **Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?**
    All patients regardless of their ability to pay will be able to take advantage of the proposed Waterbury Hospital Sleep Lab in Southbury. The current payer mix for the service is 64% commercial and 36% government. A material change in payer mix is not expected.

Attachment A

Non-Medical Equipment Purchases

(1) Refrigerator	$150
(1) Wheel Chair	$650
(1) Concentrator	$850
(2) Cots (not required if choose room format w. 2 double beds vs 1 king size bed)	$300
(1) Office Chair	$340
(1) Desk	$600
(1) Compumedics workstation (furniture to hold technician's equipment)	$1,700
(1) PC for Technician	$1,300
(1) File Cabinet	$520
(3) Portable storage carts	$165
(2) Wall - Mounted Fans	$150
(1) AED	$3,000
10% contingency	$974
Total	$10,699

COMPUMEDICS
"Defining Life's Signals"

Compumedics USA
Sales Proposal

Date	04/01/08
Acct Manager	J. Polantz
Quote #	WATERBURY2E2PC040108
Freight Terms	Shipping Point
ARO 45-60	

6605 W. WT Harris Blvd. Ste F Charlotte, NC 28269 P - 704-749-3200 F - 704-749-3298

Sold To:

Waterbury Hospital
Frank Vensel
Clinical Engineering
64 Robbins Street
Waterbury, CT 06706

Phone: (203) 573-7160 **Fax:**

Ship To:

Waterbury Hospital
Frank Vensel
Clinical Engineering
64 Robbins Street
Waterbury, CT 06706

Phone: (203) 573-7160 **Fax:**

Terms	N30	**Ship Via**	UPS	**Quote Valid Date**	05/01/08

Qty	Part Number	Description
2	9008-0010-01	Compumedics E-Series EEG/PSG 44 System: includes 44-Channel Amplifier/Headbox(inputs for 32 referential signals and 12 bipolar signals), headbox cable, PIB cover with wall mount, E-Series Control Module with 2 pressure transducer ports, 8 DC signal inputs and inputs for optional pulse-oximeter, event button and photic stimulator. LED array to indicate per channel pass/fail of impedance testing , 10 Base-T Ethernet digital data interface and AC power supply.
2	3100-0010-00	Power Cord, 120 VAC.
2	7000-0239-01	Combo XPOD 3012 & Noni 8000J Probe (MK2).
1	9107-0032-01	Compumedics PSG Online 3 Acquisition and Compumedics ProFusion PSG 3 Analysis Software Pack: Analysis includes high speed review, comprehensive automatic analysis, manual editing functions, note insertion, and user-defined reporting.
1	9107-0030-01	Compumedics PSG Online 3 Acquisition Software Package (includes NetBeacon): For PSG data acquisition.
2	9105-0079-02	ECGFree - ECG Artifact Rejection Software. Includes software CD, manual, and license code. User must provide existing dongle number for upgrade. (Requires existing ProFusion PSG 2 license code on same dongle).
2	00103871	MiniTower Computer (min. system configuration): OptiPlex 755, Pentium D 820/2.80GHz , 2.0GB Memory, 160GB SATA Harddrive, Windows XP Professional, 8X DVD+/-RW, Microsoft Office 2003 Basic Edition.
2	7500-0014-00	Uninterruptible Power Supply (may be used when device is more than 9 feet away from patient).
2	00103377	20" Flat Panel Color Monitor (LCD; Max Resolution1600 x 1200.
2	7500-0045-01	Audio Speakers - one pair (required for MiniTower computers only).
1	00103507	Gigabit Switches 8 Port
2	9100-1000-01	Compumedics Digital Video with Capture/Acquisition/Review.
2	8300-0086-00	Full Light Color/IR Camera with power pan, tilt and zoom, dome enclosure - Panasonic.
2	8300-0088-00	Remote Control for Pan/Tilt and Zoom Lens - Panasonic.
2	8300-0090-00	24 VAC Power Supply (1 each required for each camera for PSG).
2	8300-0089-00	IR Light and mounting bracket (required for each camera for PSG).
2	00101522	Louroe Audio Monitoring Kit - two stations (patient room and control room) provides intercom function and room microphone for digital audio recording, simple installation with single power supply in control room.

Qty	Part Number	Description
1	00103614	Installation Charge - System, 1 or 2 beds, single location

Cablings

2	00103230	Cabling Termination Kits (includes wall plate, keystone connectors) Per room both ends.
2	00103231	Ancillary Interface Cable Kit Per Device (includes parts for up to 4 devices)

SubTotal	$51,141
Shipping	$350
Total	**$51,491**

Cabling for cameras (video) intercoms (audio) and network connections are not provided in this quotation. Specification for cabling is provided on request of customer.

Options:

7008-0004-01 - Sensor and Electrode Starter Kit for PSG (includes piezo respiratory bands, nasal cannula, Pro-Tech airflow sensor, Electrode 10MM Gold 1.5M pk 10, External Microphone V4-Tracheal TP, Leg Sensor V5 Left, Leg Sensor V5 Right, Position Sensor, 2-pack Light Snaps 72", Ext. Mic 31

9107-0030-01 - Compumedics PSG Online 3 Acquisition Software Package (includes NetBeacon): For PSG data acquisition. 1st license $4,944

9008-9010-00 - Training - Initial 3 Day up to 4 people W/system $2,833

Initial System Warranty: One year on hardware, one year on software from date of installation, includes: after-hours phone support, 24-hour response time for email/fax support, on-site loan equipment and software updates (first year). Sensors warranted for 90 days from installation. Non-Compumedics products covered by manufacturer's warranty. Computers covered by manufacturer's warranty.
System orders include 1 x 00103364 Complimentary Kit ($30.00)
Training Manuals: 00103821 and 00103822 included (1 each) at no charge when Customer purchases training.

This price quotation supercedes all prior agreements, proposals or understandings between the parties, whether written or oral, and constitutes the entire agreement. Compumedics USA, Inc. is not liable or bound to any representations or agreements except as specifically set forth herein. Upon acceptance by both parties, this price quotation shall not be modified in any way except by written instrument signed by both parties hereto. The total purchase price includes installation but excludes taxes and local electrical inspection, if required.

I, the undersigned, have read this quotation and the attached addendum, and hereby accept the terms and conditions. The authorized Customer's signature hereon operates as acceptance of the terms and conditions of the contract as stated herein. This agreement is binding. In the event of cancellation by customer, customer agrees to reimburse Compumedics for the actual costs incurred including but not limited to charges for restocking, training and freight, or 15 percent of the total purchase price, which ever is greater.

_____
Accepted By (Authorized Customer Signature):

_____
Print Name:

_____
Date:

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0060

General Hospital

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

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

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

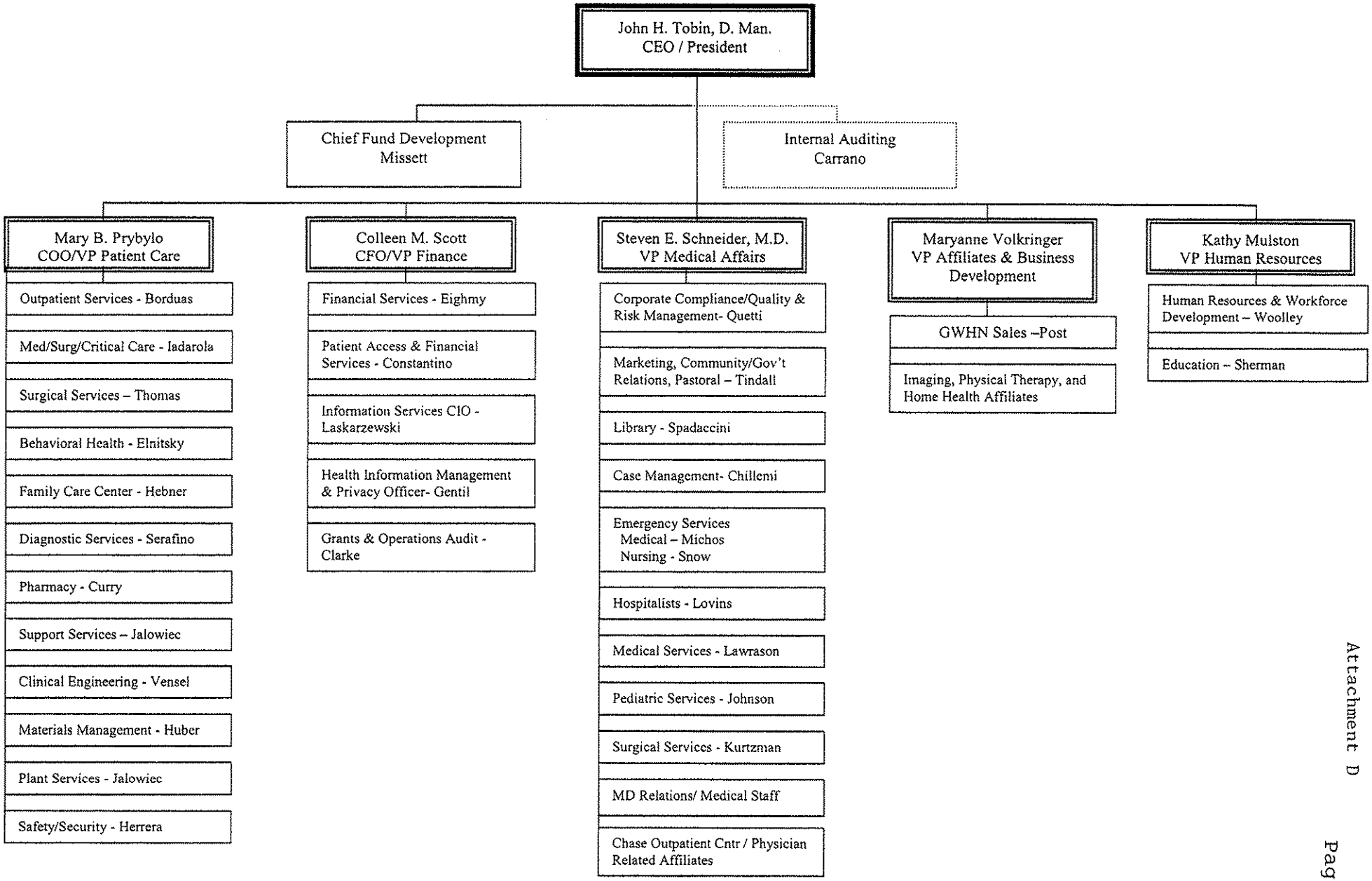
This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007. RENEWAL.

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

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

WATERBURY HOSPITAL MANAGEMENT ORGANIZATION



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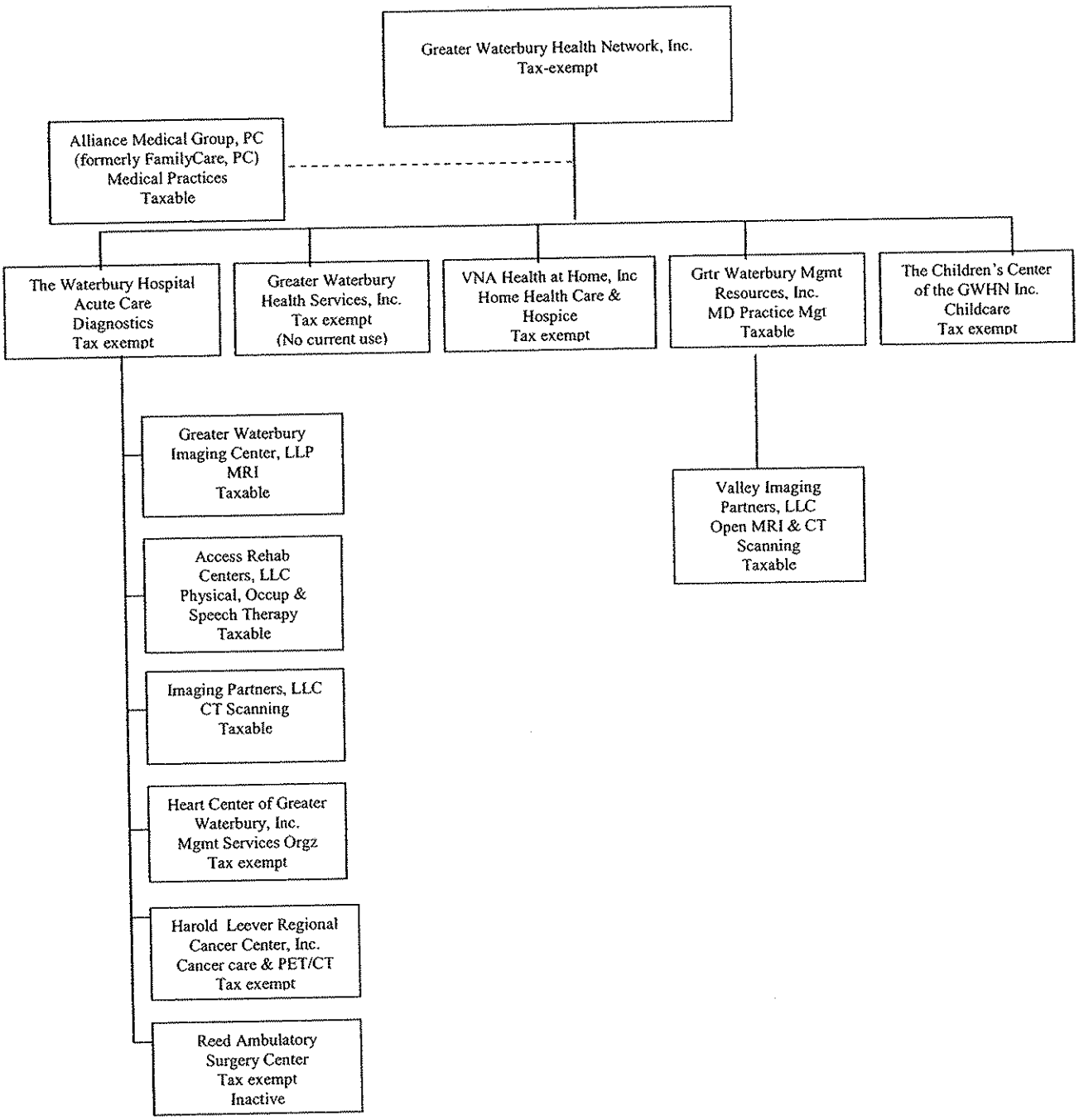
GREATER WATERBURY HEALTH NETWORK, INC.



SECTION VI. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Waterbury Hospital

Project Title: Waterbury Hospital Sleep Lab - Southbury

I, John H. Tobin (Name), CEO (Position – CEO or CFO)

of Waterbury Hospital (Organization Name) 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 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

0723/08
Date

RECEIVED
2008 JUL 25 A 11:49
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on July 23, 2008

Kelly L Keating
Notary Public/Commissioner of Superior Court

My commission expires: 8/31/2009

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 27, 2008

Colleen Scott
Vice President of Finance
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06721

Re: Letter of Intent, Docket Number 08-31211
Waterbury Hospital
Establish a Sleep Lab in Southbury
Notice of Letter of Intent

Dear Ms. Scott:

On July 25, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Waterbury Hospital ("Applicant") for the establishment of a Sleep Lab in Southbury, at a total capital expenditure of $69,010.

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

Barbara A. Durdy

Barbara Durdy
Director of Operations

BD:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 27, 2008

Requisition # HCA09-028
(203) 754-0644

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 **Sunday, August 31, 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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara Durdy
Director of Operations

Attachment

BD:PF:lmg

c: Sandy Salus, OHCA

Republican American
Docket Number 08-31211

Letter of Intent
August 27, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Waterbury Hospital
Town:	Southbury
Docket Number:	08-31211-LOI
Proposal:	Establish a 2 Bed Sleep Lab in Southbury
Total Capital Expenditure:	$69,010

The Applicant may file its Certificate of Need application between September 23, 2008 and November 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	3913
RECIPIENT ADDRESS	912037540644
DESTINATION ID	
ST. TIME	08/27 15:12
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

August 27, 2008

Requisition # HCA09-028
(203) 754-0644

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

Gentlemen/Ladies:

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara Durdy

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 27, 2008

Colleen Scott
Vice President of Finance
Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708

RE: Certificate of Need Application Forms, Docket Number 08-31211-CON
Waterbury Hospital
Proposal To Establish a 2 Bed Sleep Laboratory in Southbury

Dear Ms. Scott:

Enclosed are the application forms for Waterbury Hospital's Certificate of Need ("CON") proposal to establish a 2 bed sleep laboratory in Southbury at an associated capital expenditure of $69,010. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between September 23, 2008, and November 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, prefile 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 Paolo Fiducia. Please contact him at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone (PF)

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 23, 2008 and may be submitted no later than November 22, 2008. The Analyst assigned to your application is Paolo Fiducia; he may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31211-CON

Applicant Name: Waterbury Hospital

Contact Person: Colleen Scott
Contact Title: Vice President of Finance
Waterbury Hospital

Contact Address: 64 Robbins Street
Waterbury, CT 06708

Project Location: Southbury

Project Name: Establish a 2 Bed Sleep Laboratory in Southbury

Type of proposal: Section 19a-638

Est. Capital Expenditure: $69,010

1. Expansion of Existing or New Service

What services are currently offered at your facility 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. 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. Explain how it was determined there was a need for the proposed Sleep Laboratory in Southbury.

B. Provide the following information:
   a) List the service area towns. Provide a rationale for choosing the selected towns.
   b) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
   c) Scheduling backlogs in service area.
   d) Travel distance from the proposed site to service area towns.
   e) Hours of operation of the proposed service.

C. Discuss the methodology utilized in determining a needs assessment for the proposed Sleep Laboratory in Southbury. Please document.

D. Provide the information as outlined in the following table concerning the existing providers' in the Applicant total service area current operations:

Total Service Area:

Provider Name, Street Address, and Zip Code	Similar Services Provided? (Y/N) *	Affiliated Physicians

* Please list the services provided including the number of beds.

E. Provide the requested information in the following table to show the actual number of sleep studies, projected number of sleep studies and assumptions at Waterbury Hospital and Southbury locations:

Table 1: Actual Number of sleep studies, projected number of sleep studies, and assumptions at Waterbury Hospital and Southbury locations

	2006	2007	2008	2009	2010	2011
# of Sleep Beds						
# of Nights Open						
Total Weekly Capacity						
@ 50 weeks a year (a)						
Anticipated Capacity						
Actual/Anticipated Studies						
% Occupancy						
Assumed Cancellation Rate						

F. Provide information as to the referral pattern to the current Sleep Disorder Center at Waterbury Hospital for FY 2007 to date (i.e. list of physicians, type of condition, number of referrals by physician and condition).

G. Will the same physicians that currently refer to Waterbury Hospital Sleep Laboratory refer their patients to the proposed Southbury location? If so, provide the projected number of referrals to shift from the Waterbury Hospital location to the Southbury location for the first three years of operation.

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

I. 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.

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

☐ Epidemiological studies

☐ Public information reports ☐ 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. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. 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 Committee for Quality Assurance ☐ Public Health Code & Federal Corollary

☐ National Association of Child Bearing Centers

☐ American College of Obstetricians & Gynecologists

☐ American College of Surgeons

☐ Report of the Inter-Council for Radiation Oncology

☐ American College of Radiology

☐ Substance Society Abuse and Mental Health Services Administration

☐ Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. 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.

E. 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]

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

G. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital (Applicant), 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.

H. 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 your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ 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. 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. 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. 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.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) Provide the name and units of service for the new cost center to be established for the proposal.

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

9. 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.

10. Construction Information

A. Provide a detailed description of the any new construction or required renovation. Including the related gross square feet.

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	

11. 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.

12. 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 proposed service based on Actual Patient Mix in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	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				
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. Does the Applicant(s) 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. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) 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.).

iii) 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.

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

v) Describe how this proposal is cost effective.

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: _____

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

12. C (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 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				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.

RepublicanAmerican

389 Meadow Street - P.O. Box 2090
Waterbury, CT 06722-2090
Phone: 203-574-3636 Fax: 203-573-0090 Toll Free: 800-992-3232
e mail: advbilling@rep-am.com

Customer	A/C #	Billing Period
HEALTH CARE ACCESS	R18404	08/01/08-08/31/08

PAYMENT TERMS	30 DAYS
TOTAL AMOUNT DUE	

Fed EIN 06-0581760 * Please See Reverse Side for Pub Index

DATE	AD # / INV #	CUST ORDER #	PUB*	DESCRIPTION	SIZE	BILLED UNITS	TIMES RUN	RATE	BILLED AMOUNT
				PREVIOUS BALANCE					$
				PAYMENT APPLIED					
				PREVIOUS AMOUNT DUE					$0.00
08/31/08	RA0247607 / INV000368101	Doc. No. #08-312	RA	PUBLIC NOTICE Statute Reference: 19a-638 Applicant:	1x	0	1	$	
				CURRENT AMOUNT DUE					$74.58
				TOTAL AMOUNT DUE					

PUBLIC NOTICE

Statute Reference: 19a-638
Applicant: Waterbury Hospital
Town: Southbury
Docket Number: 08-31211-LOI
Proposal: Establish a 2 Bed Sleep Lab in Southbury
Total Capital Expenditure: $69,010

The Applicant may file its Certificate of Need application between September 23, 2008 and November 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.
R-A August 31, 2008

Past due balance accrues finance charge of 1.5% per month

All charges include any applicable Connecticut State sales tax

REMITTANCE ADVICE - PLEASE RETURN WITH PAYMENT

REMITTANCE ADDRESS

REPUBLICAN AMERICAN
PO BOX 2090
WATERBURY, CT 06722-2290

CUSTOMER	A/C #	BILLING PERIOD	TOTAL AMOUNT DUE	AMOUNT REMITTED
HEALTH CARE ACCESS	R18404	08/01/08-08/31/08		

CREDIT CARD #	
EXPIRATION DATE	
SIGNATURE	

HEALTH CARE ACCESS
MS 13HCA POBOX 340308
410 CAPITOL AVENUE
HARTFORD CT 06134

CHECK #	