STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

In Re: **Danbury Hospital**
Docket No. 09-31490-CON

FINAL DECISION

On August 17, 2010 a Proposed Final Decision was issued in the above matter pursuant to Section 4-179 of the Connecticut General Statutes. On August 18, 2010, Danbury Hospital waived the right to file exceptions and to present briefs and oral argument.

In accordance with Connecticut General Statutes Section 4-179, the attached Proposed Final Decision dated August 17, 2010 by Hearing Officer Melanie A. Dillon is hereby adopted as the final decision of the Deputy Commissioner of the Department of Public Health in this matter. A copy of the Proposed Final Decision is attached hereto and incorporated herein.

WHEREFORE, it is the final decision of the Deputy Commissioner that the application of Danbury Hospital for a facility development project including a new emergency department, new critical care unit, medical-surgical bed replacement and other facility improvements is hereby approved.

8.24.10
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner

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Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **Danbury Hospital**

Docket Number: **09-31490-CON**

Project Title: **Facility Development Project including a New Emergency Department, New Critical Care Unit, Medical-Surgical Bed Replacement and Other Facility Improvements**

Project Description: Danbury Hospital, located at 24 Hospital Avenue in Danbury, Connecticut proposes to undertake a facility development project. The building project includes the construction of a new patient care tower that will contain the following components: A relocated and expanded Emergency Department ("ED"); a relocated and modernized 30 bed critical care unit; a new patient care floor consisting of 35 private medical/surgical beds; two shelled patient care floors for 70 future private medical/surgical beds; a shelled floor for future expansion of the operating rooms; and an interstitial floor for operating room mechanical access. The project's total capital expenditure is $150,000,000.

Nature of Proceedings: On March 9, 2010, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from Danbury Hospital, ("Applicant" or "Hospital") seeking authorization to undertake a facility development project. The project's total capital expenditure is $150,000,000. The Applicant is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent to file its CON application was published in the *The News Times* on November 27, 2009, pursuant to Section 19a-639, C.G.S. A public hearing regarding the CON application was held on June 3, 2010, pursuant to Section 19a-639, C.G.S. On May 17, 2010, the Applicant was notified of the date, time and place of the hearing. A notice to the public was published in the *The News Times* on May 17, 2010. Melanie Dillon served as Hearing Officer for this case. The public hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-639, C.G.S.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-639, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. The Applicant is a general acute care hospital located at 24 Hospital Avenue, Danbury, Connecticut. *(March 9, 2010, Initial CON application submission, page 1)*

2. The Applicant's proposal is for the construction of a new patient care tower. The new tower will measure approximately 262,000 square feet ("SF"). *(March 9, 2010, Initial CON application submission, page 44)*

3. The proposed new tower project is the first step of a multi-phase, multi-year master facility plan. The plan will be as follows:

    - The first phase will include the expanded ED, the expanded critical care unit, greater bed capacity, and a greater percentage of private rooms.
    - Subsequent phases of the plan will address internal placement of services to optimize operational efficiencies, improved patient services and staff movement throughout the facility, and provide space for future increases in medical/surgical beds, as they are needed.
    - The master facility plan also addresses consolidation and modernization of clinical areas such as the operating rooms and procedural platforms for invasive procedures in Cardiology and Radiology.

    (March 9, 2010, Initial CON application submission, page 20)

4. The proposed construction will provide for a new seven story building, a partial floor "roof" penthouse, and a nine story elevator/stair core as well as renovation to specific designated areas of the existing tower. The program space for the project will include:

    - Shell space for future operating room expansion on the fourth floor,
    - New Main Entrance Lobby on the fifth floor,
    - Interstitial mechanical space for the operating rooms on the 5th floor,
    - A relocated and expanded ED on the sixth floor,
    - A relocated and modernized 30 bed Critical Care Unit on the seventh floor,
    - A new patient care floor consisting of 35 private Medical/Surgical ("Med/Surg") Beds on the eight floor,
    - Two shelled patient care floors each with the capacity of 35 future private med/surg beds on the ninth and tenth floor, and
    - Mechanical rooms on the eleventh floor.

    (March 9, 2010, Initial CON application submission, page 44 and Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 515)

5. The following table shows the changes that will occur with the proposed project.

Table 1: Physical Departmental Changes

Department	Current Square Footage	Proposed Square Footage	Current Location	Proposed Location
Elevator Cores	---------	35,127	----------	New floors 1 - 12
Surgery Shell	---------	38,124	----------	New 4th floor
Lobby	---------	8,821	----------	New 5th floor
Emergency Admin	2,000	3,007	1 Tower	New 5th Floor
Interstitial Mechanical	---------	39,169	----------	New 5th floor
Emergency Department	24,852	40,088	Tower 1st floor	New 6th floor
Critical Care Unit	14,523	24,507	Tower 7th floor	New 7th floor
Med/Surg Floor 8	---------	24,507	----------	New 8th floor
Med/Surg Shell Floor 9	---------	24,507	----------	New 9th floor
Med/Surg Shell Floor 10	---------	24,507	----------	New 10th floor
Mechanical Penthouse	---------	24,507	----------	New 11th floor

(March 9, 2010, Initial CON application submission, page 50 and June 3, 2010, Hearing Testimony)

6. Mr. Frank Kelly, President and Chief Executive Officer, Danbury Hospital testified "that the new tower will have 2 shelled floors for a total of 11 floors and the med/surg floors will have 35 private med/surg beds instead of the original 36 private med/surg beds described in the CON application". *(June 3, 2010, Hearing Testimony)*

7. Mr. Frank Kelly also testified that "this project represents a multi-year planning project probably over 5 years from the start". *(June 3, 2010, Hearing Testimony)*

8. The project will address the Hospital's most urgent capacity and care environment concerns and provide the foundation for a master facility plan that will prepare the Hospital for the needs of the future. *(March 9, 2010, Initial CON application submission, page 19)*

9. The Board of Directors granted final approval for the proposed project at its annual retreat on September 25, 2009. *(March 9, 2010, Initial CON application submission, page 33)*

10. The Hospital is not proposing any new services or any increase to its licensed bed capacity at this time. *(March 9, 2010, Initial CON application submission, page 21)*

11. The Hospital proposes to increase the size of the ED from 24,852 square feet to 40,088 square feet and relocate it to the new 6th floor of the proposed tower. *(March 9, 2010, Initial CON application submission, page 22)*

12. The proposed ED will include a fast track area, a triage area, more adult treatment rooms, and an observation unit for overnight observation patients. A dedicated radiology department, including a CT scanner and three general x-ray units, will

also be included in the new space. *(March 9, 2010, Initial CON application submission, page 22)*

13. The new ED will also have 100% private rooms as opposed to curtained bays, which will not only provide patient privacy but will also satisfy infection control standards, increase patient safety and improve the quality of communication between caregivers and family members. *(March 9, 2010, Initial CON application submission, page 22)*

14. The proposed ED will accommodate approximately 88,000 annual ED visits. *(March 9, 2010, Initial CON application submission, page 22)*

15. Currently, the ED has 34 formal treatment bays and a 10 bed observation unit located on the 8th floor of the inpatient care units. *(March 9, 2010, Initial CON application submission, page 23)*

16. The current location of the observation unit on the 8th floor of the inpatient tower requires additional, unnecessary patient transfers from the ED to the 8th floor, resulting in additional wait time in the ED for beds and inefficient use of potential inpatient beds. *(March 9, 2010, Initial CON application submission, page 23)*

17. Additionally, observation units located in proximity to the ED provide an effective way for hospital staff to care for patients who do not require an inpatient admission yet require treatment beyond that offered in the ED. *(March 9, 2010, Initial CON application submission, pages 23, 309)*

18. Observation units also reduce the need for expensive inpatient care while improving throughput in the ED and by more appropriately focusing care based on the acuity of the patient. *(March 9, 2010, Initial CON application submission, pages 23, 309)*

19. The relocation of the observation unit to the ED will release ten additional beds back to the inpatient bed inventory. *(March 9, 2010, Initial CON application, page 27)*

20. In FY 2009, the Hospital's ED handled nearly 70,000 visits in a space designed to accommodate 40,000 visits per year. *(March 9, 2010, Initial CON application submission, page 29)*

21. The following table illustrates the historical volume of ED visits for FYs 2006 through 2008:

Table 2: Actual Volume of ED Visits

Description	FY* 2006	FY* 2007	FY* 2008	FY* 2009	FY** 2010
ED Visits	66,850	67,929	67,553	69,582	34,094
Total ED Visits	**66,850**	67,929	67,553	69,582	**34,094**

**Fiscal year is from Oct.1-Sept. 30*
**October 1, 2009 – March 31, 2010*
(March 9, 2010, Initial CON application submission, page 29)

22. The Hospital has managed the volume of approximately 70,000 patients through the utilization of hallways and triage locations. *(March 9, 2010, Initial CON application submission, page 22, 29)*

23. In FY 2009, 17% of the Hospital's patients seen in the ED were not treated in a formal ED treatment bay. *(March 9, 2010, Initial CON application submission, page 22)*

24. Although the hospital is able to accommodate patient care through the utilization of hallways and triage locations, these strategies negatively impact on patient throughput, patient privacy, wait times, and ultimately patient satisfaction. *(March 9, 2010, Initial CON application submission, page 29)*

25. A report from The Advisory Board Company indicates that EDs with 1,400 to 1,600 visits per room per year are approaching an optimal level of productivity; 1,700 visits per year may be approaching the capacity tipping point; and new beds are absolutely warranted for EDs operating at 2,000 visits or above per room per year[1]. *(March 9, 2010, Initial CON application submission, page 29)*

26. In FY 2009, the ED accommodated 69,582 visits or 2,046 visits per room and will be expected to accommodate 75,131 visits or 2,210 visits per room in FY 2020 if no new capacity is provided. *(March 9, 2010, Initial CON application submission, page 29)*

27. Based upon the Advisory Board Company report minimum benchmarks, in order to meet the ED's current and projected volume with optimal capacity, the ED would require ten (10) additional treatment rooms today and thirteen (13) additional rooms by FY 2020. *(March 9, 2010, Initial CON application submission, page 29)*

28. The following table illustrates the projected volume and bed need for the ED for FY's 2010 through FY 2020:

Table 3: Projected Volume and Bed Need for the ED

Description	FY* 2010	FY* 2015	FY* 2020
ED Visits	70,069	72,916	77,398
ED Treatment Rooms Required	44	46	49
Observation Rooms Required	11	9	10
Total ED Room Need	44	55	59
Total Rooms Proposed		68	68

* *Fiscal year is from Oct.1-Sept. 30*
(March 9, 2010, Initial CON application submission, page 31)

29. Although the need for ED and Observation Room beds in the ED is projected to reach 58 by FY 2020, the Hospital is proposing additional capacity to prepare for

[1] The High Performance ED. Optimizing Capacity and Throughput to Meet Ever-Growing Demand. 2008 The Advisory Board Company. Washington, DC.

surge capacity and growth beyond the 2020 need. *(March 9, 2010, Initial CON application submission, page 31)*

30. Based upon the volume projections and the relocation of observation services into the ED, the Hospital is proposing a new ED that consists of fifty-five (55) ED treatment rooms and thirteen (13) observation rooms for a total of sixty-eight (68) rooms. *(March 9, 2010, Initial CON application submission, page 31)*

31. OHCA finds that proposal will allow the Hospital to expand the size of its current ED and provide treatment to the 70,000 patients seen in the ED annually in private rooms rather than curtained treatment bays, hallways or triage stations. Additionally, by relocating the observation units closer to the ED, patient throughput in the ED will be improved.

32. Accordingly, OHCA finds that the proposal will improve the quality and accessibility of care provided to the patients seen in the ED.

33. The proposal also includes a new thirty (30) bed CCU. *(March 9, 2010, Initial CON application submission, page 21; Prefiled Testimony of Michael Daglio, Vice President Operations, Danbury Hospital, page 523)*

34. Due to the design of the existing tower, the CCU is split into three separate units, essentially creating three independent care units, which requires additional, redundant staff to manage three different areas. *(March 9, 2010, Initial CON application submission, page 21)*

35. Additionally, when the patient census is low in one unit, the nurses move patients into another unit in an effort to consolidate staff and ensure staffing efficiency, which is inconvenient for patients and their families. *(March 9, 2010, Initial CON application submission, page 21)*

36. The current CCU is located on the same floor as the interventional cardiac laboratories ("cath lab") and extended recovery area. *(March 9, 2010, Initial CON application submission, page 22)*

37. These areas share the same waiting room and thus, not only there is little privacy for the families but families with acutely ill loved ones are comingled with those waiting for outpatient procedures to be completed. As a result, there is a high level of activity and noise due to the significant number of physician, staff, visitor and patient traffic through this area. (*March 9, 2010, Initial CON application submission, page 22*)

38. The proposed tower will have the CCU in a separate inpatient care space away from the cath labs. *(March 9, 2010, Initial CON application submission, page 22)*

39. OHCA finds that the relocation of the CCU to the proposed tower will improve privacy for the patients and their families and eliminate the necessity of moving patients between three different units thereby improving the quality of care provided in this unit.

40. The proposed tower will also provide capacity for a total of 105 private med/surg beds. Thirty-five beds will be located on a new med/surg patient floor and two shelled med/surg floors will provide additional capacity for 70 private med/surg beds. *(Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 515)*

41. The existing med/surg floors have up to fifty-two (52) beds in 18,187 square feet of departmental space. (*March 9, 2010, Initial CON application submission, page 21*)

42. The industry standard for new med/surg rooms is between six hundred (600) and seven hundred and fifty (750) square feet. Utilizing these standards would result in 25 to 30 beds on the current Danbury Hospital med/surg floor. (*March 9, 2010, Initial CON application submission, page 21*)

43. As space demands have continued to grow, the Hospital has sacrificed space for staff lounges, equipment storage, family respite and other visitor amenities. This has resulted in a lack of privacy since there is inadequate space for staff and physicians to convene and discuss patients away from visitors and patient rooms and inefficiencies for staff for since medication, supplies and equipment are not conveniently located on the units. (*March 9, 2010, Initial CON application submission, page 21*)

44. Only 41% of the med/surg beds in the existing tower are private. (*March 9, 2010, Initial CON application submission, page 21*)

45. The existing Hospital tower was completed in 1978 and no new med/surg bed capacity has been added to the Hospital in over 30 years. (*Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 516*)

46. By 2015, it is anticipated that the Hospital will not have sufficient med/surg bed capacity to support its projected volume. (*March 9, 2010, Initial CON Application submission, page 26; Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 516*)

47. The Hospital is projecting a 32% increase in med/surg discharges over the next 10 years or a compounded annual growth rate of 2.78%. (*March 9, 2010, Initial CON application submission, page 25*)

48. The following table demonstrates the total med/surg discharges, extended stay and observation volume projections for the Hospital through 2020:

Table 4: Volume Projections for Med/Surg Through 2020*

FISCAL YEAR	2010	2015	2020	Growth Rate	CAGR
Med/Surg Baseline Discharges	14,820	15,887	17,031	15%	1.40%
Med/Surg Growth Strategy Discharges	-	2,100	2,469	-	-
Total Med/Surg Discharges	**14,820**	**17,987**	**19,499**	**32%**	**2.78%**
OBV**	2,983	3,293	3,460	16%	1.50%
Extended Stay**	504	706	779	55%	4.45%
Total Med/Surg/Ext Stay/OBV Discharges	**18,307**	**21,985**	**23,739**	**30%**	**2.63%**

** Volume projections were based on population growth, sociocultural factors and consumerism, changes in payment and economic factors, advancement in technology and practice patterns, and a shift to outpatient services, as well as the Hospital's strategic plan (med/surg growth strategy and other discharges)*

*** In order to clearly demonstrate the impact of the outpatient shift and payer factors, the table includes the projected trend in observation status patients (OBV) and extended stay patients (EXT). Although these patients will not be classified as discharges, they do require a bed in a Hospital location*

(March 9, 2010, Initial CON Application submission, page 25)

49. Historical volumes demonstrate a similar growth rate. Although the change in classification of observation unit patients from inpatient to outpatient slowed the inpatient growth rate from FY2006 to FY2008, total med/surg discharges nonetheless grew by 2.04% on a CAGR basis, as demonstrated by the following table:

Table 5: Historical Utilization for Med/Surg Discharges and OBV Patients

FISCAL YEAR	2004	2005	2006	2007	2008	2009	Growth Rate	CAGR
Total Med/Surg Discharges	13,343	13,685	14,414	14,385	14,349	14, 759	10.6%	2.04%
OBV	406	850	1,062	1,257	2,632	2,868	606.4%	47.9%
Total Med/Surg Discharges & OBV	13,749	14,535	15,476	15,642	16,981	17,627	28.2%	5.10%

50. Danbury Hospital is currently licensed for 345 General Hospital beds and 26 bassinets and the beds are assigned in the following manner:

Table 6: Danbury Hospital Beds by Type and Location

Bed Type	Total Beds	Campus Location
Med/Surg Beds	260	Tower
Psychiatry	22	West
NICU	15	Stroock
Post Partum	34	Stroock
Rehabilitation	14	South
Total Beds	**345**	
Total Bassinets	26	Stroock

(March 9, 2010, Initial CON Application submission, page 25)

51. The Hospital currently staffs 319 beds, which is 92% of its licensed capacity. There are 16 beds that were taken out of inpatient service so that the rooms could be utilized for other services and 10 beds that are used for observation patients. *(March 9, 2010, Initial CON Application submission, page 25)*

52. With respect to the Hospital's 319 staffed beds, 240 are located in the existing tower and 85 beds are located in various buildings on the hospital campus. *(March 9, 2010, Initial CON Application submission, pages 25-26)*

53. Fourteen additional med/surg beds will become available in the third quarter of FY 2010 when the rehabilitation floor moves from its current location on the 12th floor of the existing tower to 7th floor of the South building. *(March 9, 2010, Initial CON Application submission, page 26)*

54. The following table illustrates the anticipated med/surg bed need for the Hospital through 2020 **if no new capacity** is added:

Table 7: Med/Surg Bed Need Without the Project:

	2010	2015	2020
Total Med/Surg/Ext. Stay/OBV Days	71,194	81,581	88,122
Total Med/Surg/Ext. Stay/OBV ADC	195	224	241
Med/Surg Capacity	254	254	254
Occupancy Rate	77%	88%	95%
Target Occupancy Rate	80%	80%	80%
Beds Required for Target Occupancy Rate	244	279	302
Variance of Beds for Target Occupancy Rate	10	(25)	(48)

(March 9, 2010, Initial CON Application submission, page 27)

55. Table 7 demonstrates that the Hospital does not currently have enough beds for the anticipated med/surg bed need in 2015.

56. The following table illustrates the maximum capacity the Hospital would have for med/surg activities **if the Tower project is approved**:

Table 8: Maximum Med/Surg Capacity With the Project:

	2010	2015	2020
Total Med/Surg/Ext. Stay	67,317	79,850	86,576
OBV Days*	3,878	-	-
Total Med/Surg/Ext. Stay/OBV Days	71,194		
Total Med/Surg/Ext. Stay/OBV ADC	195	224	241
Med/Surg Capacity	254	336	336
Occupancy Rate	77%	65%	71%
Target Occupancy Rate	80%	80%	80%
Beds Required for Target Occupancy Rate	244	273	296
Variance of Beds for Target Occupancy Rate	10	63	40

**OBV would be located in the new ED and therefore not counted in the projection beyond 2014 (March 9, 2010, Initial CON Application submission, page 27)*

57. Although it appears that the project would provide significant capacity above the need, the tables do not reflect the impact that 100% private rooms will have on bed capacity. *(March 9, 2010, Initial CON application submission, page 28)*

58. The Hospital would require 68 additional incremental patient rooms today, based on current average daily census and the current compliment of rooms that are private, in order to become a 100% private room facility. *(March 9, 2010, Initial CON application submission, page 28)*

59. The following table demonstrates how the additional bed capacity would be used to improve the private room ratio and, therefore, not create inefficient excess capacity:

Table 9: Private Rooms and Bed Capacity

	2015	2020
Total Maximum Med/Surg bed capacity	336	336
Total Maximum Med/Surg room capacity	270	270
Projected Average Daily Census	219	237
Maximum Private room percentage	100%	100%
Occupancy Rate if all private rooms	81%	88%

(March 9, 2010, Initial CON application submission, page 28)

60. The Hospital's target occupancy rate for modeling its bed need is 80% because this rate allows the Hospital to offer private room accommodations when the census is near its median and manage its peak census days without causing major delays in getting patients to an inpatient bed from the ED and PACU. *(March 9, 2010, Initial CON application submission, page 28)*

61. Additionally, it is the Hospital's experience that at the 80% occupancy rate, one in every three patients that is assigned to a semi private room will require a transfer to another patient room to accommodate roommate needs and when the

occupancy rate exceeds 80%, almost one in every two patients will require a transfer for the same reasons. *(March 9, 2010, Initial CON application submission, page 28)*

62. Although the Hospital will not file a CON for an increase in licensed beds until its current bed need approaches the Hospital's current bed license, the foregoing demonstrates that the construction of the proposed tower will not create excess capacity. (*March 9, 2010, Initial CON application submission, page 28*)

63. OHCA finds that the new med/surg floor will allow for private rooms and more space for: (1) physicians and staff members to meet and discuss patient care and (2) the storage of medication, equipment and supplies on the same floor.

64. OHCA finds that the two shelled floors will allow the Hospital to expand as necessary to meet anticipated med/surg bed need over the next 10 years.

65. In addition to providing space for future med/surg beds as they are needed to meet the anticipated increases in volume, the proposed tower will also allow the Hospital to move towards a 100% private room facility. *(March 9, 2010, Initial CON application submission, pages 20, 40; Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 516)*

66. The proposed tower will provide a more patient and family-centric facility to best accommodate the needs of patients and their families, including private bathrooms and showers. All rooms constructed in the proposed tower are intended to be private to promote the highest lever of patient care, quality control and privacy standards. (*Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, page 516)*

67. Development of the proposed tower will allow the Hospital to repurpose the existing tower into private rooms to achieve optimal reorganization of services and improved patient satisfaction in those areas as well. (*Prefiled testimony, Frank Kelly, President & Chief Executive Officer, Danbury Hospital, pages 516-517)*

68. The benefits of private rooms to the healthcare consumer includes the following:
    - Reduction of hospital acquired infection from eliminating the risk of cross-contamination from two patients in one room;
    - Better patient and family experience and reduction of patient stress resulting from the inconvenience associated with an incompatible roommate, loss of sleep due to roommate illness, interruptions and visitors, and loss of privacy and embarrassment related to having a stranger in the room during history taking and physical exams;
    - Increased opportunity to discuss need with family members and to allow family members to stay overnight for acutely ill and/or patients at the end of life;
    - Rooms large enough to provide separate service zones for patients, caregivers and visitors;
    - Room large enough to support the medical equipment, medical team and the family members
    - Increased opportunity for patient safety;

- Reduction of errors related to patient identification;
- Less clutter in the room;
- More space to accommodate needed medical equipment, such as lift equipment, bariatric furniture, etc.;
- Improved patient physician communication;
- Reduction of the need to transfer patients due to incompatibility or privacy needs; and
- Bathrooms and showers in every room.

(March 9, 2010, Initial CON application submission, pages 40-43; Attachment 15 pages 373-499)

69. Based upon the foregoing, OHCA finds that the conversion to 100% private rooms will positively impact the quality and accessibility of health care delivery to the patients of Danbury Hospital.

70. The project's capital expenditure is $150,000,000 and is itemized in the following table:

Table 10: Proposed Capital Expenditures

Description	Cost
Medical Equipment	$11,668,041
Imaging Equipment	$3,831,959
Non-Medical Equipment	$2,000,000
Construction/Renovation	$132,000,000
Other Non Construction including Contingency	$500,000
Total Capital Expenditures	**$150,000,000**

(February 4, 2010, CON application submission, page 80)

71. The proposed tower will be funded with $125 million of long-term debt and $25 million of equity. Sources for the equity will include operating cash flow, unrestricted cash and investment reserves of the Hospital and Development Fund, and funds from a planned capital campaign. *(March 9, 2010, CON application submission, page 52)*

72. As of March 1, 2010, the total commitments that have been made towards the campaign are $2,101,133. Of this amount, $1,064,914 is committed directly to the proposed tower. *(April 8, 2010, CON Completeness Responses, page 504)*

73. Mr. Frank Kelly testified that the Hospital has received approximately $5,000,000 in campaign funding as of June 3, 2010, and they anticipate reaching $40 million by the end of the 4 year capital campaign. *(June 3, 2010, Hearing Testimony)*

74. Operating cash and reserves will be used to cover shortfalls and timing differences in the capital campaign and construction needs. Danbury Health System ("DHS") has over 160 Days Cash on Hand to help support the proposed tower. *(April 8, 2010, CON Completeness Responses, page 504)*

75. As of September 30, 2009, Danbury Health Systems ("DHS") had total unrestricted cash and investments in excess of $200 million. *(March 9, 2010, CON application submission, page 52)*

76. The long-term debt will consist of tax-exempt municipal bonds issued through the Connecticut Health and Educational Facilities Authority ("CHEFA"). *(March 9, 2010, CON application submission, page 52)*

77. The Hospital has had preliminary discussions with CHEFA and has provided a letter of interest from CHEFA in connection with the proposed bond issue for the proposed tower. *(April 8, 2010, CON Completeness Responses, page 508)*

78. Mr. William Roe, Chief Financial Officer, Danbury Hospital, testified that "The Applicant has had preliminary discussions with rating agencies and they seem to be a strong "A". *(June 3, 2010, Hearing Testimony)*

79. The Hospital is projecting operating gains to fund the project as indicated in the following table. The amounts are operating gains without the project for FY's 2010 through 2017. The Hospital anticipates that the proposed tower will be completed during FY 2014:

Table 11: Hospital's Gain from Operations without the Project (In Millions)

Description	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Operating Gain from Operations	$20,051	$26,020	$27,227	$28,456	$29,767

Description	FY 2015	FY 2016	FY 2017
Operating Gain from Operations	$31,111	$32,426	$34,177

(March 9, 2010, CON application submission, Exhibit 10, page 263)

80. The Hospital's projected incremental revenue from operations, total operating expense and loss from operations associated with the implementation of the proposal is presented in the following table:

Table 12: The Hospital's Financial Projections Incremental to the Project

Description	FY 2011	FY 2012	FY 2013	FY 2014
Incremental Revenue from Operations	$1,989,000	$6,601,000	$13,473,000	$20,173,000
Incremental Total Operating Expense	$4,279,000	$10,067,000	$13,962,000	$21,340,000
Incremental Loss from Operations	**($2,290,000)**	**($3,466,000)**	**($489,000)**	**($1,167,000)**

Description	FY 2015	FY 2016	FY 2017
Incremental Revenue from Operations	$26,653,000	$30,108,000	$32,007,000
Incremental Total Operating Expense	$28,717,000	$30,782,000	$31,979,000
Incremental Loss from Operations	**($2,065,000)**	**($674,000)**	**$29,000**

(March 9, 2010, CON application submission, Exhibit 10, page 263)

81. The projected incremental losses from operations are anticipated during the construction phase until fiscal year 2017. This is directly associated with the increase in costs from the project as a result of incremental interest expense and depreciation expense. *(March 9, 2010 CON application, page 53)*

82. The Hospital's projected overall gain from operations as the proposal is being implemented is shown in the table below. The table indicates that the Hospital will experience a yearly gain from operations even with the building project in FY 2011 through 2017.

Table 13: Hospital's Overall Gain from Operations with the Project (In Thousands)

Description	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Total Gain from Operations	$23,730	$23,761	$27,967	$28,600	$29,046

Description	FY 2016	FY 2017
Total Gain from Operations	$31,752	$34,206

(March 9, 2010, CON application submission, Exhibit, 10, page 263)

83. The overall financial projections appear to be reasonable and will allow the Applicant to move forward with the proposed building project.

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

The Applicant is a general acute care hospital located at 24 Hospital Avenue in Danbury, Connecticut. The Applicant proposes to undertake a facility development project that includes the construction of the proposed tower that will contain the following components: a relocated and expanded ED; a relocated and modernized 30 bed CCU; a new patient care floor consisting of 35 private med/sur beds; two shelled patient care floors for 70 future private med/surg beds; a shelled floor for future expansion of the operating rooms; and an interstitial floor for operating room mechanical access. The Applicant asserts that the proposal is designed to ensure adequate capacity to accommodate the health care needs of the community, improve customer satisfaction, meet the highest infection control standards, and provide a patient and family-centered approach to care.

The proposed ED will increase in size to accommodate approximately 88,000 annual visits, will incorporate the observation unit that is currently located on the 8th floor and have 100% private rooms instead of curtained treatment bays. OHCA finds that proposal will allow the Hospital to expand the size of its current ED and provide treatment to the 70,000 patients seen in the ED annually in private rooms rather than curtained treatment bays, hallways or triage stations. Additionally, by relocating the observation units closer to the ED, patient throughput in the ED will be improved and 10 beds will be available for inpatient use.

The proposed tower will also have a new CCU in a separate inpatient care space located on one floor instead of three separate units and away from the current cath labs. OHCA finds that the relocation of the CCU to the proposed tower will improve privacy for the patients and their families and eliminate the necessity of moving patients between three different units thereby improving the quality of care provided in this unit. Finally, the proposed tower will allow for the establishment of a new med/surg floor with 35 private rooms and two shelled floors with capacity for an additional 70 med/surg beds. OHCA finds that the new med/surg floor will allow for 100% private rooms and more space for: (1) physicians and staff members to meet and discuss patient care and (2) the storage of medication, equipment and supplies on the same floor. OHCA further finds that the two shelled floors will allow the Hospital to expand as necessary to meet anticipated med/surg bed need over the next 10 years.

The proposed tower is the foundation for the Hospital's movement towards a 100% private room facility. The proposed tower will provide a more patient and family-centric facility to best accommodate the needs of patients and families, including private

bathrooms and showers. All rooms constructed in the proposed tower are intended to be private to promote the highest level of patient care, quality control and privacy standards. Based upon the foregoing, OHCA concludes that the proposal will improve the quality and accessibility of health care delivery to the patients of Danbury Hospital.

The total capital expenditure for the proposal is $150,000,000. The Applicant contends that the project will be financed through CHEFA financing and fundraising contributions. The Hospital demonstrated that it will be able to obtain sufficient funds for a portion of the master facility plan through fundraising based upon its current capital campaigns. Moreover, the Hospital anticipates that it will be able to obtain an A rating from CHEFA. CHEFA has provided a letter of interest for financing the project. In FY 2009, the Hospital experienced overall operating gains in excess of $38,000,000. (Source: Hospital Audited Financial Statements) Although the Hospital will initially experience some losses incremental to the project once construction begins, it will continue to experience overall operating gains through FY 2017. Based upon the foregoing, OHCA finds that the financial projections appear to reasonable and the project is financially feasible.

ORDER

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Danbury Hospital to construct a new patient care tower at a total capital expenditure of $150,000,000 is hereby **granted,** subject to the following condition:

1. Should the Hospital plan an increase in licensed beds in order to utilize the approved shelled medical/surgical floors for inpatient care, the Hospital shall file with OHCA, a Certificate of Need Application regarding the proposed increase in licensed beds.

Should the Hospital fail to comply with the aforementioned condition, OHCA reserves the right to take additional action as authorized by law.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

Based upon the foregoing, I respectfully recommend that the Deputy Commissioner approve the application of Danbury Hospital to construct a new patient care tower at a total capital expenditure of $150,000,000.

8-17-10
Date

Melanie A. Dillon, Esq.
Hearing Officer