RECEIVED
DEC 30 2013
OFFICE OF
HEALTH CARE ACCESS

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 13-31884-CON **Check No.:** 0073838
OHCA Verified by: KR **Date:** 12-30-13

X☐ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

X☐ **Attached are completed Financial Attachments I and II.**

☒ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to the following email addresses: steven.lazarus@ct.gov **and** leslie.greer@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☒ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

AFFIDAVIT

Applicant: Gaylord Specialty HealthCare

Project Title: Termination of Service, Gaylord Sleep Medicine-North Haven

I, _____Janine Epright_____, ___CFO_____
(Individual's Name) (Position Title – CEO or CFO)

of ____Gaylord Hospital_ being duly sworn, depose and state that
(Hospital or Facility Name)

__Gaylord Sleep Medicine, North Haven_'s information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Janine Epright
Signature

12/30/13
Date

Subscribed and sworn to before me on 12/30/13

M Calle

Notary Public/Commissioner of Superior Court

My commission expires: MAR 31 2016

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

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant: Gaylord Hospital

Contact Person: Janine Epright

Contact Person's Title: CFO

Contact Person's Address: Gaylord Hospital, P.O. Box 400, Gaylord Farms Road, Wallingford, CT 06492

Contact Person's Phone Number: 203-284-2800

Contact Person's Fax Number: 203-741-3408

Contact Person's Email Address: jepright@gaylord.org

Project Town: North Haven

Project Name: Gaylord Sleep Medicine-North Haven

Statute Reference: Section 19a-638, C.G.S.

Estimated Total

Capital Expenditure: $0

1. **Project Description: Service Termination**

   a. **For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.**

Response: Gaylord Hospital is a long term acute care hospital (LTACH) that provides health care services for patients requiring care for spinal cord injury, traumatic brain injury, stroke, pulmonary disease and other medically complex illnesses and sleep medicine. Gaylord Hospital's services include both inpatient and outpatient care. Gaylord Sleep Medicine-North Haven is located at 8 Devine St #3, North Haven, CT, Connecticut. Gaylord Sleep Medicine-North Haven provides physician consultation and patient evaluation, and the Center is equipped for day and overnight sleep testing as well as CPAP therapy. The sleep service program at the North Haven location consists of 12 beds operating 7 nights a week. The services include diagnostic polysomnography, split-night polysomnography and therapeutic polysomnography. The Center is accredited by the American Academy of Sleep Medicine.

The Sleep Center has a broad geographic reach, with the top 10 towns of patient origin representing 73% of the total patient population. Patient census information can be found in the Appendix.

Response: The decision to discontinue Gaylord Sleep Medicine-North Haven was made by Gaylord Specialty Healthcare as it plans for the changing health environment.

   b. **Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.**

Response: Gaylord Sleep Medicine-North Haven began providing services in July, 2006. A CON authorization was received, Docket Number 06-30811, April 2, 2007. On January 4, 2007, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application of Gaylord Hospital, Inc. seeking authorization to terminate two sleep laboratories located at Gaylord Farms Road, Wallingford, and 1 Long Wharf Drive, New Haven and establish a sleep laboratory at 8 Devine Street, North Haven, Connecticut, and increase the capacity from eleven to twelve beds.

   c. **Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.**

Response: The decision to discontinue Gaylord Sleep Medicine-North Haven was made by Gaylord Specialty Healthcare as it plans for the changing health environment. Gaylord's focus will be on those resources that support its core services for complex rehabilitation and medically complex patients. The decision to terminate the service was made by management at Gaylord Specialty Healthcare.

d. **Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.**

Response: The decision to discontinue Gaylord Sleep Medicine - North Haven did not require a vote of the Board of Directors of Gaylord Hospital.

e. **Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.**

Response: Not Applicable

2. Termination's Impact on Patients and Provider Community

a. **List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.**

Response: YNHH currently provides sleep medicine services in the city of New Haven. Additionally, sleep medicine services are also provided by Middlesex Hospital, at the Sleep Disorder Center at Middlesex Hospital in Middletown, and MidState Medical Center Sleep Laboratory in Meriden, Connecticut. Because these are outpatient facilities, patient volume and utilization rates are unavailable.

b. **Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.**

Response: The Applicant, Gaylord Sleep Medicine-North Haven, and YNHH and Connecticut Children's Medical Center (CCMC) have agreed to work collaboratively to ensure a seamless transition of the clinical service from the patient's perspective. Gaylord Sleep Medicine-North Haven will notify patients of the availability of sleep medicine services provided by the sleep program affiliated with YNHH for adult patients and CCMC Sleep program for pediatric patients.

c. **For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.**

Response: Since these are outpatient facilities, patient volume, utilization and available capacity are not available.

d. **Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.**

Response: Not applicable.

e. **Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.**

Response: : Gaylord Sleep Medicine-North Haven has a written agreement with YNHH for the smooth transition of its adult patients and with CCMC for the transition of its pediatric patients. (See Appendix).

f. **Describe how clients will be notified about the termination and transferred to other providers.**

Response: Patients will be sent a letter informing them of treatment options available in the area. (Appendix)

3. **Actual and Projected Volume**

a. **Provide volumes for the most recently completed FY by town.**

Gaylord Sleep Medicine North Haven Attended Patient Visit Volume

TOWN	YEAR 2013
Ansonia	18
Ashford	1
Auburn	1
Avon	6
Beacon Falls	5
Berlin	9
Bethany	82
Black Island	1
Bloomfield	1
Bolton	1
Branford	189
Bridgeport	57
Bristol	35
Broadbrook	2
Brookfield	1
Canton	2
Cheshire	484
Chester	20
Clinton	45
Colchester	4
Columbia	1
Coventry	1
Cromwell	6

Cushing	1
Danbury	15
Dayville	6
Deep River	13
DERBY	30
Durham	44
East Haven	21
East Berlin	1
East Haddam	4
East Hampton	11
East Hartford	8
East Haven	320
Eastford	1
Easton	4
Elmira	5
Essex	4
Fairfield	25
Falls Village	3
Farmington	2
Glastonbury	7
Guilford	79
Haddam	1
Hamden	1058
Hartford	11
Higganum	6
Hoboken	1
Hope Valley	1
Huntington	1
Ivoryton	7
Jersey City	1
Johns Island	2
Killingworth	35
Leander	1
Madison	109
Manchester	6
Marlborough	1
Meriden	658
Middlebury	16
Middlefield	16
Middletown	64
Milford	280
Monroe	12
Moodus	3
N Tonawanda	1
Naugatuck	36
New Haven	10
New Britain	33
New Britian	1
New Haven	2100
New London	8

New Milford	1
New York	6
Newington	3
Newport	2
Newtown	2
Niantic	3
NO HAVEN	5
Norfolk	1
North Branford	52
North Granby	1
North Haven	601
Northford	160
Norwalk	4
Oakdale	2
Oakville	7
Old Lyme	13
Old Saybrook	13
Orange	101
Oxford	9
Plainfield	1
Plainville	7
Plantsville	24
Plymouth	2
Pompano Beach	2
Portland	6
Prospect	24
Providence	2
Redding	2
ROCKFALL	3
Rockville	1
Rocky Hill	8
Sandy Hook	5
Seymour	20
Sharon	1
Shelton	39
South Meriden	14
Southbury	5
Southbury Ct	1
Southington	50
Southport	4
Spring Hill	5
St Johnsbury	1
Stamford	5
Storrs	1
Stratford	31
Suffield	2
Taftville	1
Thomaston	2
Tolland	3
Torrington	5

Trumbull	23
Uncasville	1
Vernon	1
Wallingford	1
Wallingford	873
Wapiti	1
Waterbury	126
Watertown	10
Weatogue	2
Wellingford	3
West Hartford	3
West Haven	522
Westbrook	25
Westport	6
Wethersfield	7
Williston	3
Windsor	5
Wolcott	41
Woodbridge	72
Woodbury	1
Yalesville	3
Grand Total	**9047**

b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

Table 1: Historical and Current Visits & Admissions (MSLT and Sleep Studies)

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***
	FY 2011	FY 2012	FY 2103	FY2014
Sleep Medicine	2627	2343	1951	155
Total	**2627**	**2343**	**1951**	**155**

Gaylord fiscal year (October 1-September 30)

c. **Explain any increases and/or decreases in volume seen in the tables above.**

Response: The volume of sleep medicine patients in North Haven has been declining over the course of the last 3 years. Physician referrals and direct patient referrals have both declined. Sleep services are provided by other practices in the area.

For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:

i. Average daily census;
ii. Number of clients on the last day of the month;

iii. Number of clients admitted during the month; and
iv. Number of clients discharged during the month.

Response: Not applicable

4. Quality Measures

a. **Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.**

Response: The Curriculum Vitae for the following sleep medicine physicians practicing at the North Haven location has been included in the Attachment: Drs. Dixon, Hilbert, Schneeberg, Kenkare, and Klapper.

b. **Explain how the proposal contributes to the quality of health care delivery in the region.**

Response: The decision to discontinue sleep medicine services in North Haven does not impact the quality of health care services being delivered since sleep medicine services are available in the area.

c. **Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.**

Response: Gaylord Hospital is licensed to operate and maintain an long term acute care hospital through the Department of Public Health (DPH). DPH does not separately specify the types of services that are provided under that license. The termination of this service will not result in any changes to Gaylord Hospital's license from DPH.

5. Organizational and Financial Information

a. **Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).**

Response: Gaylord Specialty HealthCare is a corporation.

b. **Does the Applicant have non-profit status?**
X☐ Yes (Provide documentation) ☐ No

Response: Documentation provided in the Appendix

c. **Financial Statements**

i. **<u>If the Applicant is a Connecticut hospital:</u> 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 hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.**

Response: The Audited Financial Statement is provided in the Appendix.

ii. **<u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)**

Not Applicable

d. **Submit a final version of all capital expenditures/costs.**

Response: There are no capital expenditures/costs to be incurred by Gaylord Hospital as a result of discontinuing this program.

e. **List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.**

Response: Not Applicable

f. **Demonstrate how this proposal will affect the financial strength of the state's health care system.**

Response: This proposal will have no effect on the current financial state of the health care system.

6. **Financial Attachments I & II**

a. **Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. Complete *Financial Attachment I.* (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three <u>full</u> fiscal years of the project.**

Response: Please see **Attachment** for Financial Attachment I.

b. **Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Complete Financial Attachment II. The projections must include the first three full fiscal years of the project.**

Response: Financial Attachment II has been provided as an **Attachment** however it should be noted that there are no incremental revenue, expense, or volume statistics attributable to the termination of sleep medicine services at North Haven.

c. **Provide the assumptions utilized in developing both Financial Attachments I and II (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).**

Response: The assumptions utilized to develop Financial Attachment I and Financial Attachment II are as follows:

The number of hospital FTEs will decrease by approximately 25 FTEs.

All inpatient volumes for Gaylord Hospital will remain constant at FY2013 levels with or without the approval of the CON. Gaylord Sleep Medicine-North Haven is a physician office which provides evaluations and follow up consultations and does not provide inpatient services.

Operating expenses for Gaylord Hospital will increase 3 % each year though FY2015 from the levels experienced in FY2013 due to inflation and assumes no changes in operations that would contribute to an increase or decrease in expenses beyond the impact of inflation. The overall Payer Mix for the System will remain constant at the percentage distribution reported in the FY2012 audited financial statement.

d. **Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).**

Response: Not Applicable

e. **Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?**

Response: Gaylord Sleep Medicine-North Haven was reimbursed for sleep services, however the decision to terminate services was not dependent on reimbursement levels but on declining volume and leasing considerations.

f. **Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.**

Response: Not applicable

g. **Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.**

Response: There is no anticipated operating revenue increases with or without this proposal.

h. **Describe how this proposal is cost effective.**

Response: This proposal will have no effect on the current financial state of the health care system.

APPENDIX

Contents

A. CVs for physicians practicing at Gaylord Sleep Medicine-North Haven
B. Not-For-Profit Certificate
C. Financial Attachments 1 and 2
D. Patient Census
E. Financial Statement
F. Newspaper Notification
G. Patient Notification
H. Agreement between Gaylord Sleep Medicine and CCMC

A. CV of Janice Hilbert

Curriculum Vitae

JANET HILBERT HOWARD-FLANDERS, M.D., F.C.C.P.
Gaylord Sleep Services
P.O. Box 400-Gaylord Farm Rd.
Wallingford, CT 06492
203-284-2853

PERSONAL DATA	DOB: 9/8/60, New York

EDUCATION AND POSTDOCTORAL TRAINING

1978-1982	B.S., Biology, Cornell University, Ithaca, NY
1982-1986	M.D., SUNY Downstate College of Medicine, Brooklyn, NY
1986-1989	Internship and Residency, Internal Medicine, Columbia University, New York, NY
1989-1992	Postdoctoral Fellowship, Pulmonary and Critical Care Medicine, Yale University School of Medicine, New Haven, CT

CURRENT POSITION

2/2005-present	Sleep Physician, Gaylord Hospital, Wallingford, CT

OTHER PROFESSIONAL EXPERIENCE

8/1992-9/1997	Associate Director, Pulmonary and Critical Care, St. Mary's Hospital, Waterbury, CT
8/1992-9/1997	Medical Director, Intensive Care Unit, St. Mary's Hospital, Waterbury, CT
10/1997-6/2003	Assistant Professor of Medicine, Full-time Faculty, Yale Pulmonary/Critical Care and Yale Center for Sleep Medicine, Yale University School of Medicine, New Haven, CT
6/1999-12/1999	Associate Medical Director, Gaylord-Wallingford Sleep Disorders Laboratory, Gaylord Hospital, Wallingford, CT
1/2000-6/2000	Medical Director, Gaylord- Wallingford Sleep Disorders Laboratory Gaylord Hospital, Wallingford, CT
7/2000-6/2003	Associate Medical Director, Yale Center for Sleep Medicine, New Haven, CT

ACADEMIC APPOINTMENTS

8/1992-6/1995	Clinical Instructor of Medicine, Yale University School of Medicine, New Haven, CT
7/1995-9/1997	Assistant Clinical Professor of Medicine, Yale University School of Medicine, New Haven, CT
10/1997-6/2003	Assistant Professor of Medicine, Yale University School of Medicine, New Haven CT

BOARD CERTIFICATIONS AND LICENSURE

Certifications	American Board of Internal Medicine, Internal Medicine, 1989 (valid indefinitely)
	American Board of Internal Medicine, Pulmonary Disease, 1992 (valid through 2013)
	American Board of Internal Medicine, Critical Care Medicine, 1993 (valid through 2013)
	American Board of Sleep Medicine, 1999 (valid indefinitely)

Licensure New York #176360 (inactive), 1988
Connecticut #030380, 1989

HONORS AND AWARDS

1982	B.S. With Honors (for Academic Achievement) and With Distinction (for Research)
1985	Alpha Omega Alpha
1986	M.D. Cum Laude
1986	Merck Award for Outstanding Academic Performance
1992	NIH Training Grant, Clinical Investigation
1994	Fellowship, American College of Chest Physicians
1999	Fellowship, American Academy of Sleep Medicine

TEACHING ACTIVITIES

Major Courses

1992-1997	Course Developer/Coordinator/Instructor, Yale Primary Care Internal Medicine Intensive Care Rotation, St. Mary's Hospital, Waterbury, CT
1999-2003	Course Developer/Coordinator/Instructor, Yale Pulmonary/Critical Care Fellow Sleep Medicine Elective, Yale University, New Haven CT
2001-2003	Course Developer/Coordinator/Instructor, Yale Outpatient Pulmonary/Sleep Medicine Resident Elective, Yale University, New Haven, CT
2002-2003	Student Tutor, Doctor-Patient Encounter Course, Yale University, New Haven, CT

Selected Invited Lectures 2000-2003 (exclusive of fellow/resident/student lectures and rounds)

2/9/2000	Medical Management of Sleep-Related Breathing Disorders – Yale State Chest Conference, Yale University, New Haven CT
6/8/2000	Obstructive Sleep Apnea – Gaylord Hospital, Wallingford, CT
6/10/2000	Medical Management of Obstructive Sleep Apnea - Yale University School of Medicine Primary Care Update 2000: Snoring and Sleep Apnea, Norwich CT
9/6/2000	Hypersomnia - Yale State Chest Conference, Yale University, New Haven CT
9/9/2000	Hypersomnia: Causes, Consequences, and Treatment, - Yale University Symposium on Sleep Medicine: Update for Primary Care Physicians, Pediatricians, and Family Physicians, Norwich CT
3/9/2001	Sleep in the Elderly - Yale Elder Life Program, Yale University, New Haven CT
3/31/2001	Movement Disorders in Sleep – Northeastern Sleep Society Meeting: Health Consequences of Sleep Disorders, New Haven, CT
5/21/2001	Seminar on Hypersomnia - American Thoracic Society Meeting, San Francisco, CA
9/5/2001	Hypersomnia - Yale State Chest Conference, Yale University, New Haven CT
9/21/2001	Obstructive Sleep Apnea – Medical Grand Rounds, Greenwich Hospital, Greenwich, CT
11/16/2001	Obstructive Sleep Apnea – Medical Grand Rounds, St. Mary's Hospital, Waterbury, CT
11/16/2001	Professor's Rounds: Pleural Effusion - St. Mary's Hospital, Waterbury, CT
4/15/2002	Normal Human Sleep and Sleep Disorders – Yale Nursing-Oncology Program, Yale University, New Haven CT
9/11/2002	Beyond Sleep Apnea: Sleep Medicine for the Pulmonologist - Yale State Chest Conference Yale University, New Haven CT

4/15/2003	Normal Human Sleep and Sleep Disorders – Yale Nursing-Oncology Program Yale University, New Haven CT

EDITORIAL ACTIVITIES

1999-2000	Guest Reviewer, Journal of Nuclear Cardiology
2001-2003	Guest Reviewer, Chest

PROFESSIONAL ORGANIZATIONS

American College of Chest Physicians
American Academy of Sleep Medicine
American Thoracic Society
Connecticut Thoracic Society

PROFESSIONAL SERVICE

1995-1996	Member-At-Large, Connecticut Thoracic Society Executive Committee
1996-1997	Chair, Connecticut Thoracic Society 1997 Critical Care Conference Program Planning Committee
1999-2002	Chair, Connecticut Thoracic Society Membership Committee
2000-2001	Member, Northeastern Sleep Society 2001 Annual Meeting Program Planning Committee
2000-2003	Member, Sleep Medicine Fellowship Training Committee, American Academy of Sleep Medicine
2002-2003	ACCP Governor for Connecticut, American College of Chest Physicians
2002-2003	Ad Hoc Advisor re: sleep medicine training in pulmonary fellowship, Association of Pulmonary and Critical Care Medicine Program Directors Executive Committee

OTHER PROFESSIONAL ACTIVITIES

National

1994	AAMC Women Liaison Officer, Association of American Medical Colleges

Regional

1992-1995	Advisory Committee Member, Respiratory Care Program, Naugatuck Valley Community Technical College, Waterbury, CT
1995-1997	Medical Director, Respiratory Care Program, Naugatuck Valley Community Technical College, Waterbury, CT
1995-1996	Member, 1996 Asthma Community Education Program Planning Committee, St. Mary's Hospital, Waterbury CT
2000	Project Consultant, Sleep Disorders: A Primary Care Approach on the Web, New England Research Institute

Hospital

1992-1997	Chair, Intensive Care Unit Committee, St. Mary's Hospital, Waterbury CT
1994-1997	Member, Quality Coordinating Council, St. Mary's Hospital, Waterbury CT
1994-1997	Member, Medical Peer Review Committee, St. Mary's Hospital, Waterbury, CT
1994-1997	Member, Medical Library Committee, St. Mary's Hospital, Waterbury, CT
1994-1997	Chair, Respiratory Inpatient Clinical Pathways Committee, St. Mary's Hospital, Waterbury, CT
1994-1997	Medical Advisor, Respiratory Care Patient-Centered Protocols Committee, St. Mary's Hospital, Waterbury CT

University

1999-2000	Member, Yale University Symposium 2000: Sleep Medicine Update Program Planning Committee, Yale University, New Haven, CT

2002-2003	Member, Technology Subcommittee of the Educational Policy Committee, Yale University, New Haven, CT
2002-2003	Member, Pediatric Respiratory Medicine Junior Faculty Search Committee, Yale University, New Haven, CT

OTHER PROFESSIONAL ACTIVITIES (continued)

Departmental

1992-1997	Member, Yale Primary Care Internal Medicine Intern Selection Committee, Yale University, New Haven, CT
1992-1996	Member, Yale/Waterbury Pulmonary/Critical Care Fellow Selection Committee, Yale University, New Haven, CT
1993-1997	Chair, Medical Resident Chart Review Committee, St. Mary's Hospital, Waterbury CT
1995-1997	Member, Sleep Disorders Medical Advisory Committee, St. Mary's Hospital, Waterbury CT
1997-1998	Chair, Winchester Fellows Clinic Committee, Yale University, New Haven, CT
1997-2002	Member, Yale Traditional Internal Medicine Intern Selection Committee, Yale University, New Haven, CT
1997-2003	Member, Pulmonary/Critical Care Fellow Selection Committee, Yale University, New Haven, CT

PUBLICATIONS

Fortune JE, Hilbert JL, Estradial secretion by granulosa cells from rats with four or five day estrous cycles: the development of responses to follicle-stimulating hormone versus luteinizing hormone. Endocrinology 118:2395-2401; 1986

Quirk SM, Hilbert JL, Fortune JE. Progesterone secretion by granulosa cells from rats with four or five day estrous cycles: the development of responses to follicle-stimulating hormone, luteinizing hormone, and testosterone. Endocrinology 118: 2402-2405; 1986

Mohsenin V, Guffanti EE, Hilbert JL, Ferranti R. Daytime oxygen saturation does not predict nocturnal oxygen desaturation in patients with chronic obstructive pulmonary disease. Arch Phys Med Rehabil 75:285-289; 1994

Lee-Chiong TL, Hilbert, JL. Extensive idiopathic benign bilateral asynchronous pleural fibrosis. Chest 109:564-565; 1996

Hilbert J, Mohsenin V. Adaptation of lung antioxidants to cigarette smoking in humans. Chest 110:916-920; 1996

Murin S, Hilbert J, Reilly SJ. Cigarette smoking and the lung. Clin Rev Allergy and Immunol 15(3):307-61;1997

Hilbert J, Mohsenin V. Can periodic limb movement disorder be diagnosed without polysomnography? A case-control study. Sleep Med 4(1):35-41;2003

Hilbert J. Cardiovascular abnormalities in sleep disordered breathing. PCCU Volume 17, Lesson 11, 2003
http://www.chestnet.org/education/online/pccu/vol17/lessons11_12/11/index.php

Roux F, Hilbert J. CPAP: new generations. Clin Chest Med 24(2):315-342; 2003

Hilbert J. Yale Outpatient Pulmonary and Sleep Medicine Elective for Residents, on-line syllabus 7/2001-6/2003

3933 Park Avenue
Fairfield, CT 06825
(201) 923-5421
dixonkel@excite.com

Keith R. Dixon, M.D.

Education

New Jersey Medical School - University of Medicine and Dentistry M.D, 2000
Newark, New Jersey

Montclair State University B.S. (Cum Laude), 1996
Montclair, New Jersey Major: Biology

Training

Sleep Medicine Fellowship (Accredited 1996) 2003-2005
The Sleep/Wake Institute
Hackensack University Medical Center
Hackensack New Jersey

Internal Medicine Residency 2000-2003
The University Hospital
Newark, New Jersey

Military Experience

United States Army

Honorable Discharge 1994

Independent Ready Reserves 1989 –1994

Active Duty 1986 -1989

- **Medical Specialist**
  Medical Detachment Group
- **Non-Commissioned-Officer-In-Charge**
  Allergy/Immunization Clinic
  Irwin Army Community Hospital
- **Non-Commissioned-Officer-In-Charge**
  Troop Medical Clinic – 1st Infantry Division

Work Experience

Sleep Physician
Gaylord Hospital – Sleep Medicine Services 2005 - present

Cardiac Unit Coordinator 1990 -1996
Holy Name Hospital

Academic Honors

- Greater Newark Alliance Participation Research Scholarship, 1996
- Who's Who Among Students in American Colleges and Universities, 1995
- Award for Academic Excellence, Health Careers Program, 1994
- National Deans List, 1993

Affiliations

American Academy of Sleep Medicine, Member

Research and Presentations

Sleep Medicine

Presentation
Common Sleep Problems For School-Age Children
Gaylord Hospital – North Haven, Connecticut
2007

Presentation
Diagnosis and Treatment of Infantile Apnea in Apparent Life Threatening Events
American College of Chest Physicians Annual Conference - Seattle, Washington
2004

Research – Principal Investigator
Validation of Specific Quantified Parameters vs. Traditional Measurements in the Diagnosis of Increased Upper Airway Resistance Syndrome
Hackensack University Medical Center - Hackensack, New Jersey
Dr. H. Ashtyani
2003- Present

Presentation
Introduction to Sleep Medicine
Hackensack University Medical Center, Internal Medicine Program - Hackensack, New Jersey
2003

Hematology

Presentation
Thrombotic Thrombocytopenic Purpura
The University Hospital, Internal Medicine Program – Newark, NJ
2002 and 2003

Molecular Biology

Research
Joint DNA sequencing project –Microbiology, Biochemistry and Molecular Biology departments
Montclair State University
Dr. Delaney, Dr. L. Lee
1995-1996

Publications

Principal Author - Diagnosis and Treatment of Infantile Apnea in ALTE
Chest, 10/2004 Vol. 126, Issue 4

Extracurricular Activities

University of Medicine and Dentistry of New Jersey (UMDNJ)

Instructor - New Jersey Medical School FIRST Program, 1997
Instructor - High School Scholars Program, 1996
Vice President - Student National Medical Association, 1997-1998

Montclair State University
Peer Tutor – Health Careers Program, 1994

Certification and Licensure

Internal Medicine Board Certification – American Board of Internal Medicine, 2003
Sleep Medicine Board Certification – American Board of Sleep Medicine, 2005

LYNELLE M. SCHNEEBERG

BUSINESS ADDRESS
Gaylord Hospital
Department of Sleep Medicine
P.O. Box 400
Gaylord Farm Road
Wallingford, CT 06492
(203) 284-2812

EDUCATION

Diplomate, American Board of Sleep Medicine (ABSM)
Licensed by the State of Connecticut, License number 001943

University of Denver, Denver, Colorado
School of Professional Psychology (APA approved)
Psy.D. granted August 1993 (4.0 GPA)

Texas A&M University, College Station, Texas
Bachelor of Arts, cum laude, 1980
Major: English; Minors: Technical Writing and Spanish

ACADEMIC HONORS AND AWARDS

Recipient of the West Haven VA Medical Center's Jacob Levine Intern Award for Outstanding Clinical Scholarship
Psi Chi National Honor Society in Psychology
Dean's Tuition Scholarship, School of Professional Psychology, Univ. of Denver
Dean's Scholar, Texas A&M University

CLINICAL EXPERIENCE

Gaylord Hospital, Wallingford, Connecticut, August 1993-present.

Director of Behavioral Sleep Medicine Program: Provide initial evaluations and follow-up care for adults and adolescents with a variety of sleep disorders including obstructive sleep apnea, psychophysiologic insomnia, narcolepsy, delayed sleep phase syndrome, and so on. Also treat pediatric patients and their parents who present with limit-setting sleep disorders, sleep-onset association disorders and so on. As a diplomate of the American Board of Sleep Medicine, I am credentialed to review and interpret sleep studies and provide the necessary patient follow-up.

West Haven VA Medical Center, West Haven, Connecticut, September 1992-present. Predoctoral Psychology Intern (APA approved site, Yale affiliated training institution): As a psychology intern, completed two six month rotations in cardiovascular behavioral medicine and chronic pain. Cardiovascular rotation involved responsibility for intake and follow-up on psychosocial evaluations and co-leading outpatient post-MI/CABG education and support groups; chronic pain rotation involved responsibilities for case management, treatment plan development, and individual therapy. Additional clinical activities included evaluating and treating sexual dysfunction, leading health promotion

groups in smoking cessation and stress management, providing inpatient consult/liaison services to medical units (with a special focus in the renal dialysis unit) for patients experiencing psychological sequelae to medical problems. Also completed a twelve month rotation in the Mental Hygiene Clinic providing outpatient treatment for a variety of psychological disorders.

A.F. Williams Family Medicine Center, Denver, Colorado, July 1991-July 1992.
Clinical Faculty Instructor: For the School of Medicine's Department of Family Medicine, provided individual psychotherapy to pediatric, adolescent, adult, and geriatric patients as well as family therapy to clients with identified social, psychological and health concerns: also address health promotion/disease prevention, pain management, and stress management, and provided consultation services to medical staff.

Neurobehavioral Institute of the Rockies, Boulder, Colorado, August 1990-November 1990. Staff therapist: Conducted group therapy (social and communication skills) and neuropsychological assessments for neurologically impaired inpatients.

RESEARCH AND PROGRAM EVALUATION EXPERIENCE
West Haven VA Medical Center, West Haven, Connecticut
Supervisor: Matthew Burg, Ph.D.
Evaluated a cognitive-behavioral stress management program for its effectiveness in reducing cardiovascular reactivity.

School of Professional Psychology, University of Denver, Denver, Colorado.
For my doctoral paper, Helping Psychologists Put the "Bio" Back into the Biopsychosocial Model: Medical Screenings To Be Conducted Early in Psychological Treatment, delineated potential medical bases for psychological problems and investigated the specific roles that relevant organismic variables (such as cardiovascular, endocrinologic, and neurologic) play in psychological and medical problems, evaluated and recommended an instrument to gather medical data from clients, and discussed strategies for using the obtained data when developing a treatment plan.

OTHER PROFESSIONAL EXPERIENCE
AT&T Bell Laboratories, Denver, Colorado, January 1981-August 1992.
Senior Technical Writer: Planned, researched, wrote, edited, and produced on-line and hardcopy technical documentation, newsletters, tutorials, and training materials. Presented papers at national conferences on technical documentation. Published technical articles and books, three of which won the Society for Technical Communications Award of Merit.

PRESENTATIONS AND PUBLICATIONS

Schneeberg, L.M. (February 2009). How to Get the Best Sleep of Your Life. Lecture presented to undergraduate psychology students at Quinnipiac University, Hamden, Connecticut.

Plummer, J.K. Cline, J. C., Schneeberg, L.M., Rubman, S. (October 2006). Psychology and Sleep Medicine. Symposium presented at the annual convention of the Connecticut Psychological Association in Hartford, Connecticut.

Schneeberg, L.M., Kerns, R.D., Jacob M.D., Ohlin, R., Greene, B. (May 1993). Health Psychology Training at the West Haven VA Medical Center: Preparing Psychologists for Future Roles in Health Care Settings. Symposium presented at the annual convention of the Connecticut Psychological Association in Stamford, Connecticut.

Schneeberg, L.M., Ohlin, R., and Greene, B. (March 1993). Health Psychology Training at the West Haven VA Medical Center: Preparing Psychologists for Future Careers in Health Psychology. Invited address at the Department of Psychology, Yale University.

Schneeberg, L.M. and Rainwater, N. (September 1991). Helping children cope with noxious medical procedures. Paper presented at the third annual convention of the Colorado Society for Behavioral Analysis and Therapy, Denver, Colorado.

Schneeberg, L.M., (August 1991), Women's historical contributions to psychology. Invited lecture for History and Systems of Psychology course at University of Denver.

Published articles in scientific journals, corporate journals and newsletters, and technical manuals.

PROFESSIONAL MEMBERSHIPS, ACTIVITIES, AND CERTIFICATIONS

Ad hoc reviewer, Journal of Behavioral Medicine
Society of Behavioral Sleep Medicine
American Academy of Sleep Medicine
American Psychological Association
Connecticut Psychological Association
Association for the Advancement of Behavior Therapy
Society of Behavioral Medicine

34 Chipping Stone Court
Cheshire, Connecticut 06410

Phone (203) 623 - 8864
jaykenkare@yahoo.com

Jay D. Kenkare, M.D.

Education

Fellowship: Sleep Medicine
Gaylord Sleep Medicine, Research and Education
June 2007 to Present

Residency: Yale Internal Medicine Primary Care Program
2002 - 2005

M.D. U.M.D.N.J. – Robert Wood Johnson Medical School
May 2001

B.A. Rutgers College – Rutgers University
Major: Biological Science: 1996
Graduated with High Honors

Employment

Academic Hospitalist: Waterbury Hospital June 2005 – June 2007
Responsibilities include clinical inpatient medicine, consultative medicine, teaching attending for the Yale Primary Care residency, voting membership on multiple hospital committees.

Professional activities

North East Sleep Society Planning Committee

Clinical Instructor of Medicine: Yale School of Medicine

Resident Recruitment Committee: Yale Internal Medicine Program

Consult Curriculum: Designed and implemented the Consult Rotation for the IM Residency Program

Research experience

Research Associate: Cytogen Corporation

Henry Rutgers Scholar: Evolutionary Molecular Biology

Certifications

Board Certified American Board of Internal Medicine 2005

Honors and Awards

Intern of the Year Award 2002: Awarded to the one Intern who best exemplifies the qualities of a conscientious, dependable, and dedicated physician to the residency program and patient population

National Science Foundation Research Fellowship Award

S. Oakley Van der Poel, Merck Index, Award for Bacteriology and Medical Chemistry

Henry Rutgers Scholar Award: Evolutionary Molecular Biology

David Klapper, MD

C/O Gaylord Sleep Services
8 Devine Street
North Haven, CT 06473
Office Phone (203) 284-2818
Cell Phone: (786) 942-0532
Email: dklapper@gaylord.org

CLINICAL BACKGROUND

2006- Present	Gaylord Sleep Medicine, North Haven, CT Sleep Medicine Physician
2005-2006	Neuroscience Consultants, Miami, FL Outpatient and inpatient general neurologist at Cedars Medical Center
2005-2006	Sleep Medicine Fellow, Jackson Memorial Hospital, Miami, FL
2004-2005	Neuromuscular Fellow, Jackson Memorial Hospital, Miami, FL
1999-2003	Neurologist and internal medicine coverage, Quigley Memorial Hospital, Chelsea, MA
1998	Internal medicine floor attending, Braintree Hospital, Braintree MA
1995-1998	Resident in neurology, Boston Medical Center, Boston MA Teaching Fellow
1994-1995	Intern in internal medicine, The Brooklyn Hospital, Brooklyn N.Y.

RESEARCH

2001-2003 N.I.H. Medical Informatics Fellow, Decision Systems Group, Brigham and Women's Hospital, Boston MA. Thesis: "Use of a Wearable Ambulatory Monitor in the Classification of Movement States in Parkinson's Disease". Patent application submitted in conjunction with a medical device manufacturer.

CERTIFICATION

Board Certified in Sleep Medicine (American Board of Sleep Medicine)
Board Certified in Neurology (American Board of Psychiatry and Neurology)
Connecticut Medical License 044776 expires 8/31/08
Connecticut Controlled Substance CSP40703 expires 2/29/08
DEA BK5771844 expires 12/31/07 (renewing)

EDUCATION

2001-2003 Massachusetts Institute of Technology, Cambridge MA

	Masters of Science in medical informatics M.S. 9/2003
Summer 2002	Harvard School of Public Health, Boston MA Clinical Effectiveness Program
2000-2001	University of Massachusetts, Boston MA Computer science masters student
1989-1994	Albert Einstein College of Medicine, Bronx N.Y. Biomedical Science Pathway honors in 12 basic science courses MD 1/1994
1986-1988	Yeshiva University, New York N.Y. Major in computer science Belkin Scholar
1984-1986	New York University, New York, N.Y. National Merit Scholar

Community Service

Adopt a Classroom: Mentoring 4th grade and high school students at underprivileged school in Waterbury, CT

Soccer and Baseball Coach: Age 5-6 Cheshire CT

B. Not-for-Profit Certificate

Internal Revenue Service

Department of the Treasury

Washington, DC 20224

Person to Contact: Mr. Gillette

Telephone Number: (202) 566-3586

Refer Reply to: E:EO:R:2-5

Date: JUN 10 1991

Gaylord Farm Association, Inc.
Gaylord Farm Road, Box 400
Wallingford, CT 06492

Legend: H = Gaylord Hospital, Inc.
P = Gaylord Farm Association, Inc.
S = Farm Properties Incorporated

Dear Applicant:

This is in reply to your request of August 22, 1990, and subsequent correspondence for rulings concerning a proposed reorganization.

H is a nonstock not-for-profit hospital. H has been recognized as exempt from federal income taxes under section 501(c)(3) of the Code and classified as a public charity under sections 509(a)(1) and 170(b)(1)(A)(iii).

P is a nonstock not-for-profit corporation. P's Certificate of Incorporation provides that its principal purpose is to benefit, perform the functions of, carry out the purposes of and uphold, promote and further the welfare, programs and activities of H. It has been recognized as exempt from federal income taxes under section 501(c)(3) of the Code and a supporting organization within the meaning of section 509(a)(3).

S is a stock corporation with P as its sole shareholder. S is a for-profit corporation and will be subject to federal income taxes. It is not anticipated that P or H will provide services to S, although some personnel and facilities may be shared in the beginning in an effort to reduce costs. If services are provided, an arms-length fee will be charged. The primary purpose of S is to perform real estate development and management functions for P and H.

In addition to its operation of a hospital, H has significant operational and administrative responsibilities in areas not directly related to the providing of medical care to hospital patients. The complexities of operating H's general acute care hospital and H's associated activities have become increasingly burdensome in recent years. At the same time, the demands on the time of persons on the Board of Trustees and Executive Committee of H have also increased. Furthermore, H's commitment to make its services available to all who may need them requires that some of these services be performed at

C. Financial Attachment I & II

FINANCIAL ATTACHMENT DESCRIPTIONS

Financial Attachment A – Long Form Total Facility Not-for-Profit

Financial Attachment B – Long Form Total Facility For-Profit

Financial Attachment C – Long Form Total Hospital Health System Not-for-Profit

Financial Attachment D – Long Form Total Hospital Health System For-Profit

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 2013 Actual Results	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE										
Non-Government	$1,996,621	$1,998,283	($1,998,283)	$0	$1,998,283	($1,998,283)	$0	$1,998,283	($1,998,283)	$0
Medicare	$582,480	$582,480	($582,480)	$0	$582,480	($582,480)	$0	$582,480	($582,480)	$0
Medicaid and Other Medical A	$662,578	$662,578	($662,578)	$0	$662,578	($662,578)	$0	$662,578	($662,578)	$0
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Reve	$3,241,678	$3,243,340	($3,243,340)	$0	$3,243,340	($3,243,340)	$0	$3,243,340	($3,243,340)	$0
Other Operating Revenue	$0	$0			$0			$0		
Revenue from Operations	$3,241,678	$3,243,340	($3,243,340)	$0	$3,243,340	($3,243,340)	$0	$3,243,340	($3,243,340)	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits	$2,442,759	$2,491,614	($2,491,614)	$0	$2,541,446	($2,541,446)	$0	$2,592,275	($2,592,275)	$0
Professional / Contracted Ser	$265,122	$265,123	($265,123)	$0	$265,123	($265,123)	$0	$265,123	($265,123)	$0
Supplies and Drugs	$79,725	$79,728	($79,728)	$0	$79,728	($79,728)	$0	$79,728	($79,728)	$0
Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense	$293,526	$293,527	($293,527)	$0	$293,527	($293,527)	$0	$293,527	($293,527)	$0
Subtotal	$3,081,132	$3,129,992	($3,129,992)	$0	$3,179,824	($3,179,824)	$0	$3,230,653	($3,230,653)	$0
Depreciation/Amortization	$104,378	$104,378	($104,378)	$0	$104,378	($104,378)	$0	$104,378	($104,378)	$0
Interest Expense	$33,026	$33,026	($33,026)	$0	$33,026	($33,026)	$0	$33,026	($33,026)	$0
Lease Expense	$160,834	$172,638	($172,638)	$0	$177,817	($177,817)	$0	$183,152	($183,152)	$0
Total Operating Expense	$3,379,370	$3,440,034	($3,440,034)	$0	$3,495,045	($3,495,045)	$0	$3,551,209	($3,551,209)	$0
Gain/(Loss) from Operations	($137,692)	($196,694)	$196,694	$0	($251,705)	$251,705	$0	($307,869)	$307,869	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expen:	($137,692)	($196,694)	$196,694	$0	($251,705)	$251,705	$0	($307,869)	$307,869	$0
FTEs	26.50	26.50	(26.50)	-	26.50	(26.50)	-	26.50	(26.50)	-
Volume Sleep Studies	1,951	1,952	(1,952)	0	1,952	(1,952)	-	1,952	(1,952)	-

*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.

D. Patient Census

TOWN	2011	2012	2013	2014	Grand Total
Amston	16	1			17
Andover		1			1
Ansonia	23	23	18		64
Ashford	2	5	1		8
Atlanta	3				3
Auburn			1		1
Avon	12	14	6		32
Baltic	1				1
Beacon Falls	9	19	5	1	34
Belmont		2			2
Berlin	28	23	9		60
Bethany	53	75	82	7	217
Bethel		4			4
Bethleham	3				3
Bethlehem	2				2
Black Island			1		1
Bloomfield	14	4	1		19
Bolton	2	2	1		5
Brandford		7			7
Branford	169	203	189	28	589
Bridgeport	63	32	57	4	156
Bristol	34	32	35	3	104
Broad Brook		1			1
Broadbrook	1	1	2		4
Brookfield			1		1
Brookline	3				3
Brooklyn	1				1
Burlington	9	1			10
Canton	9		2		11
Centerbrook	4				4
Chaplin	3	1			4
Cheshire	416	423	484	41	1364
Chester	12	11	20	4	47
Clinton	51	59	45	4	159
Cobalt	1				1
Colchester	7	6	4	2	19
Columbia		2	1		3
Coventry	7	4	1		12
Cromwell	13	7	6		26
Cushing			1		1
Danbury		7	15	1	23
Danielson		1			1
Darien	6				6
Dayville		1	6		7

Deep River	8	8	13		29
Deltona		5			5
DERBY	9	19	30	2	60
Durham	60	55	44	6	165
East Haven	4	21	21		46
East Berlin			1		1
East Haddam	2	1	4		7
East Hampton	15	18	11		44
East Hartford	18	25	8		51
East Haven	391	388	320	29	1128
East Otis				1	1
East Windsor		2			2
Eastford			1		1
Easton	3	4	4		11
Ellington	3	6			9
Elmira			5		5
Enfield	7	3			10
Essex	9	3	4		16
Fairfield	26	15	25	4	70
Falling Waters		3			3
Falls Village			3		3
Fairfield	2				2
Farmington	3	7	2		12
Fontana	6				6
Forestville		1			1
Free Union	2				2
Gales Ferry	1	6			7
Glastonbury	26	14	7		47
Goshen	3	2			5
Groton	8	2		1	11
Guilford	94	125	79	17	315
Haddam		4	1		5
Hamden	841	958	1058	96	2953
Hampton	2				2
Hartford	37	27	11	4	79
Harwinton	1				1
Hebron	2	3			5
Higganum	6	10	6	2	24
Hoboken	1	1	1		3
Hohokus		2			2
Hope Valley			1		1
Huntington	1	1	1		3
Hyattsville	6				6
Ivoryton	6	12	7		25
Jersey City	5	2	1		8
Jewett City	1				1
Johns Island	1	2	2		5
Kensington	1	2			3
Killingworth	31	28	35	1	95
Lakewood	2				2

Landenberg		1			1
Leander		7	1		8
Lebanon	3	2			5
Ledyard	2				2
Lincoln	4	2			6
Litchfield	1	2			3
Madison	95	84	109	9	297
Manchester	41	61	6		108
Mansfield	1	1			2
Marion	11	5		2	18
Marlborough		5	1		6
Massena	5				5
MERDIEN	3				3
Meriden	662	620	658	46	1986
Mesquite	1	2			3
Miami Lakes		3			3
Middlebury		10	16		26
Middlefield	26	27	16		69
Middletown	152	89	64	7	312
Milford	182	212	280	27	701
Monroe	2	12	12	2	28
Moodus			3		3
Moosup				1	1
Muskegon		2			2
N Tonawanda	1	2	1		4
Naugatuck	24	44	36	7	111
New Haven	4	12	10		26
New Britain	26	53	33	2	114
New Britian		10	1		11
New Canaan	4				4
New Canaan		1			1
New Hartford	2	1		1	4
New Haven	1725	2086	2100	163	6074
New London	12	9	8		29
New Milford	2		1		3
New York	2		6		8
Newington	18	17	3	2	40
Newport			2		2
Newtown	3		2		5
Niantic	6	6	3		15
NO HAVEN			5		5
Norfolk	2	1	1		4
North	4	1			5
North Haven	2	1			3
North Branford	59	47	52	15	173
North Granby			1		1
North Haven	540	511	601	66	1718
North Windham		1			1
Northfield	1				1
Northford	133	133	160	20	446

Norwalk	5	1	4		10
Norwich	1	6			7
Nutting Lake	10				10
Oakdale			2		2
Oakville	1	10	7	1	19
Old Lyme	24	16	13	1	54
Old Saybrook	42	37	13	2	94
Orange	88	85	101	11	285
Oxford	6	4	9		19
Plainfield	2	4	1		7
Plainville	13	13	7		33
Plantsville	23	10	24		57
Plymouth	2		2		4
Pompano Beach	3	3	2		8
Portland	13	3	6		22
Prescott Valley	1	1			2
Prospect	42	37	24		103
Providence	7	4	2		13
Punta Gorda	9	2			11
Quaker Hill		1			1
Reading	3				3
Redding			2		2
Ridgefield	4	1		1	6
Riverside	1				1
ROCKFALL		4	3		7
Rockville		3	1		4
Rocky Hill	9	13	8	2	32
Saco		1			1
Sandy Hook	1	10	5		16
Seymour	10	3	20	1	34
Sharon			1		1
Shelton	29	34	39	7	109
Simsbury	7	3			10
Smithtown	1				1
South Glastonbury	3	5			8
South Meriden	11	15	14		40
South Windsor	12	29			41
Southbury	4	9	5		18
Southbury Ct			1		1
Southington	84	44	50	5	183
Southport	1	2	4		7
Spring Hill	2		5		7
St Johnsbury			1		1
Stafford Springs	1	3			4
Stamford	14	8	5	2	29
Sterling	1				1
Storrs	4	1	1		6
Stratford	31	30	31	1	93
Suffield	3	6	2		11
Taftville			1		1

Tampa	2				2
Tarifville		1			1
Terryville	8	1		1	10
The Villages		1			1
Thomaston	2		2		4
Tolland	5	4	3		12
Toronto	2				2
Toronto	2				2
Torrington	7	8	5		20
Trumbull	14	13	23	8	58
Uncasville			1		1
Unionville	1				1
Vernon	9	15	1		25
Villa Roca	4	2			6
Virginia Beach	2	2			4
Wallingford		9	1		10
Wallingford	703	874	873	85	2535
Wapiti	6		1		7
Warrenton	3				3
Waterbury	204	204	126	11	545
Waterford	2	1			3
Watertown	20	1	10		31
Weatogue			2		2
Wellingford			3		3
West Haven	3				3
West Hartford	16	17	3	1	37
West Haven	502	576	522	44	1644
Westbook	2	1			3
Westbrook	27	20	25	7	79
Weston	4				4
Westport	8	4	6	1	19
Wethersfield		3			3
Wethersfield	13	8	7		28
Whitinsville	1				1
Willimantic	3	14		1	18
Willimantic	1				1
Willington		1			1
Williston			3		3
Wilton	4	1			5
Winchester	3				3
Windsor	6	13	5		24
Windsor Locks		5			5
Winsted	5				5
Wolcott	21	31	41	2	95
Woodbridge	48	69	72	6	195
Woodbury	3		1		4
Yalesville	2	2			4
Yaleville			3		3
Grand Total	**8578**	**9202**	**9047**	**829**	**27656**

E. Financial Statement

Gaylord Farm Association, Inc.

Independent Auditors' Report,
Consolidated Financial Statements and
Supplemental Information

As of and for the Years Ended
September 30, 2012 and 2011

SLB | Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

40

Gaylord Farm Association, Inc.
Independent Auditors' Report, Consolidated Financial Statements
and Supplemental Information
As of and for the Years Ended September 30, 2012 and 2011

Table of Contents

Page

Independent Auditors' Report 1

Consolidated Financial Statements:
- Consolidated Balance Sheets 2
- Consolidated Statements of Operations and Changes in Net Assets and Shareholder's Equity 3
- Consolidated Statements of Cash Flows 5
- Notes to the Consolidated Financial Statements 6

Supplemental Information:
- Consolidating Balance Sheet - 2012 32
- Consolidating Balance Sheet - 2011 33
- Consolidating Statement of Operations - 2012 34
- Consolidating Statement of Operations - 2011 35

SLB | Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

Independent Auditors' Report

To the Board of Directors of
Gaylord Farm Association, Inc.:

We have audited the accompanying consolidated balance sheets of Gaylord Farm Association, Inc. (the Association) as of September 30, 2012 and 2011, and the related consolidated statements of operations and changes in net assets and shareholder's equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Gaylord Risk Solutions, Ltd., a wholly-owned subsidiary, whose statements reflect total assets of $5,243,107 and $5,354,067, total liabilities of $3,783,397 and $3,550,951 as of September 30, 2012 and 2011, and total revenues of ($415,079) and ($135,312) and net loss of ($702,372) and ($121,844) for the years then ended, respectively. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Gaylord Risk Solutions, Ltd., is based solely on the report of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Association's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall consolidated financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Gaylord Farm Association, Inc. as of September 30, 2012 and 2011, and the results of its consolidated operations and its consolidated cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information listed within the Table of Contents is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and it is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual companies. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Saslow Lufkin & Buggy, LLP

January 8, 2013
Avon, Connecticut

10 Tower Lane
Avon, Connecticut 06001
Phone 860.678.9200

4600 E. Washington Street, Suite 300
Phoenix, Arizona 85034
Phone 602.252.7373

30 Main Street, Suite 215
Burlington, Vermont 05401
Phone 802.865.9300

Gaylord Farm Association, Inc.
Consolidated Balance Sheets
September 30, 2012 and 2011

	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	$ 635,238	$ 884,695
Patient accounts receivable (less allowance for doubtful accounts of $458,000 in 2012 and $503,000 in 2011)	10,522,310	10,001,815
Assets whose use is limited:		
Assets held under bond indenture agreement	189,467	179,780
Pledges receivable, net	90,046	386,657
Other current assets	2,003,316	1,944,851
Total current assets	13,440,377	13,397,798
Assets whose use is limited:		
Pledges receivable	231,120	310,105
Board-designated investments	14,349,648	13,693,257
Donor restricted investments	5,555,747	5,529,789
Beneficial interest in trusts held by others	11,240,066	9,748,956
	31,376,581	29,282,107
Property, plant and equipment, net	38,177,394	41,937,586
Investments held for captive insurance liabilities	3,846,709	3,517,224
Reinsurance recoverable relating to captive insurance liabilities	663,930	678,921
Other assets (Notes 4 and 7)	946,160	1,086,089
Total assets	$ 88,451,151	$ 89,899,725
Liabilities, Net Assets and Shareholder's Equity		
Current liabilities:		
Accounts payable and accrued expenses	$ 2,811,631	$ 4,853,991
Accrued payroll and related taxes	4,730,818	3,819,490
Line of credit	-	450,000
Estimated amounts due to third-party payers	246,805	246,805
Current portion of accrued pension obligation	1,493,193	2,743,352
Current portion of long-term debt and capital lease obligations	1,526,815	1,487,242
Total current liabilities	10,809,262	13,600,880
Long-term debt and capital lease obligations, less current portion	18,153,360	19,570,309
Accrued pension obligation	16,609,410	14,699,268
Captive insurance losses and other reserves	2,819,498	2,827,083
Interest rate swap liability	4,712,094	4,155,222
Total liabilities	53,103,624	54,852,762
Net assets and shareholder's equity:		
Unrestricted net assets	15,942,540	16,757,868
Temporarily restricted net assets	1,149,464	1,207,234
Permanently restricted net assets	16,795,813	15,278,745
Shareholder's equity	1,459,710	1,803,116
Total net assets and shareholder's equity	35,347,527	35,046,963
Total liabilities, net assets and shareholder's equity	$ 88,451,151	$ 89,899,725

The accompanying notes are an integral part of these consolidated financial statements.

43

Gaylord Farm Association, Inc.
Consolidated Statements of Operations and
Changes in Net Assets and Shareholder's Equity
For the Years Ended September 30, 2012 and 2011

	2012	2011
Revenues:		
Net patient service revenue	$ 70,326,743	$ 67,064,747
Contributions and bequests	1,076,207	913,165
Ceded premium	(325,000)	(332,500)
Other operating revenue	725,080	637,668
Net assets released from restrictions used for operations	279,175	145,235
Total revenues	72,082,205	68,428,315
Expenses:		
Salaries and related expenses	49,528,721	46,823,400
Other operating expenses	5,606,698	5,531,291
Professional fees and contract services	8,060,187	6,818,453
Supplies	5,034,738	5,064,540
Depreciation and amortization	3,900,452	3,890,429
Occupancy costs	2,145,309	2,099,698
Provision for bad debts	420,830	344,715
Interest	882,966	919,764
Losses and loss adjustment expenses (recoveries)	164,137	(141,200)
Total expenses	75,744,038	71,351,090
Loss from operations	(3,661,833)	(2,922,775)
Other gains, net:		
Dividend and interest income	522,282	586,562
Net realized gains on investments	515,365	140,830
Loss on equity investments	(75,252)	(5,304)
Change in fair value of interest rate swap agreement	(556,872)	(508,193)
Total other gains, net	405,523	213,895
Excess of revenues under expenses	$ (3,256,310)	$ (2,708,880)

The accompanying notes are an integral part of these consolidated financial statements.

Gaylord Farm Association, Inc.
Consolidated Statements of Operations and
Changes in Net Assets and Shareholder's Equity (continued)
For the Years Ended September 30, 2012 and 2011

	2012	2011
Unrestricted net assets:		
Excess of revenues under expenses	$ (3,256,310)	$ (2,708,880)
Net unrealized gains (losses) on investments	2,557,046	(1,132,499)
Pension related changes other than net periodic pension cost	(1,708,412)	(3,183,532)
Net loss of GRS	702,372	121,844
Net assets released from restrictions used for purchases of property, plant and equipment	889,976	616,837
Change in unrestricted net assets	(815,328)	(6,286,230)
Temporarily restricted net assets:		
Restricted pledges and contributions	719,251	187,488
Investment income and realized gains on investments	74,943	-
Net unrealized gains on investments	317,187	-
Net assets released from restrictions	(1,169,151)	(762,072)
Change in temporarily restricted net assets	(57,770)	(574,584)
Permanently restricted net assets:		
Restricted contributions and bequests	25,958	29,320
Change in beneficial interest in trusts held by others	1,491,110	(419,464)
Change in permanently restricted net assets	1,517,068	(390,144)
Shareholder's equity:		
Net loss of GRS	(702,372)	(121,844)
Net unrealized gains (losses) on investments of GRS	358,966	(260,304)
Change in shareholder's equity	(343,406)	(382,148)
Change in net assets and shareholder's equity	300,564	(7,633,106)
Net assets and shareholder's equity, beginning of year	35,046,963	42,680,069
Net assets and shareholder's equity, end of year	$ 35,347,527	$ 35,046,963

The accompanying notes are an integral part of these consolidated financial statements.

45

Gaylord Farm Association, Inc.
Consolidated Statements of Cash Flows
For the Years Ended September 30, 2012 and 2011

	2012	2011
Operating activities:		
Change in net assets and shareholder's equity	$ 300,564	$ (7,633,106)
Adjustments to reconcile change in net assets and shareholder's equity to net cash (used in) provided by operating activities:		
Depreciation and amortization	3,900,452	3,890,429
Pension related changes other than net periodic pension cost	1,708,412	3,183,532
Change in fair value of interest rate swap	556,872	508,193
Net realized and unrealized (gains) losses on investments	(3,464,541)	991,669
Loss from equity investments	75,252	5,304
Change in beneficial interest in trusts held by others	(1,491,110)	419,464
Restricted contributions and bequests received	(745,209)	(216,808)
Changes in operating assets and liabilities:		
Patient accounts receivable	(520,495)	(885,966)
Other current assets	(58,465)	(219,834)
Pledges receivable	375,596	487,544
Investments held for captive insurance liabilities	(329,485)	392,772
Reinsurance recoverable relating to captive insurance	14,991	78,729
Other assets	109,677	121,120
Accounts payable and accrued expenses	(2,042,360)	(246,346)
Accrued payroll and related taxes	911,328	444,036
Accrued pension obligation	(1,048,429)	(830,029)
Captive insurance losses and other reserves	(7,585)	(222,216)
Net cash (used in) provided by operating activities	(1,754,535)	268,487
Investing activities:		
Assets held under bond indenture agreement	(9,687)	(7,997)
Investments in joint ventures	(45,000)	(30,601)
Purchases of property, plant and equipment	(140,260)	(1,625,423)
Sales and purchases of investments, net	2,782,192	1,744,509
Net cash provided by investing activities	2,587,245	80,488
Financing activities:		
Principal payments on long-term debt	(1,220,000)	(640,000)
Net payments on lines of credit	(450,000)	(575,000)
Principal payments on capital lease obligations	(157,376)	(842,100)
Restricted contributions and bequests received	745,209	216,808
Net cash used in financing activities	(1,082,167)	(1,840,292)
Change in cash and cash equivalents	(249,457)	(1,491,317)
Cash and cash equivalents, beginning of year	884,695	2,376,012
Cash and cash equivalents, end of year	$ 635,238	$ 884,695

The accompanying notes are an integral part of these consolidated financial statements.

410

Gaylord Farm Association, Inc.
Notes to the Consolidated Financial Statements
As of and for the Years Ended September 30, 2012 and 2011

Note 1 - General

Organization - Gaylord Farm Association, Inc. (the Association) is a not-for-profit corporation, which is a supporting corporation for Gaylord Hospital, Inc. (Gaylord), Gaylord Research Institute, Inc. (GRI), The Gaylord Foundation, Inc. (TGF), Farm Properties, Inc. (FP), Gaylord Farm Rehabilitation Center (GFRC) and Gaylord Risk Solutions, Ltd. (GRS).

Gaylord operates a chronic disease hospital that specializes in the care and treatment of people with medically complex conditions and rehabilitation including brain and spinal cord injury, pulmonary illness, stroke, neurological and orthopedic conditions. In addition, Gaylord runs outpatient clinics to provide physical therapy, occupational therapy, speech therapy and physiatry services as well as sleep disorder centers.

GRI, TGF and FP are dormant corporations with no activity and GFRC is the supporting corporation for the Traurig House, which is a component of the Association's traumatic brain injury care and treatment department.

GRS was incorporated on December 12, 2007 and operates subject to the provisions of the Companies Law of the Cayman Islands. GRS was granted an Unrestricted Class "B" Insurer's license on December 28, 2007, which it holds subject to the provisions of the Insurance Law of the Cayman Islands. GRS is a wholly owned subsidiary of the Association.

Note 2 - Summary of Significant Accounting Policies

Basis of Presentation - The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The consolidated financial statements include the accounts of the Association and its wholly-owned subsidiaries. All significant inter-company balances and transactions have been eliminated in consolidation.

Use of Estimates - The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and related footnotes. Actual results could differ from those estimates. Significant accounts that are impacted by such estimates and assumptions are the allowance for doubtful accounts, allowances for third-party payer discounts and settlements, accrued pension liabilities, malpractice loss reserves and the reserves for workers' compensation insurance.

Cash and Cash Equivalents - Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. In general, the Federal Deposit Insurance Corporation (FDIC) insures cash balances up to $250,000 per depositor, per bank. The FDIC also provides separate unlimited coverage for deposit accounts that meet the definition of non-interest bearing accounts. Unlimited coverage on non-interest bearing accounts extends until December 31, 2012. It is the Association's policy to monitor the financial strength of the banks that hold its deposits on an ongoing basis. During the normal course of business, the Association maintains cash balances in excess of the FDIC insurance limit.

Property, Plant and Equipment - Property, plant and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Maintenance and repairs are charged to expense as incurred.

Note 2 - Summary of Significant Accounting Policies (continued)

Gifts of long-lived assets such as land, buildings or equipment are reported as unrestricted support, and are excluded from the excess of revenues over (under) expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Investments - Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over (under) expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over (under) expenses unless the investments are trading securities. Unrealized losses that have been deemed to be other than temporarily impaired are included within excess of revenues over (under) expenses.

Other Than Temporary Impairments on Investments - The Association accounts for other than temporary impairments in accordance with FASB ASC 320-10 *"Investments - Debt and Equity Securities"* and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other than temporary. There were no impairments recorded in 2012 or 2011.

Equity Investments - The Association has a fifty percent ownership interest in North Haven Fitness & Wellness, LLC (Fitness & Wellness). In addition, the Association has a fifty percent ownership in Gaylord Sleep HealthCenters of Connecticut, LLC (GSHC). The Association accounts for its investment interest in these entities using the equity method of accounting. As such, the Association adjusts its investments by its share of the investees net income (loss).

Deferred Financing Costs - Deferred financing costs have been recorded as an asset and are being amortized using the effective interest method over the term of the related financing agreement.

Temporarily and Permanently Restricted Net Assets - Temporarily restricted net assets are those whose use by the Association has been limited by donors to a specific time frame or purpose and are included in investments. Temporarily restricted net assets are available primarily for health care services, including cancer and pediatric programs and capital replacement.

Permanently restricted net assets consist of funds held in trust by others and the Association's permanently restricted endowments, which are included in donor restricted investments. Permanently restricted endowments are investments to be held in perpetuity, the income from which is expendable to support health care services. The income from funds held in trust by others is expendable to support health care services.

Donor Restricted Gifts - Unconditional promises to give cash and other assets to the Association are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets.

Note 2 - Summary of Significant Accounting Policies (continued)

When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Excess of Revenues Over (Under) Expenses - The consolidated statements of operations and changes in net assets includes excess of revenues over (under) expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over (under) expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, assets released from restrictions for purchase of property, plant and equipment and certain changes in the pension liability.

Income Taxes - The Association is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal and state income taxes on related income pursuant to Section 501(a) of the Code. GRS is a not-for-profit captive insurance company organized under the laws of the Cayman Islands.

The Association accounts for uncertain tax positions with provisions of FASB ASC 740, *"Income Taxes"* which provide a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their consolidated financial statements. The Association may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Association does not have any uncertain tax positions as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, the Association did not record any penalties or interest associated with uncertain tax positions. The Association's prior three tax years are open and subject to examination by the Internal Revenue Service.

Assets Whose Use is Limited - Assets which have limited use include assets deposited with a trustee for debt service, pledges, assets set aside by the Board of Directors for future capital improvements and the Association's beneficial interest in funds held in trust held by others.

Interest Rate Swap Agreement - The Association uses an interest rate swap agreement to modify its variable interest rate debt to a fixed interest rate, thereby reducing the Association's exposure to interest rate market fluctuations. The interest rate swap agreement involves the exchange of amounts based on a fixed interest rate for amounts based on variable rates over the life of the agreement without the exchange of the notional amount upon which payments are based. The differential of amounts paid and received during the year is charged to interest expense and the amounts payable or receivable from the counter-party is included as an adjustment to accrued interest.

Net Patient Service Revenue - Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period in which the related services are rendered and adjusted in the future periods as final settlements are determined.

Charity Care - The Association provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Association does not pursue collection of amounts determined to qualify as charity care, the charges related to charity care services are offset within net patient service revenue.

Note 2 - Summary of Significant Accounting Policies (continued)

The amount of traditional charity care provided, determined on the basis of cost, was approximately $19,019 and $19,524 for the years ended September 30, 2012 and 2011, respectively. Previously, the Association reported its estimates of services provided under its charity care programs based on gross charges. In connection with the Association's adoption of Accounting Standards Update (ASU) 2010-23, *"Health Care Entities (Topic 954): Measuring Charity Care for Disclosure,"* amounts previously reported for care provided under its charity care programs have been restated to reflect the Association's estimates of its direct and indirect cost of providing these services. This change had no impact on the Association's consolidated results of operations.

Estimated Malpractice Costs - The Association maintains malpractice insurance coverage under claims made policies through GRS in 2012 and 2011. A provision for estimated medical malpractice claims includes estimates of the ultimate costs for claims incurred but not reported and is included within accounts payable and accrued expenses on the Association's consolidated balance sheets.

Workers Compensation Costs - The Association is self-insured for workers' compensation. Estimated self-insurance liabilities are included within accrued payroll and related taxes and are $1,102,510 and $1,092,336 as of September 30, 2012 and 2011, respectively, and include estimates for claim obligations related to claims occurring through September 30, 2012 and 2011.

Unpaid Losses and Loss Adjustment Expenses - The reserve for unpaid losses and loss adjustment expenses and the related reinsurance recoverable includes case basis estimates of reported losses, plus supplemental amounts calculated based upon loss projections utilizing actuarial studies, Gaylord's own historical data and industry data. In establishing this reserve and the related reinsurance recoverable, GRS utilizes the findings of an independent consulting actuary. Management believes that its aggregate reserve for unpaid losses and loss adjustment expenses and the related reinsurance recoverable at year-end represents its best estimate, based on the available data, of the amount necessary to cover the ultimate cost of losses; however, because of the nature of the insured risks and limited historical experience, actual loss experience may not conform to the assumptions used in determining the estimated amounts for such asset and liability at the consolidated balance sheet date. Accordingly, the ultimate asset and liability could be significantly in excess of or less than the amount indicated in these consolidated financial statements. As adjustments to these estimates become necessary, such adjustments are reflected in current operations.

Recognition of Premium Revenues - Premiums written are earned on a pro-rata basis over the related policy period. The portion of premiums that will be earned in the future is deferred and reported as unearned premiums.

Reinsurance - In the normal course of business, GRS seeks to reduce its loss exposure by reinsuring certain levels of risk with reinsurers. Reinsurance is accounted for in accordance with FASB ASC 944-20, *"Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts"*. Premiums ceded are expensed over the term of their related policies and recorded as a reduction of revenues.

Legislation - The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Association is in compliance with fraud and abuse as well as other applicable government laws and regulations. While no known regulatory inquiries are pending, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Note 2 - Summary of Significant Accounting Policies (continued)

Accounting Pronouncements Adopted - In August 2010, the FASB issued ASU No. 2010-23, *"Health Care Entities (Topic 954): Measuring Charity Care for Disclosure"*. ASU No. 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU No. 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct or indirect cost of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for fiscal years beginning after December 15, 2010, with retrospective application required. The Association's adoption of ASU 2010-23 did not have a material impact on its overall consolidated financial statements.

In August 2010, the FASB issued ASU No. 2010-24, *"Health Care Entities (Topic 954) Presentation of Insurance Claims and Related Insurance Recoveries"*. ASU No. 2010-24 clarifies that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010. The Association's adoption of ASU 2010-24 did not have an impact on its overall consolidated financial statements.

Pending Accounting Pronouncements - In May 2011, the FASB issued ASU No. 2011-04, *"Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRs"*. ASU No. 2011-04 amends certain guidance in ASC 820, *"Fair Value Measurement"*. ASU 2011-04 expands ASC 820's existing disclosure requirements for fair value measurements and makes other amendments. ASU 2011-04 is effective for interim and annual reporting periods beginning after December 15, 2011 and will be applied on a prospective basis. The Association is currently evaluating the effect that the provisions of ASU 2011-04 will have on the Association's consolidated financial statements.

In July 2011, the FASB issued ASU No. 2011-07, *"Health Care Entities (Topic 954), Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities"*. ASU 2011-07 requires a health care entity to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenues from an operating expense to a deduction from patient service revenues (net of contractual allowances and discounts). Additionally, enhanced disclosures about an entity's policies for recognizing revenue, assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts are required. ASU 2011-07 is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2012. The Association does not believe adoption of ASU 2011-07 will have a material impact on its overall consolidated financial statements.

Reclassification - Certain amounts in the 2011 consolidated financial statements have been reclassified to conform to the 2012 presentation. These reclassifications had no material effect on the 2011 consolidated financial statements.

Subsequent Events - Subsequent events have been evaluated through January 8, 2013, the date through which procedures were performed to prepare the consolidated financial statements for issuance. Management believes there are no subsequent events having a material impact on the consolidated financial statements.

Note 3 - Net Patient Service Revenue

The Association has agreements with third-party payers that provide for payments to the Association at amounts different from its established rates. Contractual payment rates are subject to final determination by reimbursement agencies under each program. A summary of the payment arrangements with major third-party payers follows:

Note 3 - Net Patient Service Revenue (continued)

Medicare - Inpatient and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Inpatient payments are made based on a per discharge amount under the LTCH-DRG inpatient payment system. Outpatient payments are made based on a per encounter amount under the APC outpatient payment system. The Association is reimbursed under the prospective payment system and files annual cost reports, which are subject to audit.

Medicaid - Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospective rates per day of hospitalization. These rates are not subject to retroactive adjustment. Outpatient services are reimbursed based on a fee schedule or percent of charges based on the services provided.

Blue Cross - Services rendered to Blue Cross beneficiaries are reimbursed on a per diem basis based on contracted rates.

The Association has also entered into payment agreements with certain other commercial insurance carriers and health maintenance organizations. The basis for payment to the Association under these agreements includes prompt payment provisions and discounts from established charges.

Net patient service revenue for the years ended September 30, 2012 and 2011 is as follows:

	2012	**2011**
Gross patient service revenue	**$ 195,997,746**	$ 195,812,053
Contractual allowances and adjustments	**(125,671,003)**	(128,747,306)
Net patient service revenue	**$ 70,326,743**	$ 67,064,747

Revenue from the Medicare and Medicaid programs accounted for approximately 37% and 10%, respectively, of the Association's net patient revenue for 2012 and 40% and 9%, respectively, for 2011. Revenue from Blue Cross accounted for approximately 22% and 19% in 2012 and 2011, respectively. No other payer accounted for more than 10% of revenue in 2012 and 2011. Net patient service revenues are based upon complex payment systems and include estimates of amounts yet to be collected. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. Any changes to estimates are recorded within current year operations.

The Association grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. The following summarizes payers that account for more than 10 percent of patient accounts receivable as of September 30, 2012 and 2011:

	2012	**2011**
Medicare	**38%**	46%
Medicaid	**10%**	11%
Blue Cross	**19%**	14%

Monthly, management reviews accounts receivable for uncollectible amounts and records an allowance for doubtful accounts based on specifically identified accounts, as well as an amount for expected bad debt based on historical losses.

Note 4 - Investments

Board-designated and donor restricted investments are invested as follows as of September 30, 2012 and 2011:

	2012		2011	
	Cost	Market Value	Cost	Market Value
Cash and money market funds	$ 81,275	$ 81,275	$ 318,590	$ 318,590
Alternative investment funds	2,080,608	2,224,716	2,519,488	2,047,429
Equity securities	4,258,787	5,324,232	5,116,350	5,164,432
Mutual funds - fixed income	5,642,829	5,901,987	5,840,852	5,786,021
Mutual funds - equity	5,287,290	6,373,185	5,747,393	5,906,574
Total	$ 17,350,789	$ 19,905,395	$ 19,542,673	$ 19,223,046

Investment balances that have been restricted by donors as of September 30, 2012 and 2011 are $5,555,747 and $5,529,789, respectively. The Board of Directors of the Association has restricted all other investments.

Current assets that are held under a bond indenture agreement, are deposited with a trustee for debt service funds. Such amounts are invested in United States treasury notes. In addition, investments held for funding of captive insurance liabilities of $3,846,709 and $3,517,224 as of September 30, 2012 and 2011, respectively, are invested in bonds and fixed income mutual funds.

The Association also has a beneficial interest in trusts held by others of $11,240,066 and $9,748,956 as of September 30, 2012 and 2011, respectively. These funds are managed by the trustees of each fund and are invested primarily in cash equivalents, fixed income and equity securities.

The following table shows the investments' gross unrealized losses and fair value, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position, as of September 30, 2012 and 2011:

	Less than 12 Months		Greater than 12 Months		Total	
2012	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Equity securities	$ 88,786	$ (13,811)	$ 159,203	$ (25,459)	$ 247,989	$ (39,270)
Alternative investment funds	-	-	996,770	(186,230)	996,770	(186,230)
Mutual funds	-	-	932,271	(21,926)	932,271	(21,926)
Total	$ 88,786	$ (13,811)	$ 2,088,244	$ (233,615)	$ 2,177,030	$ (247,426)

Note 4 - Investments (continued)

	Less than 12 Months		Greater than 12 Months		Total	
2011	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Equity securities	$ 641,790	$ (141,811)	$ 105,990	$ (18,418)	$ 747,780	$ (160,229)
Alternative investment funds	-	-	1,543,651	(430,058)	1,543,651	(430,058)
Mutual funds	3,788,645	(140,895)	5,542,242	(884,964)	9,330,887	(1,025,859)
Total	$ 4,430,435	$ (282,706)	$ 7,191,883	$ (1,333,440)	$ 11,622,318	$ (1,616,146)

In 2012 and 2011, none of the investments that were in an unrealized loss position were considered to be other than temporarily impaired.

Investment income is comprised of the following for the years ended September 30, 2012 and 2011:

	2012	**2011**
Income:		
Dividend and interest income	**$ 522,282**	$ 586,562
Net realized gains on investments	**515,365**	140,830
Total investment return	**$ 1,037,647**	$ 727,392
Other changes in unrestricted net assets:		
Unrealized gains (losses) on other than trading securities	**$ 2,557,046**	$ (1,132,499)

Investments in Joint Ventures - The Association has a fifty percent ownership interest in Fitness & Wellness and a fifty percent ownership interest in GSHC. The Association accounts for its investment interest in these entities using the equity method of accounting.

The Association's share of Fitness & Wellness's net loss for the years ended September 30, 2012 and 2011 was $195,647 and $118,629, respectively. In addition, the Association made a capital contribution to Fitness & Wellness of $45,000 and $30,601 during the fiscal years ended September 30, 2012 and 2011, respectively. The carrying amount of the Fitness & Wellness investment was $335,919 and $486,566 as of September 30, 2012 and 2011, respectively, and is included in other assets.

The Association's share of GSHC's net gain for the year ended September 30, 2012 and 2011 was $120,396 and $113,325, respectively. The Association has a receivable of $95,635 and $102,213 due from GSHC for a capital distribution as of September 30, 2012 and 2011, respectively, which is included within other current assets on the accompanying consolidated balance sheets. The carrying amount of the GSHC investment was $125,323 and $100,562 as of September 30, 2012 and 2011, respectively and is included in other assets.

54

Note 5 - Fair Value Measurements

FASB ASC 820-10, *"Fair Value Measurements and Disclosures"*, provides a framework for measuring fair value. That framework provides a fair value hierarch that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820-10 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Association has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) terms, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies for assets and liabilities measured at fair value. There have been no changes in methodologies used as of September 30, 2012 and 2011:

Cash and money market funds - Valued at the closing price reported on the active market on which the individual securities are traded.

Equity securities - Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds - Valued at the closing price reported on the active market on which the individual securities are traded.

Limited partnerships - Valued based on net asset value (NAV) as calculated separately for each class and subclass of shares and for each series within a class of shares equal to the value of gross assets less gross liabilities at the date of determination divided by the total number of outstanding shares. Certain investments may not have readily available market values and may be subject to certain withdrawal restrictions. Liquidity can vary based on various factors and may include lock-up periods as well as redemption fees and/or restrictions. Audited financial statements were obtained as of December 31, 2011 and 2010, which reported unqualified opinions. Values as of September 30, 2012 and 2011 were determined utilizing the same methodologies as those reported in the audited financial statements as of December 31, 2011 and 2010. The following are the major categories of limited partnerships:

Note 5 - Fair Value Measurements (continued)

REITs - This asset class seeks to generate net returns in excess of the UBS Global Real Estate Investor Index through the creation and active management of a portfolio of publicly traded securities issued by real estate investment trusts and other publicly held real estate company in North America, Europe, Australia and Asia.

Limited liability companies - Valued periodically based on the NAV per share. The NAV is determined by the investee company's investment manager or custodian by deducting from the value of assets of the investee company all its liabilities and the resulting number is divided by the outstanding number of shares or units. The NAV per share is then multiplied by the total number of shares held by the Fund at the fiscal year end. Certain investments may not have readily available market values and may be subject to certain withdrawal restrictions. Liquidity can vary based on various factors and may include lock-up periods as well as redemption fees and/or restrictions. Audited financial statements were obtained as of December 31, 2011 and 2010, which reported unqualified opinions. Values as of September 30, 2012 and 2011 were determined utilizing the same methodologies as those reported in the audited financial statements as of December 31, 2011 and 2010. The following are the major categories of limited liability companies:

Domestic equity - This asset class seeks to achieve long-term capital appreciation by investing in a portfolio of small and medium capitalization companies defined as companies whose market capitalizations fall within the range of the Russell 2500 index at the time of purchase.

Registered investment companies - Shares of registered investment companies are valued at the NAV of the shares held by the Fund at year end, where NAV is based on the fair value of the underlying assets in each fund. The following are the major categories of registered investment companies:

REITs - This asset class seeks to provide the diversification and total return potential of investments in real estate by investing primarily in companies whose business is to own, operate, develop and manage real estate.

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). Securities typically priced using Level 2 inputs include government securities, corporate bonds and certificates of deposit.

Beneficial interest in trusts held by others - The value of the Association's assets is based on total fund values and the Association's corresponding beneficiary percentage.

Interest rate swap liability - The interest rate swap agreement is valued using third-party models that use observable market conditions as their input.

Investments measured at NAV are subject to various management, incentive and other fees based on NAV, classes, capital account balances and/or capital commitments. Investments may also be subject to lock up periods. The following table outlines restrictions on investments valued at NAV as of September 30, 2012 and 2011:

	Fair Value		Redemption Frequency	Redemption Notice
	2012	2011	(if Currently Eligible)	Period
Limited partnerships - REITs	$ 511,599	$ 525,469	Monthly	15 business days prior to month end
Limited liability companies - domestic equity	$ 1,151,558	$ 1,018,182	Daily	Not applicable
Registered investment companies - REITs	$ 485,172	$ 503,778	Daily	Not applicable

510

Note 5 - Fair Value Measurements (continued)

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Association believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the financial instruments carried at fair value as of September 30, 2012 by the valuation hierarchy:

2012	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and money market funds	$ 81,275	$ -	$ -	$ 81,275
Limited partnerships - REITs	-	511,599	-	511,599
Limited liability companies - domestic equity	-	1,151,558	-	1,151,558
Registered investment companies - REITs	-	485,172	-	485,172
Public REITs	-	76,387	-	76,387
Equity securities:				
U.S. large cap	3,724,618	-	-	3,724,618
U.S. mid cap	1,514,569	-	-	1,514,569
International developed	60,820	-	-	60,820
Emerging markets	24,225	-	-	24,225
Mutual funds - fixed income:				
Investment grade taxable	3,901,578	-	-	3,901,578
International developed	2,000,409	-	-	2,000,409
Mutual funds - equity:				
International developed	5,440,914	-	-	5,440,914
Emerging markets	932,271	-	-	932,271
Total	17,680,679	2,224,716	-	19,905,395
Investments held for captive insurance liabilities:				
Mutual funds - fixed income	52,476	979,871	-	1,032,347
Mutual funds - equity	424,542	-	-	424,542
Fixed income securities	-	2,389,820	-	2,389,820
Total	477,018	3,369,691	-	3,846,709
Funds held under bond indenture agreements	189,467	-	-	189,467
Beneficial interest in trusts held by others	-	-	11,240,066	11,240,066
Total	$ 18,347,164	$ 5,594,407	$ 11,240,066	$ 35,181,637
Liabilities:				
Interest rate swap liability	$ -	$ 4,712,094	$ -	$ 4,712,094
Total	$ -	$ 4,712,094	$ -	$ 4,712,094

Note 5 - Fair Value Measurements (continued)

The following table presents the financial instruments carried at fair value as of September 30, 2011 by the valuation hierarchy:

2011	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and money market funds	$ 318,590	$ -	$ -	$ 318,590
Limited partnerships - REITs	-	525,469	-	525,469
Limited liability companies - domestic equity	-	1,018,182	-	1,018,182
Registered investment companies - REITs	-	503,778	-	503,778
Equity securities:				
U.S. large cap	3,815,823	-	-	3,815,823
U.S. mid cap	1,320,396	-	-	1,320,396
Emerging markets	28,213	-	-	28,213
Mutual funds - fixed income:				
Investment grade taxable	3,955,053	-	-	3,955,053
International developed	1,830,968	-	-	1,830,968
Mutual funds - equity:				
International developed	4,995,026	-	-	4,995,026
Emerging markets	911,548	-	-	911,548
Total	17,175,617	2,047,429	-	19,223,046
Investments held for captive insurance liabilities:				
Mutual funds - fixed income	47,232	896,974	-	944,206
Mutual funds - equity	269,369	-	-	269,369
Fixed income securities	-	2,303,649	-	2,303,649
Total	316,601	3,200,623	-	3,517,224
Funds held under bond indenture agreements	179,780	-	-	179,780
Beneficial interest in trusts held by others	-	-	9,748,956	9,748,956
Total	$ 17,671,998	$ 5,248,052	$ 9,748,956	$ 32,669,006
Liabilities:				
Interest rate swap liability	$ -	$ 4,155,222	$ -	$ 4,155,222
Total	$ -	$ 4,155,222	$ -	$ 4,155,222

As of September 30, 2012 and 2011, the Association's other financial instruments included accounts receivable, pledges receivable, accounts payable and accrued expenses, line of credit, estimated third-party payer settlements, captive insurance reserves, long-term debt and capital lease obligations. The carrying amounts reported in the consolidated balance sheets for these financial instruments approximate their fair value.

58

Note 5 - Fair Value Measurements (continued)

The following are the changes within the beneficial interest in trusts held by others for the years ended September 30, 2012 and 2011, which are classified as Level 3 within the fair value hierarchy:

	2012
Balance as of October 1, 2011	$ 9,748,956
Net change in market value	1,960,344
Distributions	(469,234)
Balance as of September 30, 2012	$ 11,240,066

	2011
Balance as of October 1, 2010	$ 10,168,420
Net change in market value	48,072
Distributions	(467,536)
Balance as of September 30, 2011	$ 9,748,956

Note 6 - Property, Plant and Equipment

Property, plant and equipment consists of the following as of September 30, 2012 and 2011:

	2012	2011
Land and improvements	**$ 1,820,966**	$ 3,567,551
Buildings and improvements	**57,491,710**	57,358,538
Fixed and moveable equipment	**33,563,642**	32,234,859
	92,876,318	93,160,948
Less: accumulated depreciation and amortization	**(54,894,036)**	(51,406,912)
	37,982,282	41,754,036
Construction in progress	**195,112**	183,550
Total	**$ 38,177,394**	$ 41,937,586

Depreciation expense for the years ended September 30, 2012 and 2011 amounted to $3,487,125 and $3,455,220, respectively. Amortization expense for equipment under capital lease obligations was $395,108 and $416,990 as of September 30, 2012 and 2011, respectively.

Note 7 - Other Assets

Other assets as of September 30, 2012 and 2011 are as follows:

	2012	2011
Investment in Fitness & Wellness	$ **355,919**	$ 486,566
Investment in GSHC	**125,323**	100,562
Deferred financing costs	**336,390**	352,214
Deposits and other	**128,528**	146,747
Total	$ **946,160**	$ 1,086,089

Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements

Lines of Credit - The Association had available a $5,000,000 line of credit agreement, which was available for payment of costs associated with the construction of the 36-bed inpatient pavilion. On January 30, 2009, the Association converted this line of credit to a line of credit note in the amount of $1,625,000. As of September 30, 2012 and 2011, the Association had $0 and $450,000, respectively, outstanding on this line of credit note. Borrowings on the line of credit note were payable in annual installments with the final payment due on July 3, 2012. At the Association's option, the line of credit note bears interest at the bank's prime rate, as defined, plus 150 basis points or LIBOR plus 175 basis points.

Long-term Obligations - The Association also had a $3,000,000 line of credit agreement, which was renewable on an annual basis. On January 30, 2009, the Association converted this line of credit into a term loan promissory note whereby the $3,000,000 is payable in equal monthly installments of $50,000 with a final payment on January 31, 2014. At the Association's option, the term loan promissory note bears interest at the bank's prime rate, as defined, or LIBOR plus 100 basis points. As of September 30, 2012 and 2011, the Association had $850,000 and $1,400,000, respectively, outstanding on this term loan.

In April 2007, the Association, in conjunction with the State of Connecticut Health and Educational Facilities Authority (CHEFA), issued $21,530,000 of Gaylord Hospital Series B variable rate demand revenue bonds (the Series B Bonds). The bond proceeds were used to refinance the amounts outstanding on the CHEFA Series A revenue bonds and for the construction of a 36-bed addition.

The Series B Bonds bear interest at a variable rate as determined by a re-marketing agent (approximately 0.2% and 0.3% as of September 30, 2012 and 2011, respectively), which is adjusted weekly, and matures on July 1, 2037. For as long as the bonds are variable rate, the bond holders have the option to tender their bonds for repayment. The Association has a letter of credit from Bank of America, N.A., which is available to support its obligations under the Series B Bonds during this period. The letter of credit expires on January 3, 2014, subject to extension or earlier termination upon the occurrence of certain events set forth in the letter of credit agreement. At that time, the letter of credit can be renewed, at the bank's discretion, the Association can convert the bonds to a fixed rate or repurchase the bonds outstanding on that date at their par value. Tenders made by bond holders will be remarketed or, if necessary, paid by the drawdowns on the letter of credit. Any tender drawings made under the letter of credit are to be repaid by the Association on the expiration date of the letter of credit. As of September 30, 2012 and 2011, the Association had $18,465,000 and $19,135,000, respectively, outstanding on the Series B Bonds.

Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements (continued)

The Series B loan and letter of credit agreements include certain financial covenants including a minimum debt service coverage ratio of 1.25 to 1, a minimum required amount of unrestricted liquid assets of $10.0 million, and other restrictions, including limitations on future indebtedness and liens. The Association was in compliance with all covenants for 2012 and 2011.

Lease Abandonment Obligations - During 2010, the Association recorded a loss on abandonment of a long-term rental property in the amount of $147,543. The lease was previously accounted for as an operating lease and the Association was no longer utilizing the rental property and is unable to sublease the property. Consequently, the Association's liability represents the present value of future minimum lease payments under this lease of $23,568 as of September 30, 2012. The lease expires in January 2013.

During 2009, the Association recorded a loss on abandonment of a long-term rental property in the amount of $92,035. The lease was previously accounted for as an operating lease and the Association was no longer utilizing the rental property and is unable to sublease the property. Consequently, the Association's liability represents the present value of future minimum lease payments under this lease of $5,530 as of September 30, 2012. The lease expires in December 2013.

Letter of Credit - As a result of being self-funded for its workers' compensation program, the Association is required by the State of Connecticut Workers' Compensation Commission to hold a letter of credit in the aggregate amount of $650,000 as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, there are no outstanding balances on the letter of credit.

Capital Lease Obligations - The Association leases certain equipment and software under capital lease obligations, expiring through December 2019. Future payments, including interest are as follows:

2013	$ 173,687
2014	56,108
2015	32,593
2016	32,593
2017	29,045
Thereafter	55,059
Less: interest	(43,008)
Total	$ 336,077

61

Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements (continued)

A summary of long-term debt and capital lease obligations as of September 30, 2012 and 2011 are as follows:

	2012	2011
Long-term debt obligation	**$ 18,465,000**	$ 19,135,000
Term loan promissory note	**850,000**	1,400,000
Capital lease obligations	**336,077**	416,044
Lease abandonment obligation	**29,098**	106,507
	19,680,175	21,057,551
Less: current portion	**(1,526,815)**	(1,487,242)
Total	**$ 18,153,360**	$ 19,570,309

Scheduled principal repayments on the long-term debt and capital lease obligations as of September 30, 2012 are as follows:

2013	$ 1,526,815
2014	983,500
2015	785,919
2016	817,286
2017	850,129
Thereafter	14,716,526
Total	$ 19,680,175

Operating Leases - The Association leases various equipment and space under operating leases expiring at various dates and month-to-month agreements. Some of these leases contain renewal options. Rent expense under such operating leases and agreements is $495,570 and $490,304, in 2012 and 2011, respectively. The following is a schedule of future minimum payments under non-cancellable operating leases as of September 30, 2012:

2013	$ 421,727
2014	422,506
2015	401,315
2016	360,003
2017	198,333
Thereafter	394,222
Total	$ 2,198,106

In addition, the Association leases land under a long-term lease agreement through 2106 to a third-party. Rental income is based on a percentage of the gross income earned by the lessee. Total rental income from this property was $196,124 and $182,096 for 2012 and 2011, respectively, and is included in other operating revenue in the accompanying consolidated statements of operations and changes in net assets and shareholder's equity.

62

Note 9 - Derivatives

The Association uses derivative instruments, specifically an interest rate swap, to manage its exposure to changes in the interest rate on its CHEFA debt. The use of derivative instruments exposes the Association to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below, and the Association has defined risk management practices to mitigate these risks, as appropriate.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Association will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Association, which creates credit risk. Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Termination risk represents the risk that the Association may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Association's ability to meets its debts or liquidity covenants.

On August 1, 2007, the Association entered into an interest rate swap agreement with an initial notional amount of $21,530,000 to reduce the exposure to fluctuations in interest rates related to its CHEFA debt. The swap agreement, which expires in June 2027, requires that the Association make monthly payments to the counter-party, Bank of America, N.A., based upon a fixed interest rate of 4.28% and in return receives monthly payments from Bank of America, N.A. based on the Bond Index Association Municipal Swap Rate Index rate (0.18% and 0.16% as of September 30, 2012 and 2011, respectively). The notional amount is scheduled to decrease as principal is paid on the CHEFA debt. Net amounts paid under the swap is recorded as additional interest expense. Based on information received from the counter-party, the swap agreement had an unfavorable fair value of $4,712,094 and $4,155,222 as of September 30, 2012 and 2011, respectively.

Management has not designated the swap agreement as a hedging instrument. The change in fair value of the interest rate swap of $556,872 and $508,193 for the years ended September 30, 2012 and 2011, respectively, is recorded in the consolidated statements of operations and changes in net assets as a component of non-operating income.

Note 10 - Net Assets

Temporarily restricted net assets are available for the following purposes as of September 30, 2012 and 2011:

	2012	2011
Health care services:		
Patient special needs	**$ 6,789**	$ 11,506
Other restricted purposes	**821,509**	498,966
Capital campaign	**321,166**	696,762
Total	**$ 1,149,464**	$ 1,207,234

18

Note 10 - Net Assets (continued)

The assets in the above table restricted for health care services are included within cash and cash equivalents on the accompanying consolidated balance sheets.

Permanently restricted net assets are restricted to the following purposes as of September 30, 2012 and 2011:

	2012	2011
Investments to be held in perpetuity, the income of which is expendable to support patient special needs and other services	**$ 5,555,747**	$ 5,529,789
Beneficial interest in trusts held by others, the income of which is expendable to support other health care services	**11,240,066**	9,748,956
Total	**$ 16,795,813**	$ 15,278,745

The Association's endowment consists of multiple funds established for a variety of purposes. The endowment includes both donor-restricted endowment fund and funds designated by the Board of Directors to function as endowments. As required by GAAP, net assets associated with endowment funds, included funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Association has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Association during its annual budgeting process.

The Association considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Association and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Association; and (7) the investment policies of the Association.

Note 10 - Net Assets (continued)

Changes in net assets for endowments and temporary restricted funds for the year ended September 30, 2012 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balance as of October 1, 2011	$ 13,693,257	$ 510,472	$ 5,529,789	$ 19,733,518
Investment return:				
Investment income	522,282	74,943	-	597,225
Net change in market value	3,357,842	317,187	-	3,675,029
Contributions	-	719,251	25,958	745,209
Expenditures	(3,223,733)	(793,555)	-	(4,017,288)
Balance as of September 30, 2012	$ 14,349,648	$ 828,298	$ 5,555,747	$ 20,733,693

Changes in net assets for endowments and temporary restricted funds for the year ended September 30, 2011 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balance as of October 1, 2010	$ 16,458,755	$ 597,512	$ 5,500,469	$ 22,556,736
Investment return:				
Investment income	586,562	-	-	586,562
Net change in market value	(1,321,431)	-	-	(1,321,431)
Contributions	-	187,488	29,320	216,808
Expenditures	(2,030,629)	(274,528)	-	(2,305,157)
Balance as of September 30, 2011	$ 13,693,257	$ 510,472	$ 5,529,789	$ 19,733,518

Funds with Deficiencies - From time to time the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Association to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2012 and 2011, there were no funds that were below the level required by donor or law.

Return Objectives and Risk Parameters - The Association's investment and spending policies for endowment assets attempts to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of the S&P 500 index while assuming a moderate level of investment risk.

Strategies Employed for Achieving Objectives - To satisfy its long-term rate-of-return objectives, the Association relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Board targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

65

Note 10 - Net Assets (continued)

Spending Policy - During its annual budgeting process, the Association appropriates donor restricted endowment funds for expenditure in accordance with donor purpose and time restrictions. During the year ended September 30, 2012 and 2011, the Board appropriated $3,223,733 and $2,030,629, respectively of funds for expenditure from its board restricted endowment funds. The board restricted endowment funds are being held for long-term growth and to maintain capital reserves for the Association.

Note 11 - Pension Plans

The Association has a noncontributory, defined benefit plan (the Plan). The benefits are based on years of service and an average of the five consecutive calendar years of highest compensation during the last ten years of employment. The Association makes contributions in amounts sufficient to fund the Plan as required by ERISA. The Plan was frozen effective October 31, 2004.

The following summarizes significant disclosures relating to the Plan as of September 30, 2012 and 2011:

	2012	2011
Change in benefit obligations:		
Benefit obligations at beginning of year	$ **36,167,672**	$ 34,102,808
Interest cost	**1,664,730**	1,712,734
Service cost	**280,000**	250,000
Actuarial loss	**4,540,807**	2,410,259
Expected administrative expenses	**(247,351)**	(250,000)
Benefits and plan expenses paid	**(2,487,533)**	(2,058,129)
Benefit obligations at end of year	$ **39,918,325**	$ 36,167,672
Change in plan assets:		
Fair value of plan assets at beginning of year	$ **18,725,052**	$ 19,013,691
Actual return on plan assets	**3,616,821**	418,501
Employer contributions	**2,208,733**	1,669,458
Benefits and plan expenses paid	**(2,487,533)**	(2,058,129)
Administrative expenses	**(247,351)**	(318,469)
Fair value of plan assets at end of year	$ **21,815,722**	$ 18,725,052
Accrued pension liability:		
Unfunded status	$ **(18,102,603)**	$ (17,442,620)

66

Note 11 - Pension Plans (continued)

	2012	2011
Net periodic benefit cost:		
Interest cost	**$ 1,664,730**	$ 1,712,734
Service cost	**280,000**	250,000
Actuarial loss recognized	**446,966**	302,929
Expected return on plan assets	**(1,231,392)**	(1,426,234)
Net periodic benefit cost	**$ 1,160,304**	$ 839,429

Benefits expected to be paid over the next five years and the five years thereafter are as follows:

2013	$ 2,477,396
2014	$ 2,749,163
2015	$ 2,538,032
2016	$ 2,489,282
2017	$ 2,698,586
Years 2018-2022	$ 12,769,366

Amounts recorded in unrestricted net assets as of September 30, 2012 and 2011, not yet amortized as components of net periodic benefit cost are as follows:

	2012	2011
Unamortized actuarial loss	**$ 19,876,724**	$ 18,168,312

The amortization of the above items expected to be recognized in net periodic benefit income for the year ended September 30, 2012 is $638,042.

The following summarizes the key weighted-average actuarial assumptions used in determining the Plan's benefit obligation and net benefit income:

	2012	2011
Benefit obligations:		
Discount rate	**3.85%**	4.75%
Net periodic benefit cost:		
Discount rate	**4.75%**	5.25%
Expected long-term return on plan assets	**6.00%**	6.80%

67

Note 11 - Pension Plans (continued)

The fair values of the Association's plan assets, by asset category are as follows, for the year ended September 30, 2012 and 2011:

2012	Level 1	Level 2	Level 3	Total
Money market funds	$ 750,129	$ -	$ -	$ 750,129
Mutual funds - fixed income	9,541,727	-	-	9,541,727
Mutual funds - equities	7,911,780	-	-	7,911,780
Equity securities:				
Consumer discretionary	502,451	-	-	502,451
Consumer staples	269,917	-	-	269,917
Energy	174,229	-	-	174,229
Financial	218,765	-	-	218,765
Health care	331,953	-	-	331,953
Industrials	140,853	-	-	140,853
Information technology	954,988	-	-	954,988
Other	168,623	-	-	168,623
Limited liability company	-	749,504	-	749,504
REIT	-	100,803	-	100,803
Total	$ 20,965,415	$ 850,307	$ -	$ 21,815,722

2011	Level 1	Level 2	Level 3	Total
Money market funds	$ 634,938	$ -	$ -	$ 634,938
Mutual funds - fixed income	8,943,175	-	-	8,943,175
Mutual funds - equities	6,302,610	-	-	6,302,610
Equity securities:				
Consumer discretionary	357,790	-	-	357,790
Consumer staples	233,928	-	-	233,928
Energy	193,891	-	-	193,891
Financial	173,403	-	-	173,403
Health care	228,892	-	-	228,892
Industrials	96,075	-	-	96,075
Information technology	773,860	-	-	773,860
Other	208,820	-	-	208,820
Limited liability company	-	577,670	-	577,670
Total	$ 18,147,382	$ 577,670	$ -	$ 18,725,052

108

Note 11 - Pension Plans (continued)

The Association's investment policy is to minimize risk by balancing investments between equity securities and fixed income debt securities, utilizing a weighted average approach with a minimum split of 60% equity securities and 40% fixed income debt securities and a maximum split of 80% equity securities and 20% fixed income debt securities. The expected return on plan assets assumption was determined based on a review of the Plan's asset mix, capital market assumptions, and a review of the actual return on plan assets over the past ten years.

The Association has a defined contribution benefit plan, which became effective January 1, 2005. Substantially all full time employees are eligible to participate in the defined contribution plan. The Association made contributions to this plan totaling $194,812 and $131,973 in 2012 and 2011, respectively. Employees become vested in the Association's contributions in three to five years. The portion of the employees contributions unvested upon termination are forfeited and used to reduce future contributions made by the Association on a dollar-for-dollar basis.

The Association also has established a 403(b) plan. Participants may elect to contribute a specific percentage of their compensation in pre-tax deferrals subject to established Internal Revenue Code limitations. Currently, the Association does not contribute to this plan.

The Association also has supplemental retirement plan agreements with certain former and current senior executives. The obligation related to this agreement is approximately $50,000 and $1,067,000 as of September 30, 2012 and 2011, respectively, and is recorded within accounts payable and accrued expenses within the accompanying consolidated balance sheets. During 2012, the Association made a payment of approximately $1,230,000 related to these agreements.

Note 12 - Functional Expenses

The Association provides health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2012 and 2011 is as follows:

	2012	2011
Health care services	$ **57,381,203**	$ 54,890,641
General and administrative	**17,551,669**	15,821,689
Fundraising	**811,166**	638,760
Total	$ **75,744,038**	$ 71,351,090

Note 13 - Captive Insurance Activities

Effective January 1, 2008, GRS provided commercial and general liability coverage on a claims made basis to the Association. The coverage limits for the Association were $1,000,000 per claim with an annual aggregate of $4,000,000, plus $100,000 each incident in the event the aggregate is fully eroded. There is no aggregate limit for the commercial general liability.

Effective January 1, 2008, GRS provided an umbrella liability claims-made policy with a limit of $10,000,000 each claim and in the aggregate. GRS has fully reinsured this coverage with a highly rated commercial reinsurance carrier.

Note 13 - Captive Insurance Activities (continued)

Effective January 1, 2008, GRS assumed through a loss portfolio transfer the outstanding loss obligations produced by CHCP, which covered incidents of healthcare professional liability and commercial general liability occurring at the Association from April 1, 2003 through December 31, 2007. The amount of the loss portfolio transfer was $1,482,688.

During the years ended September 30, 2012 and 2011, GRS issued a return premium in the amount of $900,000 and $675,000, respectively, to the Association. This return premium remains unpaid as of September 30, 2012 and 2011 and is reflected within due from affiliates on the accompanying consolidating balance sheet of the Association and is eliminated in consolidation.

A reconciliation of direct to net premiums on a written and earned basis is summarized as follows for years ended September 30, 2012 and 2011:

	Premium Written		Premium Earned	
	2012	**2011**	**2012**	**2011**
Direct premiums	**$ (157,031)**	$ 201,875	**$ (90,079)**	$ 197,188
Ceded premiums	**(325,000)**	(325,000)	**(325,000)**	(332,500)
Total	**$ (482,031)**	$ (123,125)	**$ (415,079)**	$ (135,312)

The liability for unpaid losses and loss adjustment expenses is included within captive insurance loss and other reserves on the accompanying consolidated balance sheets. Activity in the liability for unpaid losses and loss adjustment expenses is summarized as follows for the years ended September 30, 2012 and 2011:

	2012	**2011**
Balance at beginning of the year	**$ 2,388,646**	$ 2,615,549
Less: reinsurance recoverables	**(678,921)**	(757,650)
Net balance beginning of the year	**1,709,725**	1,857,899
Incurred related to:		
Current year	**290,301**	333,402
Prior years	**(126,164)**	(474,602)
Total incurred	**164,137**	(141,200)
Paid related to:		
Current year	**-**	-
Prior years	**(89,779)**	(6,974)
Total paid	**(89,779)**	(6,974)
Net balance end of the year	**1,784,083**	1,709,725
Plus: reinsurance recoverables	**663,930**	678,921
Balance at end of the year	**$ 2,448,013**	$ 2,388,646

Note 13 - Captive Insurance Activities (continued)

As a result of changes in estimates of insured events in prior years, the provision for losses and loss adjustment expenses decreased by $126,164 and $474,602 in 2012 and 2011, respectively.

The above liability for loss and loss adjustment expenses have been determined using a 4% discount rate. The ultimate settlement of losses may vary significantly from the reserves recorded. In particular, ultimate settlements on medical malpractice claims depend, among other things, on the resolution of litigation, the outcome of which is difficult to predict. Also, since the reserves have been discounted, there is the possibility that the timing of loss payments and income earned on invested assets will be significantly different than anticipated.

Included on the accompanying consolidated balance sheets is a reinsurance recoverable of $663,930 and $678,921 as of September 30, 2012 and 2011, respectively, which is due from one reinsurer. GRS continually evaluates the reinsurer's financial condition. There can be no assurance that reinsurance will continue to be available to GRS to the same extent, and at the same cost, as it has in the past. GRS may choose in the future to reevaluate the use of reinsurance to increase or decrease the amounts of risk it cedes to reinsurers.

Note 14 - Commitments and Contingencies

The Association is involved in various legal actions arising in the normal course of activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, upon the Association's financial condition.

ASC 410-20 *"Accounting for Asset Retirement Obligations"* addresses financial accounting and reporting for obligations associated with the retirement of tangible long-lived assets such as facilities containing asbestos, when the amount of the liability can be reasonably estimated. No Asset Retirement Obligation (ARO) has been established as of September 30, 2012 and 2011, as no plans to renovate or sell any facility, or area within, with significant asbestos have been identified and therefore no settlement date has been determined. Management will continue to evaluate its exposure to asbestos removal and establish an ARO for the fair value of the associated costs once sufficient information has been obtained and a settlement date has been determined. Management does not believe that the liability is material to the overall consolidated financial results of the Association.

Note 15 - Risks and Uncertainties

Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statements of financial position.

In addition, the Plan invests in various investments securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statements of financial position.

Note 16 - Pledges Receivable

Pledges receivable represent unconditional promises to give for the 36-bed addition. The following pledges are due to the Association as of September 30, 2012:

Due within one year	$	90,046
Due in one to five years		266,805
		356,851
Less: allowance for uncollectible pledges		(35,685)
Total	$	321,166

Note 17 - Supplemental Cash Flow Disclosures

The Association paid interest in the amount of $882,966 and $919,764 for the years ended September 30, 2012 and 2011, respectively.

Gaylord Farm Association, Inc.
Consolidating Balance Sheet
September 30, 2012

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Assets						
Current assets:						
Cash and cash equivalents	$ 392,491	$ 242,747	$ -	$ -	$ -	$ 635,238
Patient accounts receivable (less allowance of $458,000)	10,522,310	-	-	-	-	10,522,310
Assets whose use is limited:						
Assets held under bond indenture agreement	189,467	-	-	-	-	189,467
Pledges receivable, net	90,046	-	-	-	-	90,046
Due from affiliates	3,143,230	-	-	1,972	(3,145,202)	-
Other current assets	1,513,595	489,721	-	-	-	2,003,316
Total current assets	15,851,139	732,468	-	1,972	(3,145,202)	13,440,377
Assets whose use is limited:						
Pledges receivable	231,120	-	-	-	-	231,120
Board-designated investments	14,349,648	-	-	-	-	14,349,648
Donor restricted investments	5,555,747	-	-	-	-	5,555,747
Beneficial interest in trusts held by others	11,240,066	-	-	-	-	11,240,066
	31,376,581	-	-	-	-	31,376,581
Property, plant and equipment, net	38,177,394	-	-	-	-	38,177,394
Investments held for captive insurance liabilities	-	3,846,709	-	-	-	3,846,709
Reinsurance recoverable relating to captive insurance liabilities	-	663,930	-	-	-	663,930
Other assets	946,160	-	-	-	-	946,160
Total assets	$ 86,351,274	$ 5,243,107	$ -	$ 1,972	$ (3,145,202)	$ 88,451,151
Liabilities, Net Assets and Shareholder's Equity						
Current liabilities:						
Accounts payable and accrued expenses	$ 2,747,732	$ 63,899	$ -	$ -	$ -	$ 2,811,631
Accrued payroll and related taxes	4,730,818	-	-	-	-	4,730,818
Line of credit	-	-	-	-	-	-
Due to affiliates	-	900,000	2,245,202	-	(3,145,202)	-
Estimated amounts due to third-party payers	246,805	-	-	-	-	246,805
Current portion of accrued pension obligation	1,493,193	-	-	-	-	1,493,193
Current portion of long-term debt and capital lease obligations	1,526,815	-	-	-	-	1,526,815
Total current liabilities	10,745,363	963,899	2,245,202	-	(3,145,202)	10,809,262
Long-term debt and capital lease obligations, less current portion	18,153,360	-	-	-	-	18,153,360
Accrued pension obligation	16,609,410	-	-	-	-	16,609,410
Captive insurance losses and other reserves	-	2,819,498	-	-	-	2,819,498
Interest rate swap liability	4,712,094	-	-	-	-	4,712,094
Total liabilities	50,220,227	3,783,397	2,245,202	-	(3,145,202)	53,103,624
Net assets and shareholder's equity:						
Unrestricted	18,185,770	-	(2,245,202)	1,972	-	15,942,540
Temporarily restricted	1,149,464	-	-	-	-	1,149,464
Permanently restricted	16,795,813	-	-	-	-	16,795,813
Shareholder's equity	-	1,459,710	-	-	-	1,459,710
Total net assets and shareholder's equity	36,131,047	1,459,710	(2,245,202)	1,972	-	35,347,527
Total liabilities, net assets and shareholder's equity	$ 86,351,274	$ 5,243,107	$ -	$ 1,972	$ (3,145,202)	$ 88,451,151

See accompanying Independent Auditors' Report.

Gaylord Fari. ssociation, Inc.
Consolidating Balance Sheet
September 30, 2011

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Assets						
Current assets:						
Cash and cash equivalents	$ 487,626	$ 397,069	$ -	$ -	$ -	$ 884,695
Patient accounts receivable (less allowance of $540,000)	10,001,815	-	-	-	-	10,001,815
Assets whose use is limited:						
Assets held under bond indenture agreement	179,780	-	-	-	-	179,780
Pledges receivable, net	386,657	-	-	-	-	386,657
Due from affiliates	2,543,065	-	-	1,972	(2,545,037)	-
Other current assets	1,183,998	760,853	-	-	-	1,944,851
Total current assets	14,782,941	1,157,922	-	1,972	(2,545,037)	13,397,798
Assets whose use is limited:						
Pledges receivable	310,105	-	-	-	-	310,105
Board-designated investments	13,693,257	-	-	-	-	13,693,257
Donor restricted investments	5,529,789	-	-	-	-	5,529,789
Beneficial interest in trusts held by others	9,748,956	-	-	-	-	9,748,956
	29,282,107	-	-	-	-	29,282,107
Property, plant and equipment, net	41,937,586	-	-	-	-	41,937,586
Investments held for captive insurance liabilities	-	3,517,224	-	-	-	3,517,224
Reinsurance recoverable relating to captive insurance liabilities	-	678,921	-	-	-	678,921
Other assets	1,086,089	-	-	-	-	1,086,089
Total assets	$ 87,088,723	$ 5,354,067	$ -	$ 1,972	$ (2,545,037)	$ 89,899,725
Liabilities, Net Assets and Shareholder's Equity						
Current liabilities:						
Accounts payable and accrued expenses	$ 4,805,123	$ 48,868	$ -	$ -	$ -	$ 4,853,991
Accrued payroll and related taxes	3,819,490	-	-	-	-	3,819,490
Line of credit	450,000	-	-	-	-	450,000
Due to affiliates	-	675,000	1,870,037	-	(2,545,037)	-
Estimated amounts due to third-party payers	246,805	-	-	-	-	246,805
Current portion of accrued pension obligation	2,743,352	-	-	-	-	2,743,352
Current portion of long-term debt and capital lease obligations	1,487,242	-	-	-	-	1,487,242
Total current liabilities	13,552,012	723,868	1,870,037	-	(2,545,037)	13,600,880
Long-term debt and capital lease obligations, less current portion	19,570,309	-	-	-	-	19,570,309
Accrued pension obligation	14,699,268	-	-	-	-	14,699,268
Captive insurance reserves	-	2,827,083	-	-	-	2,827,083
Interest rate swap liability	4,155,222	-	-	-	-	4,155,222
Total liabilities	51,976,811	3,550,951	1,870,037	-	(2,545,037)	54,852,762
Net assets and shareholder's equity:						
Unrestricted	18,625,933	-	(1,870,037)	1,972	-	16,757,868
Temporarily restricted	1,207,234	-	-	-	-	1,207,234
Permanently restricted	15,278,745	-	-	-	-	15,278,745
Shareholder's equity	-	1,803,116	-	-	-	1,803,116
Total net assets and shareholder's equity	35,111,912	1,803,116	(1,870,037)	1,972	-	35,046,963
Total liabilities, net assets and shareholder's equity	$ 87,088,723	$ 5,354,067	$ -	$ 1,972	$ (2,545,037)	$ 89,899,725

See accompanying Independent Auditors' Report.

74

Gaylord Farm Association, Inc.
Consolidating Statement of Operations
For the Year End September 30, 2012

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Revenues:						
Net patient service revenue	$ 70,082,884	$ -	$ 243,859	$ -	$ -	$ 70,326,743
Contributions and bequests	1,076,207	-	-	-	-	1,076,207
Earned written premium	-	(90,079)	-	-	90,079	-
Ceded premium	-	(325,000)	-	-	-	(325,000)
Other operating revenue	599,996	-	125,084	-	-	725,080
Net assets released from restrictions used for operations	279,175	-	-	-	-	279,175
Total revenues	72,038,262	(415,079)	368,943	-	90,079	72,082,205
Expenses:						
Salaries and related expenses	48,881,515	-	647,206	-	-	49,528,721
Other operating expenses	5,263,601	203,897	49,121	-	90,079	5,606,698
Professional fees and contract services	8,060,187	-	-	-	-	8,060,187
Supplies	5,034,738	-	-	-	-	5,034,738
Depreciation and amortization	3,857,816	-	42,636	-	-	3,900,452
Occupancy costs	2,145,309	-	-	-	-	2,145,309
Provision for bad debts	420,830	-	-	-	-	420,830
Interest	877,821	-	5,145	-	-	882,966
Loss and loss adjustment expenses	-	164,137	-	-	-	164,137
Total expenses	74,541,817	368,034	744,108	-	90,079	75,744,038
Loss from operations	(2,503,555)	(783,113)	(375,165)	-	-	(3,661,833)
Other gains, net:						
Dividend and interest income	441,541	80,741	-	-	-	522,282
Net realized gains on investments	515,365	-	-	-	-	515,365
Loss on equity investments	(75,252)	-	-	-	-	(75,252)
Change in fair value of interest rate swap agreement	(556,872)	-	-	-	-	(556,872)
Total other gains, net	324,782	80,741	-	-	-	405,523
Excess of revenues under expenses	$ (2,178,773)	$ (702,372)	$ (375,165)	$ -	$ -	$ (3,256,310)

See accompanying Independent Auditors' Report.

Gaylord Farm Association, Inc.
Consolidating Statement of Operations
For the Year Ended September 30, 2011

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Revenues:						
Net patient service revenue	$ 66,776,439	$ -	$ 288,308	$ -	$ -	$ 67,064,747
Contributions and bequests	913,165	-	-	-	-	913,165
Earned written premium	-	197,188	-	-	(197,188)	-
Ceded premium	-	(332,500)	-	-	-	(332,500)
Other operating revenue	507,069	-	130,599	-	-	637,668
Net assets released from restrictions used for operations	145,235	-	-	-	-	145,235
Total revenues	68,341,908	(135,312)	418,907	-	(197,188)	68,428,315
Expenses:						
Salaries and related expenses	46,226,061	-	597,339	-	-	46,823,400
Other operating expenses	5,490,261	178,205	60,013	-	(197,188)	5,531,291
Professional fees and contract services	6,818,453	-	-	-	-	6,818,453
Supplies	5,064,540	-	-	-	-	5,064,540
Depreciation and amortization	3,825,731	-	64,698	-	-	3,890,429
Occupancy costs	2,099,698	-	-	-	-	2,099,698
Provision for bad debts	344,715	-	-	-	-	344,715
Interest	912,115	-	7,649	-	-	919,764
Loss and loss adjustment expenses	-	(141,200)	-	-	-	(141,200)
Total expenses	70,781,574	37,005	729,699	-	(197,188)	71,351,090
Loss from operations	(2,439,666)	(172,317)	(310,792)	-	-	(2,922,775)
Other gains, net:						
Dividend and interest income	536,089	50,473	-	-	-	586,562
Net realized gains on investments	140,830	-	-	-	-	140,830
Loss on equity investments	(5,304)	-	-	-	-	(5,304)
Change in fair value of interest rate swap agreement	(508,193)	-	-	-	-	(508,193)
Total other gains, net	163,422	50,473	-	-	-	213,895
Excess of revenues under expenses	$ (2,276,244)	$ (121,844)	$ (310,792)	$ -	$ -	$ (2,708,880)

See accompanying Independent Auditors' Report.

F. Newspaper Notification

PUBLIC NOTIFICATION (Insert Dates: 11/20/2013 11/21/2013 11/22/2013)

NEW HAVEN REGISTER THE REGISTER CITIZEN The Middletown Press Farmington Valley Times CONNECTICUT
SHORELINE The Foothills Trader WEST HARTFORD NEWS MINUTEMAN
Bulletin THE GRANBY NEWS the Dolphin THE LITCHFIELD COUNTY TIMES Post-Chronicle

Proof of Ad 11/15/13

Account:	141051
Name:	
Company:	GAYLORD HOSPITAL
Address:	GAYLORD FARM RD P.O. BOX 400 WALLINGFORD, CT 06492
Telephone:	(203) 284-2830
Ad ID:	179474
Description:	PUBLIC NOTICE Gaylord Hospital is ap
Run Dates:	11/18/13 to 11/20/13
Class:	1201
Orig User:	CRBCOLELLO
Words:	50
Lines:	14
Agate Lines:	16
Column width:	1
Depth:	1.75
Blind Box:	

PUBLIC NOTICE

Gaylord Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statues for the sale of its Sleep Medicine site located at 8 Devine St., North Haven. There is no capital expenditure associated with this closing as it is a transfer of ownership.

G. NOTICE TO PATIENTS

To All Our Patients:

We are writing to inform you of an upcoming change at Gaylord Sleep Medicine-North Haven. As of (Date), Gaylord Sleep Medicine will be closing its North Haven location. We understand that you may still require sleep medicine services, and your Gaylord provider and Manager of Sleep Services will work collaboratively to ensure a smooth transition for your care. Their contact information is listed below.

Should you have any questions, would like a copy of your medical records, or if you prefer to select another sleep medicine provider, please contact us at 203-284-2756. We thank you for the opportunity to serve your health care needs.

Sincerely,

Margaret Kelley
Manager, Outpatient Medical Services and Sleep Medicine
Gaylord Farm Road
Wallingford, CT 06492

H. Agreement between Gaylord and CCMC

Agreement between Gaylord Hospital, Its Sleep Medicine Division
and Connecticut Children's Medical Center

The Applicant, Gaylord Hospital, Its Sleep Medicine Division and Connecticut Children's Medical Center have agreed to work collaboratively in the implementation of external communications and outreach activities to ensure that pediatric patients have access to necessary sleep medicine services. Gaylord Sleep lab in Glastonbury shall send all pediatric patients within the prior two years a written communication (See Below). It is understood between the Parties that nothing in this Agreement is intended to require nor provides payment or benefits of any kind for the referral of individuals to Connecticut Children's Medical Center.

Janine L. Epright, CFO
Gaylord Hospital

Theresa Hendricksen, EVP & COO
Connecticut Children's Medical Center

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 29, 2014

VIA FAX ONLY

Janine Epright
CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine Services in North Haven, CT

Dear Ms. Epright:

On December 31, 2013, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Gaylord Hospital ("Applicant") for the termination of Gaylord Sleep Medicine Services in North Haven, CT, with no associated capital expenditure.

OHCA has reviewed the CON application pursuant to Section 19a-639a(c) and requests the following additional information:

1. On page 6 of the CON Application, the Applicant responded N/A to question e. Please resubmit a response to "why there is a clear public need for the proposal, provide evidence that demonstrates this need."

2. Please provide the written agreements that the Applicant has with Yale-New Haven Hospital for the transition of its adult patients and with Connecticut Children's Medical Center for the transition of its pediatric patients from the North Haven location.

3. Please provide the current utilization (October 1, 2013 – to the present) for sleep studies performed at the North Haven location.

4. On page 10 of the CON Application, the Applicant states a grand total of 9,047 patient visits by town for the most recently completed FY, where on page 10 the Applicant states 1,951 as the number of sleep studies for FY 2013. Please provide an explanation as to why these two numbers are different.

5. Please report the patient/payer mix for the last two fiscal years and the current fiscal year.

6. Please address the following regarding the Applicant's Medicaid population:

    a. Provide evidence as to how the Applicant has demonstrated how this proposal will improve or maintain quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to:

        i. Provision of any change in the access to services for Medicaid recipients and indigent persons, and

        ii. The impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

7. Provide the Applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons.

8. If the Applicant has failed to provide or reduced access to services to Medicaid recipients or indigent persons, demonstrate how the Applicant has done this due to good cause or demonstrate that it was not solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

9. Has the Applicant considered an alternative to closing the North Haven location (e.g., reducing hours, etc.)? Please provide supporting documentation.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 43 and reference "Docket Number: 13-31884-CON." Submit one (1) original and two (2) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than March 30, 2014, otherwise your application will be automatically considered withdrawn. If you have any questions concerning this letter, please feel free to contact me by email or at (860) 418-7035.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

* * * COMMUNICATION RESULT REPORT (JAN. 29. 2014 9:49AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JAN. 29. 2014 9:48AM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
013 MEMORY TX		912037413408	OK	4/4

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 12037413408

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 01/29/2014 **Time:** 9:45 am

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:
13-31884-
CON
Completeness
Letter

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

GAYLORD SLEEP MEDICINE NORTH HAVEN

RESPONSE TO ADDITIONAL QUESTIONS

DOCKET NUMBER 13-31884-CON

February 6, 2014

RECEIVED
FEB 19 2014
Office of
HEALTHCARE ACCESS

1. **Question e.**

"Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need."

Response

There are three main reasons why there is a public need for the proposal:

- Diminished in-lab patient volume. Since the opening of the Center, patient volume has diminished and it was determined that maintaining the sleep program in North Haven was not an efficient use of resources. In 2013, overnight in-lab sleep volume had fallen to 1851 from 2343 in FY12 and 2627 in FY11, representing a 34.6% decrease. The decision to terminate the sleep practice in North Haven is based on a careful evaluation of how Gaylord can best serve the needs of its patients within its core business: comprehensive health care services for individuals with brain injuries, spinal cord injuries, complex pulmonary conditions, and complex medical illnesses. Our purpose is to provide high quality, cost-efficient care while ensuring the financial health of our organization.
- Changing models of the delivery of sleep medicine services. There is an increasing trend of delivering sleep medicine away from lab testing to home-based testing, thus not necessitating as much need for free-standing sleep labs. This trend is expected to continue and thus will continue to impact volume. (Appendix: Journal of Clinical Sleep Medicine, Vol. 9, No.1, 2013 PRO: Sliding into Home: Portable Sleep testing is Effective for Diagnosis of Obstructive Sleep Apnea)
- Unnecessary duplication of services. With declining volumes and the fact that sleep services are provided by other providers in the area and will continue to be offered in the same location in North Haven by Yale New Haven Hospital, this proposal supports cost-avoidance.

2. **Please provide written agreement that the Applicant has with Yale-New Haven Hospital for the transition of its adult patients and with Connecticut Children's Medical Center for the transition of its pediatric patients from the North Haven location.**

Response

Agreement: Gaylord Sleep Medicine and Connecticut Children's Medical Center

Agreement between Gaylord Hospital, its Sleep Medicine Division
and Connecticut Children's Medical Center

The Applicant, Gaylord Hospital, its Sleep Medicine Division and Connecticut Children's Medical Center have agreed to work collaboratively in the implementation of external communications and outreach activities to ensure that pediatric patients have access to necessary sleep medicine services. Gaylord Sleep lab in Glastonbury shall send all pediatric patients within the prior two years a written communication (See Below). It is understood between the Parties that nothing in this Agreement is intended to require nor provides payment or benefits of any kind for the referral of individuals to Connecticut Children's Medical Center.

Janine L. Epright, CFO
Gaylord Hospital

Theresa Hendricksen, EVP & COO
Connecticut Children's Medical Center

Agreement: Gaylord Sleep Medicine and Yale New Haven Hospital

YALE-NEW HAVEN HOSPITAL

February 10, 2014

George Kyriacou
President & Chief Executive Officer
Gaylord Hospital, Inc.
Gaylord Farm Road
P.O. Box 400
Wallingford, Connecticut 06492

RE: Sleep Medicine Patient Transition

Dear George,

This letter confirms Yale-New Haven Hospital's ("YNHH") commitment to accept Gaylord Hospital's Sleep Medicine patients after Gaylord's termination of its Sleep Medicine service line.

YNHH and Gaylord Hospital's Sleep Division will work collaboratively to implement external communications and outreach activities to ensure that Gaylord patients have access to the necessary sleep medicine services. Prior to the closing of the sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital, Gaylord will send every adult patient seen within the last two years at its North Haven, Glastonbury, Guilford and Trumbull sites a written communication notifying them that they can continue to receive treatment from YNHH. Similarly for pediatric patients, a notification will sent that informs patients that they can be served by either YNHH or Connecticut Children's Medical Center. An example of the communication is attached to this letter.

It is understood by YNHH and Gaylord hospital that nothing in this letter is intended to require or provide payment or benefits of any kind for the referral of patients to YNHH.

Please countersign below indicating your acceptance of this plan of transition.

Sincerely,

Richard D'Aquila
President & Chief Operating Officer

Agreed upon and accepted by:
Gaylord Hospital, Inc.

George Kyriacou
President & Chief Executive Officer

Attachment: Example Patient Communication

[Gaylord Hospital Letterhead]

NOTICE TO OUR SLEEP MEDICINE PATIENTS

[DATE]

To Our Sleep Medicine Patients:

We are writing to inform you that Gaylord Hospital's Sleep Medicine Division is closing its operations. As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations. We understand that you may still require sleep medicine services, and Yale-New Haven Hospital and Connecticut Children's Medical Center have agreed to work collaboratively to ensure a smooth transition for your care. You may contact their Sleep Medicine departments at [INSERT NUMBERS].

Should you have any questions, would like a copy of your medical records, or if you prefer to select another sleep medicine provider, please contact us at [INSERT NUMBER]. We thank you for the opportunity to serve your health care needs.

Sincerely,

Gaylord Hospital, Inc.

3. **Please provide the current utilization (October 1, 2013-to the present) for sleep studies performed at the North Haven location.**

Response

Sleep Studies, October 1, 2013-Current

North Haven	
2013	9,047
YTD 2014	2,195
TOTAL	11,242

4. **On page 10 of the CON application, the Applicant states a grand total of 9,047 patient visits by town for the most recently completed FY, where on page 10 the Applicant states 1,951 as the number of sleep studies for FY2013. Please provide an explanation as to why these two numbers are different.**

Response

The two numbers are different because the grand total of patient visits reported on page 10 reflects all patient visits to the North Haven Sleep Center. The 1,951 represents visits for sleep studies only. The financial worksheet has been amended to reflect all patient visits for FY2013 and is included in the Appendix.

5. **Please report the patient/payer mix for the last two fiscal years and the current fiscal year.**

Response

PAYOR	2011	2012	2013	YTD 2014
Medicare	18%	18%	22%	25%
Medicaid	16%	31%	29%	33%
Commercial	65%	51%	46%	41%
Other	1%	0	4%	0
TOTAL	100%	100%	100%	100%

6. **Please address the following regarding the Applicant's Medicaid population:**

a. **Provide evidence as to how the Applicant has demonstrated how this proposal will improve or maintain quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to:**

   i. **Provision of any change in the access to services for Medicaid recipients and indigent persons, and**

   ii. **The impact upon the cost effectiveness of providing access to services provided under the Medicaid program.**

Response

There will be no adverse impact on the quality and access of sleep medicine services for Medicaid recipients. Medicaid patients can continue to be referred by their physicians, and Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Both organizations have sleep medicine programs accredited by the American Academy of Sleep Medicine.

The agreement between Gaylord Sleep medicine North Haven and YNHH and CCMC is included in Question 2 of this response.

7. **Provide the Applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including but not limited to access to services by Medicaid recipients and indigent persons.**

Response

Gaylord Sleep Medicine North Haven has accepted patient referrals, including Medicaid patients, for sleep services. (Payor Mix table). There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Yale New Haven Hospital will provide sleep services in the North Haven location.

PAYOR	2011	2012	2013	YTD 2014
Medicare	18%	18%	22%	25%
Medicaid	16%	31%	29%	33%
Commercial	65%	51%	46%	41%
Other	1%	0	4%	0
TOTAL	100%	100%	100%	100%

If the Applicant has failed to provide or reduce access to services to Medicaid recipients or indigent persons, demonstrate how the Applicant has done thus due to good cause or demonstrate that it was not solely on the basis of difference in reimbursement rates between Medicaid and other health payers.

Response

Gaylord has provided sleep services to Medicaid recipients. (Payor Mix Table) The decision to terminate sleep medicine services at North Haven was not based in any measure on differences in reimbursement rates between Medicaid and other health payers. Changes in the practice of sleep medicine including new technology used to diagnose sleep disorders has resulted in declining in-lab volumes toward home studies. This, coupled with the need to provide high quality, cost-effective care to patients with spinal cord injuries, brain injuries, complex pulmonary diseases, and medically complex patients influenced the decision to terminate sleep services in North Haven.

There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Additionally, there are other providers in the area that provide sleep medicine services.

PAYOR	2011	2012	2013	YTD 2014
Medicare	18%	18%	22%	25%
Medicaid	16%	31%	29%	33%
Commercial	65%	51%	46%	41%
Other	1%	0	4%	0
TOTAL	100%	100%	100%	100%

Has the Applicant considered an alternative to closing the North Haven location (e.g., reducing hours, etc.)? Please provide documentation.

Response

As part of Gaylord's strategic planning process, the decision was made to concentrate scare resources on Gaylord's core health care services which did not include sleep medicine services. Gaylord made the decision to transfer its North Haven sleep medicine services to Yale New Haven Hospital, and did not consider alternatives to closing the North Haven location.

APPENDIX

ANALYSIS AND PERSPECTIVES

PRO/CON DEBATE

ICSM
Journal of Clinical Sleep Medicine

http://dx.doi.org/10.5664/jcsm.2324

PRO: Sliding into Home: Portable Sleep Testing Is Effective for Diagnosis of Obstructive Sleep Apnea

Douglas B. Kirsch, M.D., F.A.A.S.M.

Clinical Instructor, Harvard Medical School, Regional Medical Director, Sleep HealthCenters, Brighton, MA

Whether you call it home sleep testing (HST), out of center sleep testing, portable monitoring, or something else, the debate about the use of medical devices to assess patients for obstructive sleep apnea outside the sleep laboratory setting has been ongoing for almost 20 years. In the last few years, the discussion has intensified as many United States-based insurance providers, including the government-run Center for Medicare and Medicaid Services (CMS), have approved the use of these devices for diagnosis of obstructive sleep apnea (OSA).[1] This article will briefly review the epidemic of OSA, the history of home sleep testing, and the reasons that home sleep testing is likely to play an increasingly large role in the practice of sleep medicine in the next several years.

Obstructive Sleep Apnea (OSA)

The medical community has been increasingly aware of sleep disorders over the last several years, and in particular, OSA evaluations have been occurring at an increasing rate; CMS data demonstrates that payments for polysomnography alone increased from $62 million in 2001 to $235 million in 2009.[2] These payments do not include the cost of medical consultations or the treatments for these patients. This 4-fold increase over 8 years may be explained by several factors: increasing availability for testing as sleep medicine has grown as a field (more than 2,000 centers were listed as accredited by the American Academy of Sleep Medicine in 2010),[3] the worsening epidemic of obesity in the United States (in 2010, no state had a prevalence of obesity [defined by a BMI of 30] < 20%; 12 of these states had a prevalence ≥ 30%),[4] and increasing knowledge that untreated OSA has medical and societal consequences (such as the potential to increase the risk of motor vehicle crashes, morbidity, and mortality).[5,6] Though the total amount of money used for polysomnography is small on a percentage basis when looking at the budget for CMS, it is probable that the rate of increase was particularly of concern. In the current US budget climate, many methods for reducing cost while maintaining quality were reviewed, including procedures for OSA diagnosis.

Home Sleep Testing and Auto-titrating Positive Airway Pressure (PAP) Therapy

Studying sleep objectively has generally required a laboratory, given the large amount of signals needed for a full polysomnogram (EEG, respiratory parameters, leg/chin movements, EKG, oxygen saturation), as well as the amplifiers, output methods (in recent years, computers), and technical staff. A diagnosis for OSA is typically given when a patient has an apnea-hypopnea index (AHI) ≥ 15 events/h, or an AHI ≥ 5 associated with sleep symptoms or medical disorders.[7] OSA is a relatively common disorder (data from 1993 suggests that 4% of middle-aged men and 2% of middle-aged women have the disorder[8]), and it is one of the most commonly diagnosed problems in a sleep laboratory. As well, sleep laboratories are typically localized to sites with larger populations, making testing of scattered or rural populations more difficult. Thus, portable methods have been evaluated for diagnosis of OSA.

Testing for OSA in the home only solves half of the problem. Prior to the last few years, after a diagnosis of OSA was made, an attended in-laboratory PAP titration study was also necessary to ensure the appropriate pressure was chosen for treatment. At times, both a diagnostic study and a titration study were performed in the same night as a "split-night" protocol. However, the creation, validation, and clinical use of the auto-titrating PAP device minimizes the need for an in-laboratory titration study. While there are still some lingering questions regarding the equivalence of continuous use of auto-titrating PAP therapy and standard PAP therapy, the algorithm of HST for diagnosis and auto-titrating PAP for treatment clearly allows for cost-effective patient management.

The History of Home Sleep Testing

Scarce data about home sleep testing in the early 1990s limited the use of the devices on a larger scale. A review was performed by the American Sleep Disorders Association (a precursor to the American Academy of Sleep Medicine) in 1994,[9] which suggested that home sleep testing be used only in the following situations:

1. Patients with severe symptoms or when treatment is urgent and PSG is not readily available
2. Patients unable to be studied in the laboratory
3. Follow-up study after diagnosis established by polysomnography to evaluate response to therapy

A repeated review in 1997 repeated those recommendations, suggesting that there was not enough validated data for unattended use of home sleep testing devices.[10] A Tri-Society (formed of the American Academy of Sleep Medicine, American Thoracic Society, and the American College of Chest

Physicians) Practice Parameter in 2003 stated that type 3 studies (limited channel home sleep tests) were acceptable in the *attended* setting, but that these testing methods were not recommended in unattended settings, for general screening, or for patients with comorbid conditions.[11]

An AHRQ (Agency for Healthcare Research and Quality) task force performed a technology assessment in 2007, this time with additional data from newer studies and a different viewpoint.[12] Not only did they compare baseline AHI on an in-laboratory polysomnogram to the AHI from a HST, but also they recognized that AHI data did not support that a precise AHI predicted PAP use. Thus, they evaluated outcomes of positive pressure use comparing patients who had been tested in and out of the laboratory. The major findings:

1. Type 3 home testing devices have the ability to predict AHI suggestive of OSA with high positive likelihood ratios and low negative likelihood ratios, particularly when manual scoring is employed.
2. For people with a high probability of OSA, use of laboratory-based PSG does not result in better outcomes over an ambulatory approach in terms of diagnosis and PAP titration

Studies from the last 4-5 years have examined the outcomes from home testing algorithms versus standard in-laboratory polysomnography. One of the pivotal studies used by CMS as evidence for approving HSTs was Mulgrew et al. in 2007, which demonstrated that in subjects with high pre-test probability of obstructive sleep apnea (demonstrated by oximetry and questionnaire), an ambulatory approach (portable monitoring and auto-titrating positive pressure titration) was at least equivalent to in-laboratory testing in terms of adherence of positive pressure therapy and resolution of sleep apnea symptoms after 3 months.[13] One year later, Berry et al. examined 106 Veterans Administration Medical Center (VAMC) patients with excessive daytime sleepiness and a high risk of OSA and randomized them to either portable monitoring with a 2-3 day titration via auto-titrating positive pressure therapy or in-laboratory polysomnography. Both groups were then placed on standard CPAP with no difference in adherence rates to CPAP or improvement in sleep symptoms after 6 weeks.[14] The study of Kuna et al., published in 2011, evaluated 260 VAMC patients and demonstrated that a home testing pathway was not inferior to a laboratory-based pathway for treatment of OSA. Lastly, the 2012 HomePAP study by Rosen et al., assessed 373 subjects, testing the utility of an integrated clinical pathway for obstructive sleep apnea (OSA) diagnosis and continuous positive airway pressure (CPAP) treatment using portable monitoring devices. The findings determined that there was clinical equivalence between the pathways from a standpoint of PAP adherence (in fact, PAP adherence was higher in the ambulatory group) and that a cost analysis favored the ambulatory approach.[15]

Home Sleep Testing: What Is It?

At the heart of home sleep testing is the ability to accurately make a correct diagnosis of OSA while minimizing false positives and false negatives. Most devices will rely on 3 primary signals to assess a patient's sleep-disordered breathing:

1. Airflow (nasal-oral thermistor, nasal pressure, or preferably both),
2. Respiratory effort (ideally with respiratory inductance plethysmography)
3. Oximetry (with a standard maximum signal averaging time $\leq$ 3 sec at a heart rate $\geq$ 80 beats per minute)

Additional factors on home testing devices may include cardiovascular measurements (such as pulse rate or rhythm strips), positional monitoring, and measurement of sleep time. There are several devices which use alternative metrics: venous pulsation substituting for respiratory effort (ARES device, currently under FDA review), arterial tonometry instead of nasal airflow and respiratory effort (WatchPAT), or the analysis of EKG rhythms as a surrogate for respiratory channels.

A home testing device should be validated against in-laboratory polysomnography to ensure that it functions at an adequate level. The American Academy of Sleep Medicine constructed a technology evaluation in 2011, updating their 2007 Clinical Guidelines paper.[16,17] The 2011 paper suggested that an out of center testing device should have a positive likelihood ratio (LR+) $\geq$ 5 coinciding with an in-lab- polysomnography (PSG)-generated apnea hypopnea index (AHI) $\geq$ 5, and an adequate sensitivity ($\geq$ 0.825). A review of many of the currently available devices can be found in this 2011 article.

Home sleep testing though generally effective, has some important limitations. Many portable tests underestimate OSA severity because of the differences in methods to detect obstructive events and amount of sleep. The numerator of the AHI (respiratory events) is lower for a portable test than an in-laboratory test, as subtle sleep-disordered breathing not as easily identified as it would on an in-laboratory test because of the inability to detect arousal-related events. Also, the denominator (time) is larger with portable tests because recording time is assessed rather than sleep time (EEG signal for sleep scoring is not available in many home testing devices). As well, many devices are prone to artifact and have a failure rate that ranges from 3% to 18% depending on study and device.[17]

Why Home Sleep Testing Is Here Now and Why It Might Not Be All Bad?

At this point in time, HSTs are going to play an increasing role in the practice of Sleep Medicine. That is in large part due to the changes in insurance practices around the use of HST. In the northeastern United States, particularly in Massachusetts, prior authorization programs run by utilization management companies have begun to proliferate, shunting many patients from the sleep laboratories and into home testing. Though these programs have not clearly been built exactly on the existing 2007 Practice Parameters from the AASM, it is clear that many patients who are seeking evaluations for OSA will be first evaluated in the home setting; one utilization management company's (American Imaging Management) estimate is as high as 70%.[18] Clearly, the view of these insurance companies is that money will be saved in this process as a home sleep study costs about $200-$300, whereas a sleep study may be $800 and up. Other health insurance companies, such as Aetna and United, have begun utilization management programs applying prior authorization protocols on a national level. Home sleep testing cannot be replaced back into Pandora's box.

Though viewed with much suspicion by some sleep practitioners, HSTs may actually help the field of Sleep Medicine. Certainly, adopting this method of evaluation will result in many changes in physician habits and sleep laboratories. However, as we adjust our practice styles to the new world ahead of us, we may reach a larger number of patients when not limited to a physical location of a sleep laboratory. Patients who might be intimidated by an in-laboratory test may be more willing to consider testing in the home environment. Pre-surgical sleep testing with portable sleep monitors may become a more practical method of patient assessment. Large-deductible insurance programs are proliferating as businesses try to rein in costs, and in a struggling economy, patients may see an expensive in-laboratory test as an unnecessary expense but might view a home sleep test as a more economical option. In order to maintain the cost-effectiveness of use of home studies and promote better adherence to PAP therapy, many insurance programs are limiting testing and interpretation to qualified, high-quality providers. This system provides an opportunity for sleep specialists with comprehensive management and treatment programs to increase the number of patients directed their way.

Essential Points

1. Limited channel testing outside the sleep laboratory can appropriately diagnose OSA in patients with high pretest probability for OSA
2. Portable monitoring appears to be a cost-efficient diagnostic measure at a time when medical costs are being closely scrutinized
3. In combination with auto-titrating PAP and with proper standards for use, testing and treatment of OSA may be done outside of the laboratory setting.

Closing

Regardless of your personal viewpoint on home testing, all sleep medicine clinicians should begin to evaluate their practices, assessing how they might integrate home sleep testing. Developing a reasonable home testing plan will likely involve several steps: becoming familiar with the HST devices and each device's pros and cons, learning how to interpret these studies carefully and appropriately, and finally, developing a business plan for your centers, which may include shrinking the size of the physical sleep laboratory. Many coaches say that preparation is the key to victory; for the field of sleep medicine to continue to be successful, we will have to organize and adapt to new circumstances.

CITATION

Kirsch DB. Pro: Sliding into home: portable sleep testing is effective for diagnosis of obstructive sleep apnea. *J Clin Sleep Med* 2013;9(1):5-7.

REFERENCES

1. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=226&ncdver=3&NCAId=204&NcaName=Continuous+Positive+Airway+Pressure+(CPAP)+Therapy+for+Obstructive+Sleep+Apnea+(OSA)&IsPopup=y&bc=AAAAAAAAAAAA& (Accessed 7/1/12)
2. http://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf (Accessed 7/1/12)
3. http://www.aasmnet.org/articles.aspx?id=1728 (Accessed 7/1/12)
4. http://www.cdc.gov/obesity/data/adult.html/ (Accessed 7/1/12)
5. Tregear S, Reston J, Schoelles K, et al. Continuous positive airway pressure reduces risk of motor vehicle crash among drivers with obstructive sleep apnea: systematic review and meta-analysis. *Sleep* 2010;33:1373-80.
6. Young T, Finn L, Peppard PE, et al. Sleep disordered breathing and mortality: eighteen-year follow-up of the Wisconsin sleep cohort. *Sleep* 2008;31:1071-8.
7. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=226&ncdver=3&NCAId=204&NcaName=Continuous+Positive+Airway+Pressure+(CPAP)+Therapy+for+Obstructive+Sleep+Apnea+(OSA)&IsPopup=y&bc=AAAAAAAAAAAA& (Accessed 7/1/12)
8. Young T, Palta M, Dempsey J, et al. The occurrence of sleep-disordered breathing among middle-aged adults. *N Engl J Med* 1993;328:1230-5.
9. Ferber R, Millman R, Coppola M, et al. Portable recording in the assessment of obstructive sleep apnea. ASDA standards of practice. *Sleep* 1994;17:378-92.
10. Chesson, AL Jr, Ferber RA, Fry JM, et al. The indications for polysomnography and related procedures. *Sleep* 1997;20:423-87
11. Flemons, WW, Littner, MR, Rowley JA, et al. Home diagnosis of sleep apnea: a systematic review of the literature: an evidence review cosponsored by the American Academy of Sleep Medicine, the American College of Chest Physicians, and the American Thoracic Society. *Chest* 2003;124:1543-1579
12. AHRQ Technology Assessment, 2007 (https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/id48TA.pdf) (Accessed 7/1/12)
13. Mulgrew AT, Fox N, Ayas NT, et al. Diagnosis and initial management of obstructive sleep apnea without polysomnography: a randomized validation study. *Ann Intern Med* 2007;146:157-66.
14. Berry RB, Hill G, Thompson L, et al. Portable monitoring and autotitration versus polysomnography for the diagnosis and treatment of sleep apnea. *Sleep* 2008;31:1423-31.
15. Rosen CL, Auckley D, Benca R, et al. A multisite randomized trial of portable sleep studies and positive airway pressure autotitration versus laboratory-based polysomnography for the diagnosis and treatment of obstructive sleep apnea: The HomePAP Study. *Sleep* 2012;35:757-67
16. Collop NA, Tracy SL, Kapur V, et al. Obstructive sleep apnea devices for out-of-center (OOC) testing: technology evaluation. *J Clin Sleep Med* 2011;7:531-48.
17. Collop NA, Anderson WM, Boehlecke B, et al. Clinical guidelines for the use of unattended portable monitors in the diagnosis of obstructive sleep apnea in adult patients. Portable Monitoring Task Force of the American Academy of Sleep Medicine. *J Clin Sleep Med* 2007;3:737-47.
18. http://www.npr.org/blogs/health/2012/01/16/145182935/the-sleep-apnea-business-is-booming-and-insurers-aren't-happy (Accessed 8/30/12)

SUBMISSION & CORRESPONDENCE INFORMATION

Submitted for publication August, 2012
Submitted in final revised form August, 2012
Accepted for publication August, 2012

Address correspondence to: Douglas B. Kirsch, M.D., 1505 Commonwealth Ave., 5th Floor, Sleep HealthCenters, Brighton, MA 02135; Tel: (617) 783-1441; Fax: (781) 430-5881; E-mail: Doug_Kirsch@sleephealth.com

DISCLOSURE STATEMENT

Dr. Kirsch has indicated no financial conflicts of interest.

FINANCIAL WORKSHEET

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 2013 Actual Results	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projectec With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projecte With CC
NET PATIENT REVENUE										
Non-Government	1996620.74	1998282.74	-1998282.74	0	1998282.74	-1998282.74	0	1998282.74	-1998282.74	0
Medicare	582479.74	582479.74	-582479.74	0	582479.74	-582479.74	0	582479.74	-582479.74	0
Medicaid and Other Medical Ass	662577.52	662577.52	-662577.52	0	662577.52	-662577.52	0	662577.52	-662577.52	0
Other Government	0	0	0	0	0	0	0	0	0	0
Total Net Patient Patient Revenu	3241678	3243340	-3243340	0	3243340	-3243340	0	3243340	-3243340	0
Other Operating Revenue	0	0			0			0		
Revenue from Operations	3241678	3243340	-3243340	0	3243340	-3243340	0	3243340	-3243340	0
OPERATING EXPENSES										
Salaries and Fringe Benefits	2442759	2491614	-2491614	0	2541446.28	-2541446.28	0	2592275.206	-2592275.21	0
Professional / Contracted Servic	265122	265123	-265123	0	265123	-265123	0	265123	-265123	0
Supplies and Drugs	79725	79728	-79728	0	79728	-79728	0	79728	-79728	0
Bad Debts	0	0	0	0	0	0	0	0	0	0
Other Operating Expense	293526	293527	-293527	0	293527	-293527	0	293527	-293527	0
Subtotal	3081132	3129992	-3129992	0	3179824.28	-3179824.28	0	3230653.206	-3230653.21	0
Depreciation/Amortization	104378	104378	-104378	0	104378	-104378	0	104378	-104378	0
Interest Expense	33026	33026	-33026	0	33026	-33026	0	33026	-33026	0
Lease Expense	160834	172638	-172638	0	177817.14	-177817.14	0	183151.6542	-183151.654	0
Total Operating Expense	3379370	3440034	-3440034	0	3495045.42	-3495045.42	0	3551208.86	-3551208.86	0
Gain/(Loss) from Operations	-137692	-196694	196694	0	-251705.42	251705.42	0	-307868.86	307868.8598	0
Plus: Non-Operating Revenue				0			0			0
Revenue Over/(Under) Expense	-137692	-196694	196694	0	-251705.42	251705.42	0	-307868.86	307868.8598	0
FTEs	26.5	26.5	-26.5	0	26.5	-26.5	0	26.5	-26.5	0
Volume Sleep Studies	9047	9047	-9047	0	9047	-9047	0	9047	-9047	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 exi

AFFILIATED WITH UNITE HERE INTERNATIONAL UNION

LOCAL 34

FEDERATION OF UNIVERSITY EMPLOYEES

425 COLLEGE ST., NEW HAVEN, CT 06511

TELEPHONE (203) 624-5161, FAX (203) 776-6438

RECEIVED
APR 08 2014
Office of
HEALTHCARE ACCESS

FACSIMILE TRANSMITTAL SHEET

TO: Deputy Commissioner Lisa Davis

FROM: Melissa Mason

COMPANY: OHCA

DATE: 4/8/14

FAX NUMBER: 860-418-7053

TOTAL NO. OF PAGES INCLUDING COVER: 7

NOTES/COMMENTS:

RE: Docket No. 13-31884 CON

For questions regarding this request, please contact Melissa Mason

PH: 203-623-4819

E: mason@yaleunions.org

April 8, 2014

Lisa Davis, Deputy Commissioner
Department of Public Health
Office of Health Care Access
210 Capitol Avenue
Hartford, CT 06106

RE: Docket No. 13-31884-CON

Dear Deputy Commissioner Davis:

I am writing as the President of UNITE HERE, Local 34 concerning the above referenced docket. Local 34 represents over 3,700 clerical and technical workers at Yale University, including 900 who work in the School of Medicine specialty clinical practices. Eleven of our members were laid off as a result of the proposed transaction. I am requesting a public hearing in the city of New Haven and that our union be accorded status as a party to the transaction.

Our union is concerned about how the consolidation of medical practices staffed by Yale University physicians under the control of Yale-New Haven Hospital impacts cost and access to both patients and taxpayers. The closure as described in the Certificate of Need is actually part of a larger transaction that will significantly reduce access to needed services. The full extent of this transaction is evading Office of Health Care Access (OHCA) scrutiny.

The Termination of Gaylord Hospital's Sleep Services in North Haven is Fictitious

The matter before OHCA is not a simple facility closure. We believe the above referenced docket covers only one part of a complex three-way transaction, only a small percentage of which has come under OHCA scrutiny:

1. The takeover of the Yale Medical Group Sleep Center by Yale-New Haven Hospital, and Yale-New Haven's assumption of YMG's doctors and patients
2. The termination of Gaylord Hospital's sleep medicine services in North Haven
3. Yale-New Haven Hospital's purchase of the Gaylord Hospital sleep medicine assets in North Haven

Prior to the announced termination of services, in a purportedly unrelated transaction, Yale University School of Medicine closed its outpatient sleep medicine laboratory. Yale's sleep medicine practice involves office visits with physicians and sleep testing in laboratory facilities or, more rarely, at a patient's home. Yale temporarily transferred its patients to alternate university sites for office visits and sent patients for sleep studies to Gaylord in North Haven and to other local laboratories. The timeline of the closures and the experiences of employees reveal that the "closure" was in fact a transfer of control of the practice from Yale University to Yale-New Haven Hospital:

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

- YMG's Sleep Center in Norwich closed on June 30, 2012. The technicians were transferred to the Guilford and New Haven offices.[1]
- On January 26, 2013, the Guilford lab closed and YMG's sleep services were consolidated into the New Haven lab, located at the Temple Medical Center.[2]
- Our members in the New Haven lab were given their 90-day notification of layoff on March 8, 2013. As of June 9, one clerical worker and two technicians were laid off.[3] On July 2013, a day technician was laid off.[4]
- In October 2013, the rest of the clerical and technical staff at the Temple Medical Center in New Haven received layoff letters.[5] They were told that the lab would be closing January 6, 2014.[6]
- In December 2013, YMG mailed a letter to patients saying that YMG physicians would continue to provide care at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[7]
- By December 2013, all of the clerical and technical staff at the Temple Medical Center had been laid off.

After YMG laid off the clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."[8] This directive from YMG management clearly suggests that YNHH is taking over a YMG practice.

Yale-New Haven Hospital Must Submit a Certificate of Need

The public record gives no indication that Yale-New Haven Hospital has filed a Certificate of Need in advance of purchasing the Gaylord Hospital's sleep medicine practice in North Haven. The original CON for the termination of Gaylord Hospital's sleep medicine services in North Haven made no mention of an asset transfer. Only once pressed by OHCA for additional information did Gaylord, in passing, indicate plans for an asset transfer. The CON deemed complete includes a letter from the President & CEO of Gaylord Hospital, Inc. that specifically refers to the "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital..."[9] Additionally, the draft

[1] Affidavit by Geraldine Haddon, March 21, 2014.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Affidavit by Gretchen Rose, March 24, 2014.
[7] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.
[8] Affidavit by Melissa Dawkins, March 17, 2014.
[9] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

notice to patients included in the CON deemed complete says: "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford Locations."[10] These statements clearly indicate a transfer of ownership. OHCA regulations state that a certificate of need is required for the "transfer of ownership of a health care facility."[11]

Gaylord Hospital's CON refers to the North Haven facility as a "physician's practice."[12] Yale-New Haven Hospital may claim that it does not have to file a CON prior to purchasing the North Haven facility because it meets the exemption for the purchase of physician practices stated in the OHCA regulations. Either the purchase is an instance of one hospital transferring assets to another hospital, requiring a CON, or it is not. If it is not, this transaction demonstrates acutely the need for a CON process for the acquisition of physician practices.

Even if this transaction is not deemed a transfer of ownership of a health care facility, then it will certainly result in an "increase in in the licensed bed capacity of a health care facility." Gaylord Hospital's North Haven location consists of 12 beds designated for day and overnight sleep testing.[13] According to OHCA regulations, this increase in the number of beds for Yale-New Haven Hospital should require a CON.[14]

The Transaction Viewed in its Entirety Will Reduce Access to Adult Outpatient Sleep Services

(a.) Moving Sleep Medicine Services to the Suburbs Limits Access to Low-Income and Vulnerable Groups

In response to a question regarding the potential reduction in access for Medicaid patients, Gaylord Hospital said:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[15]

Additionally, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

---

[10] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.
[11] Conn. Gen. Stat. § 19a-638

[12] Connecticut Department of Public Health, Office of Health Care Access. Certificate of Need CT DPH OHCA Docket No. 13-31885-CON, pg. 13.
[13] CT DPH OHCA Docket No. 13-31885-CON, pg. 5.
[14] Ibid.
[15] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

The closure of the Sleep Center at the Temple Medical Center leaves a void in crucial services for New Haven residents. Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[16] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

(b.) The Likely Reimbursement Models for the post-transaction sleep center will dramatically reduce access for patients.

In the CON application, OHCA asks Gaylord Hospital to "[d]emonstrate how this proposal will affect the financial strength of the state's health care system." Gaylord's response was, "[t]his proposal will have no effect on the current financial state of the health care system."[17] In fact, the entire transaction will be likely to lead to increased costs to patients, private payers and to the state.

The Medicare Payment Advisory Commission's (MedPAC) analysis of Medicare data shows that as physician services shift from doctors' offices to sites controlled by hospitals, Medicare spending increases. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[18]

The reopened sleep medicine facility in North Haven under YNNH ownership may bill as if it is part of a hospital outpatient department and charge facility fees on top of what the physicians will charge. If so, it will be part of a growing pattern in which Yale University Medical School ambulatory clinics come under nominal hospital management with resulting increased reimbursement. In the case of the Yale Congestive Heart Failure and Transplant Clinic, patients arrived one day to find new signage and to having wristbands put on them as if they were hospital patients. They were billed second copays or even large charges to their deductibles for what were once routine office visits. Some of the same patients visiting the same doctors served by the same staff suddenly had to pay twice as much or even more.[19]

OHCA must determine if Yale-New Haven Hospital intends to bill for outpatient services as if its proposed North Haven location were "provider-based," that is, part of a hospital outpatient department. If so, patients previously treated by YMG physicians in New Haven will almost certainly face higher out of pocket costs at the point of service in North Haven. The CON indicates that Gaylord's current North Haven operation is "a physician practice." If Gaylord has been billing

---

[16] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.

[17] CT DPH OHCA Docket No. 13-31885-CON, pg. 12.

[18] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.

[19] Affidavit by Gloria Timpko, April 1, 2014.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

insurers and patients as if North Haven were a physician office, two sets of patients – those previously treated by YMG physicians in New Haven and Gaylord physicians in North Haven, may shortly be treated in a "hospital" facility, with much higher overall costs, much higher out-of-pocket cost at the point of service, and an accompanying reduction in access.

Our members are witnessing the impact of the higher out-of-pocket costs generated by hospital "facility fees." Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[20]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors visits or cease treatment all together.

The Transaction Viewed in its Entirety Will Likely Increase Costs to the State

The likely increase in cost, in addition to affecting patients and their families directly, will impact the state's budget. The trend of the conversion of physician practices to hospital outpatient departments is driving costs up dramatically – both systemically and for patients out of pocket. MedPAC estimates that Medicare is overspending by $2 billion nationally for services that are equivalent in the two settings, and has repeatedly recommended that Congress and the Centers for Medicare and Medicaid Services close this loophole by equalizing payment for equivalent services.[21] The state is in the process of determining how the "provider-based" reimbursement model affects Medicaid patients and those on the state's plan. It is likely that the state is spending more to cover services to be performed in a "hospital setting." Left unchecked, the post-transaction sleep center's ability to bill as a "provider-based" facility will result in higher fees for patients and the state and create additional barriers to treatment.

Health care reform is supposed to drive patients into the most cost-effective setting possible. But just as payers are succeeding in keeping patients out of the hospital with a stronger emphasis on primary and preventive care, the rapid consolidation of physician practices is spreading high hospital prices across what used to be lower-cost settings.

Request for a Public Hearing

Gaylord Hospital is not terminating its sleep services in North Haven. Instead, Yale-New Haven Hospital is buying the Gaylord assets, taking over the sleep medicine practice of the Yale University School of Medicine, and consolidating those operations in North Haven and Madison. This entire transaction will reduce access to sleep medicine services and likely increase costs to patients and taxpayers. I request a public hearing regarding Docket No. 13-31884-CON take place in New Haven

---

[20] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

[21] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 73.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

in the evening so that members of the public who work daytime hours may attend. In addition, given our direct interest in the operations involved in these transactions and the unique information our members bring to the process, I am requesting that our union be accorded status as a party or in the alternative as an intervenor.

Thank you and I look forward to your response.

Sincerely,

Laurie Kennington
President
UNITE HERE, Local 34

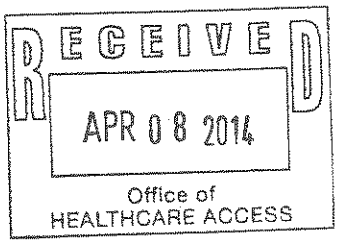
UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Greer, Leslie

From: Greer, Leslie
Sent: Tuesday, April 08, 2014 4:21 PM
To: 'jepright@gaylord.org'
Cc: Fiducia, Paolo
Subject: Gaylord Hospital Hearing Request
Attachments: 31884.pdf

Ms. Epright,
Attached is a hearing request received from Local 34 Federation of University Employees.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message



April 8, 2014

Lisa Davis, Deputy Commissioner
Department of Public Health
Office of Health Care Access
210 Capitol Avenue
Hartford, CT 06106

RE: Docket No. 13-31884-CON

Dear Deputy Commissioner Davis:

I am writing as the President of UNITE HERE, Local 34 concerning the above referenced docket. Local 34 represents over 3,700 clerical and technical workers at Yale University, including 900 who work in the School of Medicine specialty clinical practices. Eleven of our members were laid off as a result of the proposed transaction. I am requesting a public hearing in the city of New Haven and that our union be accorded status as a party to the transaction.

Our union is concerned about how the consolidation of medical practices staffed by Yale University physicians under the control of Yale-New Haven Hospital impacts cost and access to both patients and taxpayers. The closure as described in the Certificate of Need is actually part of a larger transaction that will significantly reduce access to needed services. The full extent of this transaction is evading Office of Health Care Access (OHCA) scrutiny.

The Termination of Gaylord Hospital's Sleep Services in North Haven is Fictitious

The matter before OHCA is not a simple facility closure. We believe the above referenced docket covers only one part of a complex three-way transaction, only a small percentage of which has come under OHCA scrutiny:

1. The takeover of the Yale Medical Group Sleep Center by Yale-New Haven Hospital, and Yale-New Haven's assumption of YMG's doctors and patients
2. The termination of Gaylord Hospital's sleep medicine services in North Haven
3. Yale-New Haven Hospital's purchase of the Gaylord Hospital sleep medicine assets in North Haven

Prior to the announced termination of services, in a purportedly unrelated transaction, Yale University School of Medicine closed its outpatient sleep medicine laboratory. Yale's sleep medicine practice involves office visits with physicians and sleep testing in laboratory facilities or, more rarely, at a patient's home. Yale temporarily transferred its patients to alternate university sites for office visits and sent patients for sleep studies to Gaylord in North Haven and to other local laboratories. The timeline of the closures and the experiences of employees reveal that the "closure" was in fact a transfer of control of the practice from Yale University to Yale-New Haven Hospital:

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

- YMG's Sleep Center in Norwich closed on June 30, 2012. The technicians were transferred to the Guilford and New Haven offices.[1]
- On January 26, 2013, the Guilford lab closed and YMG's sleep services were consolidated into the New Haven lab, located at the Temple Medical Center.[2]
- Our members in the New Haven lab were given their 90-day notification of layoff on March 8, 2013. As of June 9, one clerical worker and two technicians were laid off.[3] On July 2013, a day technician was laid off.[4]
- In October 2013, the rest of the clerical and technical staff at the Temple Medical Center in New Haven received layoff letters.[5] They were told that the lab would be closing January 6, 2014.[6]
- In December 2013, YMG mailed a letter to patients saying that YMG physicians would continue to provide care at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[7]
- By December 2013, all of the clerical and technical staff at the Temple Medical Center had been laid off.

After YMG laid off the clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."[8] This directive from YMG management clearly suggests that YNHH is taking over a YMG practice.

Yale-New Haven Hospital Must Submit a Certificate of Need

The public record gives no indication that Yale-New Haven Hospital has filed a Certificate of Need in advance of purchasing the Gaylord Hospital's sleep medicine practice in North Haven. The original CON for the termination of Gaylord Hospital's sleep medicine services in North Haven made no mention of an asset transfer. Only once pressed by OHCA for additional information did Gaylord, in passing, indicate plans for an asset transfer. The CON deemed complete includes a letter from the President & CEO of Gaylord Hospital, Inc. that specifically refers to the "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital..."[9] Additionally, the draft

---

[1] Affidavit by Geraldine Haddon, March 21, 2014.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Affidavit by Gretchen Rose, March 24, 2014.
[7] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.
[8] Affidavit by Melissa Dawkins, March 17, 2014.
[9] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

notice to patients included in the CON deemed complete says: "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford Locations."[10] These statements clearly indicate a transfer of ownership. OHCA regulations state that a certificate of need is required for the "transfer of ownership of a health care facility."[11]

Gaylord Hospital's CON refers to the North Haven facility as a "physician's practice."[12] Yale-New Haven Hospital may claim that it does not have to file a CON prior to purchasing the North Haven facility because it meets the exemption for the purchase of physician practices stated in the OHCA regulations. Either the purchase is an instance of one hospital transferring assets to another hospital, requiring a CON, or it is not. If it is not, this transaction demonstrates acutely the need for a CON process for the acquisition of physician practices.

Even if this transaction is not deemed a transfer of ownership of a health care facility, then it will certainly result in an "increase in in the licensed bed capacity of a health care facility." Gaylord Hospital's North Haven location consists of 12 beds designated for day and overnight sleep testing.[13] According to OHCA regulations, this increase in the number of beds for Yale-New Haven Hospital should require a CON.[14]

The Transaction Viewed in its Entirety Will Reduce Access to Adult Outpatient Sleep Services

(a.) Moving Sleep Medicine Services to the Suburbs Limits Access to Low-Income and Vulnerable Groups

In response to a question regarding the potential reduction in access for Medicaid patients, Gaylord Hospital said:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[15]

Additionally, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

---

[10] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.

[11] Conn. Gen. Stat. § 19a-638

[12] Connecticut Department of Public Health, Office of Health Care Access. Certificate of Need CT DPH OHCA Docket No. 13-31885-CON, pg. 13.

[13] CT DPH OHCA Docket No. 13-31885-CON, pg. 5.

[14] Ibid.

[15] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

The closure of the Sleep Center at the Temple Medical Center leaves a void in crucial services for New Haven residents. Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[16] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

(b.) The Likely Reimbursement Models for the post-transaction sleep center will dramatically reduce access for patients.

In the CON application, OHCA asks Gaylord Hospital to "[d]emonstrate how this proposal will affect the financial strength of the state's health care system." Gaylord's response was, "[t]his proposal will have no effect on the current financial state of the health care system."[17] In fact, the entire transaction will be likely to lead to increased costs to patients, private payers and to the state.

The Medicare Payment Advisory Commission's (MedPAC) analysis of Medicare data shows that as physician services shift from doctors' offices to sites controlled by hospitals, Medicare spending increases. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[18]

The reopened sleep medicine facility in North Haven under YNNH ownership may bill as if it is part of a hospital outpatient department and charge facility fees on top of what the physicians will charge. If so, it will be part of a growing pattern in which Yale University Medical School ambulatory clinics come under nominal hospital management with resulting increased reimbursement. In the case of the Yale Congestive Heart Failure and Transplant Clinic, patients arrived one day to find new signage and to having wristbands put on them as if they were hospital patients. They were billed second copays or even large charges to their deductibles for what were once routine office visits. Some of the same patients visiting the same doctors served by the same staff suddenly had to pay twice as much or even more.[19]

OHCA must determine if Yale-New Haven Hospital intends to bill for outpatient services as if its proposed North Haven location were "provider-based," that is, part of a hospital outpatient department. If so, patients previously treated by YMG physicians in New Haven will almost certainly face higher out of pocket costs at the point of service in North Haven. The CON indicates that Gaylord's current North Haven operation is "a physician practice." If Gaylord has been billing

---

[16] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.

[17] CT DPH OHCA Docket No. 13-31885-CON, pg. 12.

[18] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.

[19] Affidavit by Gloria Timpko, April 1, 2014.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

insurers and patients as if North Haven were a physician office, two sets of patients – those previously treated by YMG physicians in New Haven and Gaylord physicians in North Haven, may shortly be treated in a "hospital" facility, with much higher overall costs, much higher out-of-pocket cost at the point of service, and an accompanying reduction in access.

Our members are witnessing the impact of the higher out-of-pocket costs generated by hospital "facility fees." Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[20]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors visits or cease treatment all together.

The Transaction Viewed in its Entirety Will Likely Increase Costs to the State

The likely increase in cost, in addition to affecting patients and their families directly, will impact the state's budget. The trend of the conversion of physician practices to hospital outpatient departments is driving costs up dramatically – both systemically and for patients out of pocket. MedPAC estimates that Medicare is overspending by $2 billion nationally for services that are equivalent in the two settings, and has repeatedly recommended that Congress and the Centers for Medicare and Medicaid Services close this loophole by equalizing payment for equivalent services.[21] The state is in the process of determining how the "provider-based" reimbursement model affects Medicaid patients and those on the state's plan. It is likely that the state is spending more to cover services to be performed in a "hospital setting." Left unchecked, the post-transaction sleep center's ability to bill as a "provider-based" facility will result in higher fees for patients and the state and create additional barriers to treatment.

Health care reform is supposed to drive patients into the most cost-effective setting possible. But just as payers are succeeding in keeping patients out of the hospital with a stronger emphasis on primary and preventive care, the rapid consolidation of physician practices is spreading high hospital prices across what used to be lower-cost settings.

Request for a Public Hearing

Gaylord Hospital is not terminating its sleep services in North Haven. Instead, Yale-New Haven Hospital is buying the Gaylord assets, taking over the sleep medicine practice of the Yale University School of Medicine, and consolidating those operations in North Haven and Madison. This entire transaction will reduce access to sleep medicine services and likely increase costs to patients and taxpayers. I request a public hearing regarding Docket No. 13-31884-CON take place in New Haven

---

[20] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

[21] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 73.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

in the evening so that members of the public who work daytime hours may attend. In addition, given our direct interest in the operations involved in these transactions and the unique information our members bring to the process, I am requesting that our union be accorded status as a party or in the alternative as an intervenor.

Thank you and I look forward to your response.

Sincerely,

Laurie Kennington
President
UNITE HERE, Local 34

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Melissa Mason
Legislative Liaison

425 College Street
New Haven, CT 06511
(203) 623-4819
mason@yaleunions.org

April 15, 2014

Kimberly Martone, Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

RE: Docket No. 13-31884-CON

Dear Ms. Martone,

In response to a request from Paolo Fiducia, I have enclosed supporting materials related to our letter requesting a public hearing. These include four affidavits, a letter, an academic article, and an excerpt from a report. Thank you again for your office's consideration of our request.

Regards,

Laurie Kennington
President
UNITE HERE, Local 34

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Statement by Gloria Timpko - April 1, 2014

Taken by Melissa Mason

In the case of the Congestive Heart Failure and Transplant Clinic, patients arrived one day to find new signage and to having wristbands put on them as if they were hospital patients. They were billed second copays or even large charges to their deductibles for what were once routine office visits. The same patients visiting the same doctors served by the same staff suddenly had to pay twice as much or even more.

Gloria Timpko

State of Connecticut
County of New Haven } New Haven

The forgoing instrument was acknowledged before me this 4/7/14 by Gloria Timpk

DP CONLON
NOTARY PUBLIC
My Commission Expires May 31 2019

Statement by Geraldine Haddon – March 21, 2014
Interviewed by Melissa Mason
Transcribed by Melissa Mason – March 24, 2014

GH - The first sleep lab was closed, which was the Norwich lab, closed in June 30, 2012. They took the techs and moved them to the Guilford and New Haven offices. Then they closed the Guilford lab January 26, 2013. Then they had their first set of layoffs in the New Haven lab. The letter went out for the layoffs on March 8. And they were laid off as of June 9. That was 1 admin and 2 technicians. A month later, there was a layoff of one of the day techs. And then in October, was the rest of us, everybody else who was left. At this point it was just the technicians. Cause the admins went out and got new jobs where we can't because we thought that they would not really close the lab to begin with. They had to find a way to take care of the patients.

MM - What were the reasons you were given for the closures?

GH – The closures were because we weren't having enough patients. The closings were because all the insurances were changing. They were also changing around the way you did sleep studies. More were being done in home testing rather than lab testing. I wound up going out on days and took care of the day testing, then took over the DME (durable medical equipment) for all of the Yale Health Plan patients so that I still had a job because all these changes were coming through. There is a very big discrepancy about how much of this is insurance versus how much is the fact that it just wasn't managed correctly. If they knew that there was a shift in the way studies were going to be done, they should have shifted with it. And new company taking over, they're not going to take something over that they know is going to fail. So somebody's going to be changing it around, it should have been us.

GH – They said in these employee participation meetings that these things were going on, that they were going to have to close the labs one a time. They never actually came out and said that but eventually each one the employee participation meetings were about, "we're going to close this lab," "we're going to close that lab," "now we're all going to work from New Haven," "we're going to have patients seven days a week and we're going to fill all four beds." In the meantime, they ordered more equipment to do more day studies in the daytime, which was perfect for me. But there wasn't enough to, they needed more doctors, more staff to do what was coming

MM – Do you have the dates of the employee participation meetings?

GH – The first one was on a Friday, February 15, 2013. April 1 was when they were going to start opening all four beds seven days a week in New Haven. They had another mandatory employee participation meeting on March 18 at 5'oclock. The first set of people went out in June. The other supervisor who was doing the DME with me went out on leave for 8 weeks. I did that job while she was out, that was

June 3. The director left on July 14, 2013 that was for personal reasons, not because of the lab closing, at least that's what we were told.

MM – Where's the director now?

GH – Hartford Hospital
Then we had another employee participation meeting on October 7, 2013. This was when they basically told us they were going to close the lab. That was on a Friday night, I believe. That Monday, we all had our papers in our hands. Along with that, they also October 6, after they told us they were closing, and they said it was there all along, was a thing from YNHH that they were opening up a sleep lab, for adults, not just for pedies.

MM – Was October 6 the first time you were made aware that YNHH was opening a sleep clinic?

GH – At that point we were still being told that was not happening?

MM – Had you suspected it?

GH – Oh yes, because we heard all kinds of rumors. The rumors came from Gaylord, from people who were working at Gaylord because the kept hearing that it was being bought by the hospital and that they were closing. They still don't know what's going on, as far as I know.

MM – Going back to the announcement that YNHH is opening up a sleep clinic, did you inquire with your managers about it? What was their response?

GH – We were told to reapply for our jobs along with everybody else because they were closing the lab.

MM – Reapply?

GH – No, no, not reapply, apply. They told us the Yale sleep lab was closing. And the doctors were going over to the new place. But they couldn't do it right away because it was closing. So the doctors were seeing patients over on Howard Ave in a different building for what was supposed to be for two months. And then they were reopening at the Gaylord site under the hospital. And when they reopened at the hospital, we could go and get our jobs through the hospital instead of the university. The people that applied for these positions lost all their benefits, all their seniority, and $6 an hour less in pay.

MM – Have the people who have applied to the hospital been offered jobs?

GH – I believe at this point there are only two who have been offered jobs.

Pause in Recording

MM – How did that letter that YNHH was opening a site at Gaylord come to your attention?

GH – I'm not really sure who found it first. But when we brought it to people's attention, it was "no no no that's been up for year, there's nothing on there that says adult." [referring to website] There is a YNHH pedi lab because it's run in the hospital. One of the big things is the fact that as of July 14, 2013 when our director left, we were still being told that the lab wasn't closing.

MM – Even after 7 techs were laid off?

GH – Well yeah we were told we were downsizing, not closing. Of course the writing is kind of on the wall but you know I have to take that back. Because the doctor did have to give us notice. She couldn't just walk out the door on July 14. So it would have been before that. But when she told us that she was leaving, it was not that she was leaving because the lab was closing. It was for personal reasons and to be closer to her family and husband. There aren't too many people who believe that now?

MM – What would you say, in your opinion, in your experience was the order in which people knew what was going on? It sounds like the director knew what was going on before you guys knew.

GH – Honestly, that is so hard to say. It depends on which one of us you talk to. Some of the doctors I talk to, I really don't think they had a clue. And other people that I work with felt completely different that they knew all along. It's really hard to say which. The whole thing comes down to they were playing with patients, they were playing with their employees lives. And that never should have happened.

MM – At the time you left, were you aware that the sleep center was closing?

GH – When I left, they closed when I left. I stayed until the end.

MM – What were you telling patients? What were you told to tell patients?

GH – That they were seeing patients over on Howard Avenue. Come March, they would be in a new facility and they would be seen again. And that still hasn't happened. The patients are still being seen on Howard Avenue. They're not getting the same care that they were getting before.

MM – What do you mean?

GH – Well they used to be able to come into the lab and get fitted for masks, their equipment, things that they needed depending on what their insurance was and

there is one person taking care of the equipment now who stayed behind who happened to be a supervisor, not an employee. The patients are being seen at Howard Avenue. Any studies they need, or anything else, they're now being referred to the Gaylord Sleep Center.

MM – Which is not open

GH – The Gaylord Sleep Center is open in North Haven as the Gaylord Sleep Center. So seriously the New Haven sleep lab or the Yale Medical Group or whatever you want to call it, the doctors are actually referring their patients over to a different company to have their tests done? I don't think that makes sense either. And if that was the way it was going to go and they knew that, they should have kept the lab open and kept the patients. They're still paying for the lab. The lab is still there and they're still paying rent on it.

MM – Is there anything else you'd like to add?

GH - I don't think it's fair to the patients. I don't think it's fair to the employees. In our instance, we worked very very hard to keep things up and running. And I do believe with all my heart that they never should have closed that lab. And I do not believe that somebody else would have taken something over if they really didn't think they were going to make money at it. The patients shouldn't be suffering for this and neither should their employees.

Geraldine Haddon

Geraldine Haddon

State of Connecticut
County of New Haven : New Haven

The forgoing instrument was acknowledged before me
this 3/26/14 by Geraldine Haddon

D. P. CONLON
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2014

Statement by Gretchen Rose – March 24, 2014
Interviewed by Melissa Mason
Transcribed by Melissa Mason – March 26, 2014

GR - I'm Gretchen Rose. Today's March 24, 2014. I'm a former employee of the Yale University Sleep Lab. What do you want to know?

MM – Can you walk through some of the timeline leading up to the layoffs and the closure of the 40 Temple St facility?

GR – I've been there for 15 years. They started with the Guilford lab. I started in 1998. It was up and running for a bout a year. In 1999, they opened the Norwich lab and then a few years later they opened the Temple St location, so we expanded. About 2 ½ -3 years ago, they closed the Norwich lab. It had been getting slower patient wise. But I had been under the impression that we had just brought Dr. Krieger on board and he was supposed to bring all this business in from the Eastern side. And he didn't want to drive all the way to Norwich because it was too far. That's my understanding that we closed the Norwich lab so that the doctors didn't have to drive out to Norwich. In doing so, we laid off an employee and combined everybody else into Guilford and New Haven. Then another year had gone by and they closed the Guilford lab.

MM – When was that?

GR – That was January of 2013. And they moved us to New Haven. They didn't do layoffs immediately but they laid off one of our secretaries and Ralph got laid off. They laid off Diana, then brought Diana back. I don't know how that worked out. But that was last spring, so a year ago, about. And then this October we were pulled into a mandatory meeting to which our union representative was welcome to attend. We were told that they were closing the sleep lab effective January 6. They gave us 90 days notice so that was October 6. We actually saw our last patient December 23, 22, right before Christmas. We had nights.

MM – What was the reason they said for the closure at the time?

GR – I think it was money. They had a new pulmonary chief takeover and the sleep lab had been operating in the red. They had given us a timeline to turn things around. It used to be that we only worked with two patients for one tech. They increased us to three patients per tech and had us scoring studies if we were not running three patients. I believe it was too little, too late to turn to turn things around in the few months were we were given.

We were told, Lauren, our manager was, we could tell the patients that we are moving but they'll still be seen. But they'll just be seen at the Physicians Building instead of here. And we will no longer be doing overnight studies. And that was pretty late in the process before they came to that determination.

MM – Did anyone ever mention YNHH purchasing the clinic?

GR – No. Dr. Yaggi always led those meetings. He said that's not happening, I don't know where you're hearing that from. It is not an option. They had come to us earlier but nothing came of it. It was denials everywhere.

MM –Is there anything else you'd like to add?

GR – Not that I can think of.

State of Connecticut
County of New Haven : New Haven

The forgoing instrument was acknowledged before me
this 3/26/14 by Gretchen Rose

D. P. CONLON
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2014

Statement By Melissa Dawkins – March 17, 2014
Interviewed by Melissa Mason
Transcribed by Melissa Mason – March 17, 2014

As far as what know about sleep medicine.. throughout the past there have been talks about the hospital opening up, restructuring reorganizing, Guilford closed, Norwich closed, then I was told, I was internal temping in sleep medicine. Adiministration, HR came in several times and told workers that there were going to be changes but there wasn't any direct talk of the hospital taking over.

I left, there were changes, a few layoffs here and there. When I came into my new position the staff got laid off (administrative assistant)

I went over to help the clinic because the clinic continued to stay open after the staff was laid off, located at 40 Temple St in New Haven.

Clinic was taken over to 784 Howard Ave where patients were being seen until the hospital opened their clinic in North Haven. I also found out a Madison office would open. It's weird that you close a Guilford Office and open a Madison office. The doctors are going over under their YMG titles. So we were told the clinics will be opened up with YMG doctors but hospital staff. And the administrators would also be hospital.

What a coincidence that you close our office because you claim that our office isn't bringing in any money. The hospital then opens up not one but two centers and our doctors are going to be rolling over there under their YMG name to see patients and continue patient care.

MM - How many doctors who worked at 40 Temple and the other locations are going over to the hospital?

MD – All of them. There's Melissa Knauertt, Koo, Yagi, Kryger, Dr. Mohsenin and Dr. Won. That's six doctors.

MM – They will be seeing patients where?

MD – They will be seeing patients in the Madison office and North Haven. Madison will be opening in June, after that North Haven.

MM – Have you seen or heard anything else that indicates that YMG and Yale were transferring over assets and resources over to the hospital?

MD – All of our patients, as far as I know in November, were told that they would be transitioned and care would be continued over at the hospital. All of the appointments are on a spreadsheet, all the patients names and files are going to be handed over to the hospital.

MM – Were patients told they can see their doctor…

MD – over at the hospital. But they weren't told about the fees or anything. It would be the same doctor, just a different facility and different staff.

MD - From what I know there were meetings, reoccurring meetings with the hospital and YMG doctors concerning the transition of patients' care. I do know the phone number when the patients call is supposed to be switched over. Patients are being told that nothing is going to change but the facility. Your doctors will be there, your medical records, everything will be there. You're just going to be seen in a new office and there will be new staff.

MM – You've heard personnel say that to patients?

MD - I have told that to patients. That's what I was told to tell patients. That when a patient calls, you say "Yale New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."

MM – Who instructed you to

MD – the administrative staff in the clinic, management.

MM – When were you instructed to begin saying that?

MD – When I started helping them before Christmas. But staff had already been telling patients them. If I'm a patient I think I'm just going to be seen at the new hospital clinic but my doctor will still be there and nothing changes. My prescriptions are going to roll over. Not the office closed and I'm a new patient somewhere. Everythings going to just be picked up where it left off. The appointments go into the folder/spreadsheet. It's all ready for the person at the hospital to go in and input that appointment into the EPIC system as a return or follow up. If you're opening a new office and taking on new patients, everybody's just new. But no if you're a return last week, you're a return this week, just at YNHH.

Melissa Dawkins-Doumbia

Melissa Dawkins-Doumbia

State of Connecticut : New Haven
County of New Haven

The forgoing instrument was acknowledged before me
this 4/7/14 by Melissa Dawkins-Doumbia

DP CONLON
NOTARY PUBLIC
My Commission Expires May 31 2019

Yale Sleep Medicine

A PRACTICE OF THE YALE MEDICAL GROUP

Henry Klar Yaggi MD MPH
Melissa Knauert MD PhD
Brian Koo MD
Meir Kryger MD FRCPC
Christine Won MD
Vahid Mohsenin MD

40 Temple Street, Suite 3C
New Haven, Connecticut
06510

111 Goose Lane
Guilford, Connecticut
06437

(203) 785–6760 appointments
(203) 764–6787 fax

1-877-YALEREM
www.yalemedicalgroup.org

December 2013

As of December 31, 2013, the sleep laboratory facility at 40 Temple Street, managed by Yale Medical Group (YMG), will close permanently.

Our sleep physicians will continue to provide clinical care at the Yale-New Haven Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven starting on January 1, 2014. If you need a sleep study, we will be referring this service out to local laboratories.

We would be delighted to discuss options for future continuing care with you. Please feel free to contact your YMG Sleep Center physician should you have a need for future care.

For your convenience, we will continue to use the same phone and fax numbers:

Phone: **203-785-6760**
Fax: **203-764-6787**

We thank you for allowing us the privilege to care for you, and we look forward to discussing your future clinical care.

Sincerely,

Christine Won, MD

RECOMMENDATION 3-1

The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2013 by 1.0 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services beginning in 2013 to use the difference between the increase under current law and the Commission's recommended update to gradually recover past overpayments due to documentation and coding changes.

RATIONALE 3-1

The Commission balanced three factors in reaching its inpatient update recommendation. First, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. Second, hospitals' documentation and coding changes led to overpayments in 2010, 2011, and 2012. Updates must be lowered to recover these overpayments. Third, while relatively efficient hospitals generated positive overall Medicare margins in 2010, most hospitals have negative overall Medicare margins (–4.5 percent in 2010 and projected to reach –7 percent in 2012). Balancing these factors, the Commission recommends reducing the 2013 increase in inpatient payments from the level in current law (currently expected to be 2.9 percent) to 1 percent.[15] The difference between the update under current law and 1 percent should be used to gradually recover overpayments that occurred due to documentation and coding changes, which will allow Medicare to recover past overpayments and keep 2013 inpatient payment rates adequate.

For outpatient services, the Commission also recommends a 1 percent increase in payment rates. On the one hand, growth in the volume of outpatient services has been strong, suggesting the outpatient update in current law (1.9 percent) is too high. On the other hand, overall hospital margins are negative, suggesting a positive update is appropriate. A 1 percent update would balance these two considerations and also help limit growth in the disparity in payment rates between services provided in OPDs and payment rates in other sectors. The Commission maintains that Medicare should seek to pay similar amounts for similar services, taking into account differences in the quality of care and in the relative risks of patient populations.

IMPLICATIONS 3-1

Spending

- This recommendation would decrease Medicare spending by more than $2 billion in 2013 and would save more than $10 billion over five years. The spending implication of this recommendation is based on Medicare spending projections that were made prior to a sequester, as the recommendation was developed and voted on before the sequester was triggered and became current law. If a Medicare sequester does occur, it will change the spending implication of the recommendation.

Beneficiary and provider

- This recommendation should have no negative impact on beneficiary access to care and is not expected to affect providers' willingness and ability to provide care to Medicare beneficiaries.

Equalizing payment rates for outpatient office visits in freestanding physician offices and outpatient departments

As we considered an update to outpatient payment rates, we also considered ways to limit the differences in payment rates between hospitals and physician offices for the same (or similar) services. This effort is the start of a broader effort by the Commission to move toward having the same payment for the same service provided to similar patients across sites of care.

The issue of E&M payment rates is particularly timely because of the increase in physician employment by hospitals in recent years. Many factors have been cited for this trend:

- Financially, physicians are faced with rising costs associated with private practice, including new technology such as electronic health records and the administrative costs of dealing with insurers, each of which has its own requirements for submitting claims. Also, they may not have the leverage with insurers to negotiate payment rate increases that keep pace with rising expenses. Further, physicians of all specialties desire to avoid the uncertainty of changes in professional liability insurance premiums (Ginsburg 2011b, O'Malley et al. 2011).

- Many physicians—especially younger ones—desire a different work–life balance and more lifestyle flexibility than has been typical in the past (BDC Advisors 2010, Ginsburg 2011a, Healthcare Financial Management Association 2011, Kocher and Sahni 2011, O'Malley et al. 2011). Hospital employment may enable physicians to work fewer and more predictable hours and to focus on the clinical aspects of medicine. They may be willing to give up their autonomy in exchange for these benefits.

TABLE 3–9

Differences in program payments and beneficiary cost sharing for midlevel outpatient office visit provided in freestanding practices and hospital-based entities, 2011

	Service provided in freestanding physician practice*	Service provided in hospital-based entity		
		Physician facility rate*	Outpatient PPS rate**	Total, hospital-based rate
Program payment	$55.18	$39.42	$60.10	$99.52
Beneficiary cost sharing	+13.79	+9.85	+15.03	+24.88
Total payment	68.97	49.27	75.13	124.40

Note: PPS (prospective payment system). The Current Procedural Terminology code for this visit is 99213.
* Paid under the Medicare physician fee schedule.
**Paid under the outpatient PPS.

Source: MedPAC analysis of payment rates from the outpatient PPS and physician fee schedule in 2011.

- Hospitals often choose to employ physicians to ensure a stable stream of tests, admissions, and referrals to specialists who perform their services at the hospital.
- PPACA creates a Medicare shared savings program for accountable care organizations (ACOs), which are integrated health care systems composed of physicians and health care facilities that take responsibility for controlling spending and increasing quality. ACOs could be established by hospitals or by groups of physicians working together. Hospitals may be acquiring physician practices to position themselves to establish ACOs.
- Physicians and hospitals can benefit financially from hospital employment of physicians. Large hospital systems can use their market power to obtain higher rates for physician services from private insurers in some markets (Ginsburg 2010). In addition, for most services that can be provided in a physician office or OPD, total Medicare payments (program payments and cost sharing) are substantially higher if the service is provided in an OPD rather than in a physician office. The combination of higher private insurance payments and higher Medicare payments may allow hospitals to offer physicians comparable incomes as employees, even if the hospital has higher overhead than freestanding practices.

As more physicians become employed by hospitals, billing of services is likely to shift from freestanding physician practices to OPDs. Because most services have higher payment rates under the OPPS than under Medicare's physician fee schedule (PFS), the result of such a shift is higher program spending and beneficiary cost sharing.

We start our evaluation of this issue by examining differences in payment rates for E&M office visits provided in OPDs and physician offices. For example, in 2011 Medicare paid 80 percent more for a 15-minute visit—Current Procedural Terminology (CPT) code 99213—provided in an OPD than in a freestanding office of a physician or other health care professional paid under the PFS. This payment difference creates a financial incentive for hospitals to purchase freestanding physician offices and convert them to OPDs without changing their location or patient mix. We have seen a 6.7 percent increase in the number of these visits furnished in OPDs from 2009 to 2010. Thus, Medicare expenditures and beneficiary cost sharing could increase without any difference in patient care. In this section, we consider a policy of making Medicare payments for E&M office visits equal whether they are provided in OPDs or in physician offices. In the future, we plan to examine payment differentials between hospitals and physician offices for other services.

Comparing Medicare's payments for services in physician offices and outpatient departments

Services covered under the PFS have two payment rates: one rate for when the physician provides the service in his or her office (the nonfacility rate) and another rate for when the physician provides the service in a facility such as an OPD or other provider-based entity (the facility rate).[16] An outpatient facility or organization that has

provider-based status is considered part of a hospital, and provider-based status is generally available for hospital-owned entities that are on the hospital campus or within 35 miles of the hospital campus. In general, the nonfacility rate is higher than the facility rate in the PFS because physician practice costs are higher when physicians provide care in their offices than in facilities, as they have to cover their direct costs (e.g., equipment, supplies, and staff). When a service is provided in a physician office, there is a single payment for the service. However, when a service is provided in a facility, Medicare makes a payment to the facility in addition to a payment to the physician. For example, if a 15-minute E&M office visit for an established patient (CPT code 99213) is provided in a freestanding physician office, the program pays the physician 80 percent of the nonfacility payment rate from the PFS, and the patient is responsible for the remaining 20 percent. In 2011, the nonfacility rate for this service was $68.97; the program pays $55.18 and the patient is responsible for $13.79 (Table 3-9). If the same service is provided in an OPD-based entity, the program pays 80 percent of the PFS facility rate and 80 percent of the outpatient PPS rate, and the patient is responsible for 20 percent of both rates.[17] The PFS facility rate in 2012 is $49.27, and the OPPS payment is $75.13, for a total payment of $124.40. The program pays $99.52, and the patient is responsible for $24.88 (Table 3-9).

Potential spending effects of services moving from physician offices to hospital-based entities

Medicare data on the site of care for E&M office visits suggest that the increase in hospital employment of physicians has been associated with a shift of services from offices to OPDs. In 2004, 8 percent of specialists and 23 percent of primary care physicians were employed by hospitals (Kocher and Sahni 2011). In 2008, the percentages of specialists and primary care physicians employed by hospitals had increased to 15 percent and 31 percent, respectively. The proportion of E&M office visits provided in OPDs reflects this increased hospital employment of physicians. The percentage of E&M office visits provided in OPDs increased from 5.1 percent in 2004 to 7.3 percent in 2010. However, growth in the percentage of E&M office visits that are provided in OPDs has accelerated, increasing at an annual rate of 3.5 percent from 2004 through 2008, by 9.9 percent in 2009, and by 12.9 percent in 2010.[18] As more physicians become employed by hospitals, it is likely that more services will migrate from physician offices to OPDs (or other hospital-based entities), which would increase Medicare spending.

The magnitude of the increased Medicare spending is difficult to estimate for some OPD services where the packaging of ancillary services differs between the PFS and the OPPS. The OPPS packages many ancillary services and supplies with their associated procedures for payment purposes, whereas the PFS often pays separately for ancillary items and services (Medicare Payment Advisory Commission 2011b). However, we have greater confidence in estimating the potential effect of a shift of E&M office visits from offices to OPDs because the level of packaging is relatively low for these services, about 2.5 percent of the total cost. The potential effect on Medicare spending of a large shift in these visits from freestanding physician practices to hospital-based clinics that are billing as part of an OPD is significant. If the percentage of E&M office visits that are provided in OPDs grows at 12.9 percent (as it did in 2010) over 10 years, about 24.5 percent of E&M office visits will occur in OPDs in 2020. Such a shift would increase program spending by $2.0 billion per year and beneficiary cost sharing by $500 million per year (assuming 2010 payment rates).

Options for equalizing payment rates for E&M office visits across settings

Variations in payment rates among different ambulatory care settings raise questions about how Medicare should pay for the same (or similar) services in different settings. Medicare should strive to ensure that patients have access to settings that provide the appropriate level of care. If the same service can be safely provided in different settings, it may be undesirable for a prudent purchaser to pay more for that service in one setting than in another. Payment variations across settings may encourage arrangements among providers that result in more care being provided in higher cost (and higher paid) settings, thereby increasing total Medicare spending. Therefore, to be a prudent purchaser of medical care, the Commission believes that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity, to the extent that severity differences affect costs.

The easiest way to address this issue is to set payment rates in the OPPS and PFS so that payments are equal whether a service is provided in a freestanding practice or in an OPD. However, for many services, we are concerned

that such a policy would fail to account for some important differences between physician offices and OPDs:

- Hospitals incur costs to maintain standby capacity for handling emergencies and to comply with additional regulatory requirements. Hospitals are subject to the Emergency Medical Treatment and Active Labor Act, which requires them to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay.[19] This mission may make the cost of certain services performed in OPDs higher than in physician offices, which typically do not provide emergency care. In addition, hospitals are required to meet conditions of participation in the Medicare program that likely increase hospital costs; these conditions do not apply to physician offices.
- Patient complexity may differ in these two sectors. For many services, greater patient complexity may result in higher costs of care.
- For services covered under both the OPPS and the PFS, the OPPS typically packages the cost of ancillary services and supplies to a greater extent than does the PFS.

For many services, these factors can cause higher costs in OPDs than in physician offices.[20] Therefore, we chose to narrow our focus for equalizing payment rates across these two sectors to E&M office visits, which are indicated by CPT codes 99201 through 99215. For these services, we believe it is reasonable to set payment rates equal in the PFS and the OPPS because:

- Hospitals should not need to maintain standby capacity for E&M office visits that are not provided in an emergency department, nor should requirements to stabilize patients presenting at the emergency room affect the costs of furnishing E&M office visits.
- To a large extent, differences in resource needs because of patient complexity for these visits are reflected in their coding structure, which classifies visits based on their length and complexity. For example, CPT code 99213 is for visits that typically include 15 minutes of face-to-face time between the physician and patient, whereas CPT code 99214 is for visits that typically include 25 minutes of face-to-face time between the physician and patient and involve a more detailed history and examination. This coding structure is the same whether the visit is provided in a physician office or in an OPD.[21]
- On the basis of our analysis of 10,000 OPD claims that included an E&M office visit, the cost of ancillary services that are packaged with these visits when provided in an OPD is about 2.5 percent of the visits' total cost, which means that ancillaries add about $2 to the payment rate of the average E&M office visit provided in OPDs; therefore, the content of the unit of payment is similar across settings.

We conclude that the E&M visits are a service in which rates should be equalized between PPS hospital OPDs and other sites of care that use the physician fee schedule. The payment rate for both settings should be based on the cost of the most efficient setting where high-quality care can be provided. In this case, our best proxy for the cost of efficiently delivering E&M services is the E&M rate paid to physician offices. We realize that over time adjustments to E&M rates in the physician fee schedule will also affect the price paid in OPDs. Although fee schedule payment rates for primary care services such as E&M visits have increased over the past several years, the Commission has recommended further improvements to the accuracy of fee schedule payments (see text box, p. 76).

To ensure that payments for E&M services are equal across PPS settings, Medicare should set the OPPS rate equal to the difference between the nonfacility practice expense and the facility practice expense in the physician fee schedule. Under this formula, total Medicare payment rates would be the same whether the E&M visit occurs in an OPD or in a nonfacility ambulatory site such as a physician office (Table 3-10). The payment to physicians for their work would not change and payments to cost-based providers such as CAHs would not change under the proposal.

RECOMMENDATION 3-2

The Congress should direct the Secretary of Health and Human Services to reduce payment rates for evaluation and management office visits provided in hospital outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office. These changes should be phased in over three years. During the phase-in, payment reductions to hospitals with a disproportionate share patient percentage at or above the median should be limited to 2 percent of overall Medicare payments.

Scientific Investigations

The Influence of Race on the Severity of Sleep Disordered Breathing

http://dx.doi.org/10.5664/jcsm.2572

Sukanya Pranathiageswaran, M.P.H.[1]; M. Safwan Badr, M.D., F.A.A.S.M.[1]; Richard Severson, Ph.D.[2]; James A. Rowley, M.D., F.A.A.S.M.[1]

[1]Sleep Disorders Center at Detroit Receiving Hospital, Division of Pulmonary, Critical Care & Sleep Medicine, Department of Internal Medicine, Wayne State University School of Medicine, Detroit, MI; [2]Department of Family Medicine and Public Health Sciences, Wayne State University School of Medicine, Detroit, MI

ABSTRACT

Background

Studies have indicated that the prevalence of obstructive sleep apnea-hypopnea syndrome (OSAHS) is similar between white and African American patients, but it is unclear if there are differences in the severity of OSAHS. We hypothesized that in patients with diagnosed OSAHS, African Americans would have higher apnea-hypopnea index (AHI) and higher mortality than white individuals.

Methods

We analyzed a prospectively collected database of 512 patients studied between July 1996 through February 1999. Inclusion criteria included age ≥ 18 y, AHI ≥ 5/h, and full-night PSG. Statistical analysis was performed to determine the association between race and AHI while controlling for the effect of confounders and effect modifiers, which included gender, age, body mass index, and comorbidities.

Results

The database included 340 African American and 172 white patients. AHI was higher in African American patients (median 32.7/h IQR 3.3-69.2) than white patients (22.4/h IQR 12.8-40.6, $p = 0.01$). Age, sex, and BMI were found to be effect modifiers and were included in final models. In the final model, African American men younger than 39 years and between 50 and 59 years were found to have a higher AHI than white men in the same age ranges.

Conclusions

African American men younger than 39 years and between 50 and 59 years have a higher AHI compared to white men of the same ages after correcting for confounders and effect modifiers. There was no difference in mortality between African Americans and whites with OSAHS in this cohort.

Citation

Pranathiageswaran S; Badr MS; Severson R; Rowley JA. The influence of race on the severity of sleep disordered breathing. *J Clin Sleep Med* 2013;9(4):303-309.

Epidemiologic studies suggest that race may influence the prevalence and outcome of chronic illness. There is evidence

BRIEF SUMMARY

that the prevalence of obstructive sleep apnea/hypopnea syndrome (OSAHS) is higher in younger (< 25 years) African Americans than younger white individuals, with no difference in prevalence in the middle-aged[1] or in the elderly (> 55 years).[2] In contrast, there is evidence that the prevalence of severe OSAHS (defined by an apnea-hypopnea index [AHI] > 30) is increased in African American elderly.[2] Overall, it is unclear whether race is a determinant of sleep apnea severity and outcome.[1–3] Moreover, a racial difference may be due to increased prevalence of obesity and hypertension in African Americans, both of which have been associated with increased OSAHS severity.[4,5] The purpose of this study was to determine whether the severity and mortality of sleep apnea were higher in African American patients with OSAHS compared to white individuals. To study this hypothesis, we compared polysomnographic variables of OSAHS in a cohort of African American and white patients diagnosed with OSAHS in an urban clinical sleep center and determined survival of the members of the cohort after approximately 10 years.

Current Knowledge/Study Rationale: Previous work has shown differences in the prevalence of obstructive sleep apnea (OSA) between whites and African-Americans but there is less data as to whether there is a difference in severity of OSA between the races. We aimed to compare apnea-hypopnea index and mortality between white and African-Americans diagnosed with OSA in an urban sleep center.

Study Impact: In addition to gender and age, AHI also varies by race being more predominant in African-American men. The interaction between gender and race suggests that both neurochemical and anatomic factors contribute to the severity of OSA.

METHODS

The Human Investigation Committee of Wayne State University approved this study. Consent was waived as the study was an analysis of a database.

Subjects and Data Generation

We analyzed a computerized database of patients with an AHI ≥ 5/h, studied in the sleep center between July 1996 through February 1999. Patients from this time period were selected as we had self-identified racial demographics during this period, as many of these patients were also included in a previously reported study from our center.[6] We chose not to include patients with an AHI < 5/h because we were interested in the influence of race on the AHI in patients with OSA, not the predictors of OSAHS in patients presenting to a sleep center, which have been determined.[1,7–9] We excluded patients who underwent a split-night polysomnography to compare sleep architecture between the groups. Because there were very small numbers of other racial and ethnic groups, only African American and white patients were included in the analysis.

The following variables were included in the analysis: gender, self-identified race, age, body-mass index (BMI), neck circumference measured in the sleep center at the time of the sleep study, and comorbidities. The following comorbidities were identified as they have been associated with OSAHS: hypertension,[10] diabetes mellitus,[11] and heart disease.[12] Presence of lung disease was also included. Comorbidities were considered present if the patient provided the diagnosis as part of the medical evaluation or if the patient was on a medication consistent with one of the comorbidities. Zip codes were used to estimate the patient's median income using the website, http://homeadvisor.msn.com. In March 2009, the Social Security Death Database (Social Security Death Index search results using http://ssdi.rootsweb.ancestry.com/cgi-bin/ssdi.cgi) was used to determine if each patient was alive or had died since the initial PSG.

Sleep-study variables included: total sleep time (TST), time in bed (TIB), sleep efficiency, percentage of the TST for different stages of sleep, and multiple indices of sleep disordered breathing including the apnea index (AI), hypopnea index (HI), apnea-hypopnea index (AHI), and the percentage of sleep time with a saturation < 90%.

Polysomnography

Polysomnography was performed as previously described.[6,12] Respiration was monitored throughout the night with thermo-couples at the nose and mouth and thoracic strain gauges. Oxy-hemoglobin saturation was obtained with an oximeter. Sleep stage scoring was performed using standard criteria in use at that time.[13] Apnea was defined as complete cessation of airflow for ≥ 10 sec and labeled as obstructive if there was effort noted in the strain gauge channel and central if effort was absent. Hypopnea was defined as a reduction in the airflow ≥ 10 sec associated with either an arousal or a 3% drop in the oxyhemoglobin saturation. The AHI, apnea index (AI), and hypopnea index (HI) were calculated using standard definitions.

Analysis/Statistical Methods

Prior to the statistical analysis, AHI, race, and other variables were checked for missing values and their suitability (normality of the variable dataset) for multivariate analysis. One subject had a missing value for BMI which was replaced by the mean value for all subjects. There were no other missing values. As the AHI was not normally distributed, a natural log transformation was applied. Demographic and sleep study variables were compared between the 2 groups using the Mann-Whitney rank sum test for continuous variables or χ^2 test for nominal variables.

The goal of the statistical analysis was to determine the association between race and AHI while controlling for effects of confounders and effect modifiers. To achieve this goal, multivariate linear regression was used to assess the effect of race on AHI, while controlling for confounding and effect modification. In the first model, $\log_e$AHI was the dependent factor and race the independent factor. In subsequent models, a potential effect modifier, such as BMI, was added both individually and as an interaction term computed by multiplying race and the potential modifier (race*BMI). The following effect modifiers were added to the basic model: age, BMI, sex, presence of hypertension, diabetes mellitus, heart disease, and lung disease. The interaction terms were statistically significant for age ($p = 0.019$), sex ($p = 0.011$), and lung disease ($p = 0.011$).

Linear regression was also used to assess potential confounders. The risk estimate (or geometric mean ratio, 1.32) associated with race was compared between a model including only race and a model including both race and the potential confounder. Sex, age, BMI, presence of hypertension, diabetes mellitus, heart disease, and lung disease were assessed as potential confounders. If the risk estimate for race differed by > 5% between the 2 models, that covariate was considered an important confounder and was included in the final model.

Variables found to be both a confounder and an effect modifier were treated as effect modifiers in the final model. As age and sex were found to be effect modifiers, age and sex stratified regression models were run with $\log_e$AHI as the independent variable and race and BMI as independent variables.

Cox regression analysis was run to identify the predictors of the mortality for the patients with the AHI > 5. Death was considered as the outcome of interest. The period of follow-up was calculated from the date of the patient having PSG to the date of death for the participants with the event, while for those without the event, the period of follow-up was calculated from the date of the PSG to date that they were checked for the mortality data. Sex, age, BMI, median income, presence of hypertension, heart disease, lung disease, diabetes mellitus, $\log_e$AHI, and $\log_e$AI were run as covariates.

RESULTS

During the time period, 867 patients presented for evaluation. Of these, 272 were excluded for AHI < 5/h, and 123 were excluded for split-night studies. This resulted in 472 charts for analysis. There were 244 (52%) men and 228 (48%) women. Among the 340 African Americans, there were 152 (45%) men and 188 (55%) women. Among the 132 white patients, there were 92 (70%) men and 40 (30%) women (**Table 1**). The prevalence of hypertension was higher in the African Americans (46.2% v. 12.5%, $p < 0.001$), but there was no

difference in the prevalence of diabetes, heart or lung disease between the 2 groups.

Patient demographics

	White	African Americans	p
Men, n (%)	92 (70)	244 (52)	< 0.001
Age, y	51 (41, 58)	47 (49, 56)	0.010
Age range, n (%)			
18-39 y	25 (25.6)	87 (18.9)	
40-49 y	37 (32.6)	111 (28.0)	
50-59 y	38 (24.7)	84 (28.8)	
> 60 y	32 (17.1)	58 (24.2)	0.101
BMI, kg/m^2	33 (28, 42)	40 (33, 48)	< 0.05
Median income, $	50,009 (34,570, 65,052)	18,531 (15,962, 29,240)	< 0.001
Hypertension, n (%)	59 (12.5)	218 (46.2)	< 0.001
Diabetes, n (%)	21 (4.4)	79 (16.7)	0.05
Heart disease, n (%)	29 (6.1)	65 (13.7)	0.28
Lung disease, n (%)	27 (5.7)	100 (21.2)	0.001

Values for continuous variables are median (interquartile range).

Table 1

Patient demographics

(more ...)

Sleep architecture and indices of sleep disordered breathing were compared by running a nonparametric test (Mann-Whitney rank sum; see **Table 2**). Whites and African Americans differed significantly in %Stage 1, %slow wave, AHI events/h, and SpO_2 during REM; they did not differ in time in bed (TIB), total sleep time (TST), sleep efficiency, %Stage 2, %REM, AI (events/h), HI (events/h), and SpO_2 in

NREM.

Sleep study architecture and indices of sleep disordered breathing

	White	African American	p
TST, min	401.5 (350.0,426.0)	386.5 (330.5, 421.5)	0.14
TIB, min	470.0 (459.0,479.0)	469.0 (451.5,479.0)	0.75
SpO_2 NREM	92.0 (89.5, 93.9)	91.6 (87.8, 93.4)	0.1
SpO_2 REM	89.6 (81.4, 93.0)	88.00 (80.08,91.15)	0.01
AHI	22.4 (12.8, 40.6)	32.7 (3.3, 69.2)	0.01
Sleep efficiency, %	0.84 (0.78, 0.91)	0.87 (0.74, 0.90)	0.06
AI	4.3 (1.2,16.8)	7.9 (1.6, 28.5)	0.06
HI	14.8 (7.7, 25.0)	15.6 (7.4, 31.7)	0.54
Stage 1 %	0.19 (0.12, 0.28)	0.23 (0.14, 0.38)	0.02
Stage 2 %	0.63 (0.53, 0.71)	0.6 (0.49, 0.68)	0.1
Slow wave %	0.02 (0.0, 0.07)	0.00 (0.0, 0.04)	< 0.05

Values are median (interquartile range).

Table 2

Sleep study architecture and indices of sleep disordered breathing

(more ...)

To ascertain the independent effect of race on AHI, we built several multivariate linear regression models to assess the potential confounding and effect modification of the relationship between race and increasing AHI by age, gender, HTN, DM, heart disease, lung disease, BMI, and income (**Table 3**). In evaluating effect modification, we found that the relationship between race and AHI severity varied by age level (interaction p = 0.019), by gender (interaction p = 0.011), and by whether or not the patient had lung disease (interaction p = 0.011). In further modeling, the interaction term for race and lung disease was not significant, so this term was dropped. Thus, we retained interaction terms for race*age and race*gender in all future analyses. When we evaluated potential confounding (**Table 4**), there was a 12.1% decrease in the main effect term for race when BMI was included in the model. Based on these findings, we subsequently included BMI in all further models.

Measures of potential modifiers of the effect of race on sleep disordered breathing

Interaction	p
race*age	0.019
race*sex	0.011
race*HTN	0.053
race*DM	0.348
race*heart disease	0.184
race*lung disease	0.011
race*BMI	0.43
race*median income	0.621

Table 3

Measures of potential modifiers of the effect of race on sleep disordered breathing

(more ...)

Measures of potential confounders of the effect of race on sleep disordered breathing, sleep disorders center

Model IV	R^2	Coefficient of β (Race)	Geometric Mean Ratio	% Change in OR
race	0.018	0.274	1.32	
race*age	0.02	0.265	1.30	1.52%
race*sex	0.057	0.366	1.45	9.84%
race*HTN	0.027	0.24	1.27	3.79%
race*DM	0.021	0.266	1.30	1.52%
race*heart disease	0.021	0.277	1.32	0%
race*lung disease	0.019	0.271	1.31	0.34%
race*BMI	0.084	0.148	1.16	12.12%
race*median income	0.02	0.264	1.30	1.15%

Table 4

Measures of potential confounders of the effect of race on sleep disordered breathing, sleep disorders center

(more ...)

Age and gender specific regression models were run with race and BMI as the independent variable and $\log_e$AHI as the dependent variable (**Table 5**). In the age and gender stratified model, being an African American male ≤ 39 years increased the $\log_e$AHI by 1.17 or AHI by 3.21/h ($p < 0.05$) compared to a white male in the same age range with the same BMI. For the age group of 50-59 years, being an African American male increased $\log_e$AHI by 1.03 units or increased AHI by 2.79/h compared to a white male in the same age range with the same BMI.

Univariate estimates of the risk (risk estimate) of a one unit increase in the apnea hypopnea index in African Americans compared to whites, stratified by age and sex

Age	Sex	Geometric Mean Ratio (95% CI)
< 40	Male	3.22 (1.6, 6.49)
	Female	0.61 (0.07,5.47)
40-49	Male	1.3 (0.63,2.7)
	Female	1.04 (0.25,4.24)
50-59	Male	2.79 (1.24,6.27)
	Female	0.99 (0.35,2.82)
> 60	Male	0.842 (0.31,2.28)
	Female	1.04 (0.80,1.34)

Table 5

Univariate estimates of the risk (risk estimate) of a one unit increase in the apnea hypopnea index in African Americans compared to whites, stratified by age and sex

(more ...)

The mean follow-up period was 10.5 ± 5.3 years. During the follow-up period, 20 white patients died (11.6% of group; 11 men, 9 women); in the African American group, 57 (17.1% of cohort; 34 men, 23 women) patients died. In the Cox regression analysis (**Table 6** and **Figure 1**) for the whole cohort, only heart disease ($p = 0.002$), diabetes mellitus ($p = 0.005$), age ($p < 0.001$), and male gender ($p = 0.027$) were identified as significant predictors of the mortality for patients with AHI > 5. Baseline AHI and race were not identified as independent predictors.

Multivariate analysis of the risk (hazard ratio) of death associated with AHI, race, and other covariates

Variable	Coefficient (β)	Standard Error	Wald	p	Hazard Ratio	UB	LB
$\log_e$AHI	0.193	0.141	1.872	0.171	1.213	0.920	1.601
Race	-0.030	0.341	0.008	0.930	0.971	0.497	1.894
Sex	-0.579	0.261	4.920	0.027	0.560	0.336	0.935
BMI	0.003	0.013	0.041	0.840	1.003	0.977	1.030
Age	0.040	0.011	13.135	0.000	1.041	1.019	1.064
HTN	-0.265	0.280	0.893	0.345	0.767	0.443	1.329
DM	-0.593	0.256	5.379	0.020	0.553	0.335	0.912
Heart disease	-0.878	0.250	12.370	0.000	0.225	0.255	0.678
Lung disease	-0.504	0.242	4.345	0.037	0.376	0.376	0.970
Median income	0.000	0.000	1.706	0.192	1.000	1.000	1.000

Table 6

Multivariate analysis of the risk (hazard ratio) of death associated with AHI, race, and other covariates

(more ...)

Kaplan-Meier survival curves for African American (dashed line) and white (solid line) patients

There was no difference in survival between the two groups.

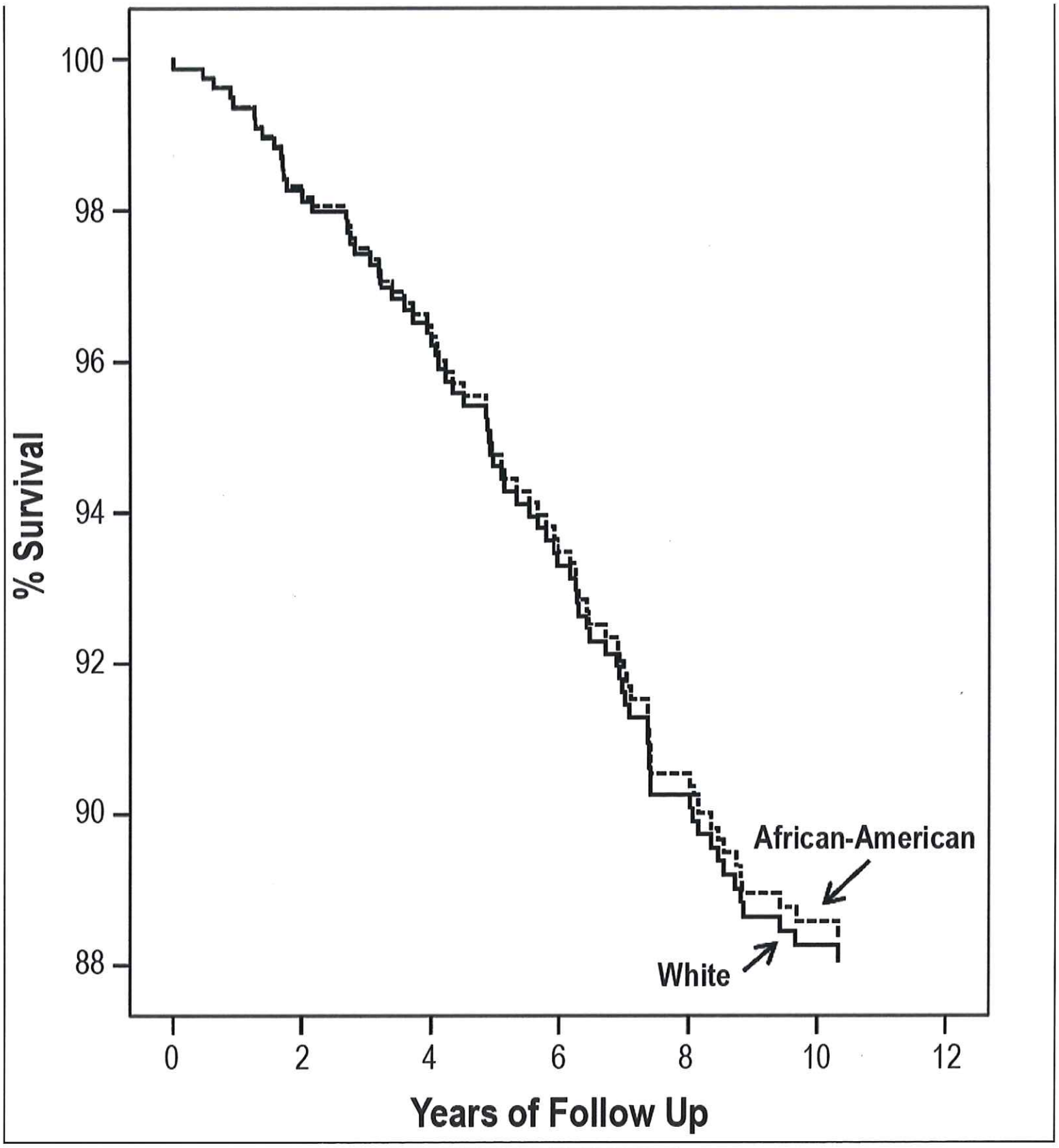
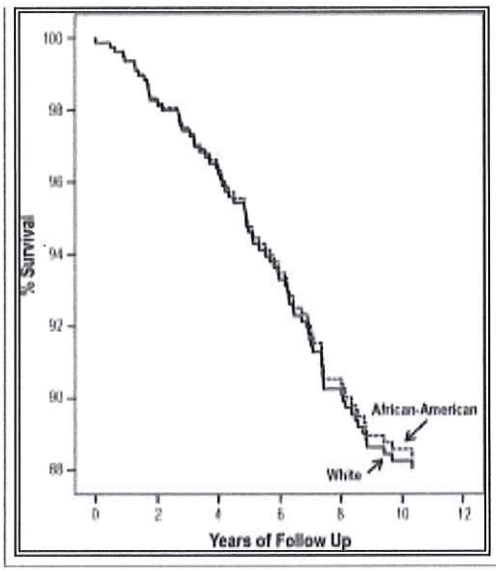


Figure 1

Kaplan-Meier survival curves for African American (dashed



line) and white (solid line) patientsThere was no difference in survival between the two groups.

(more ...)

In summary, AHI was higher in African American males younger than 39 years, and between 50-59 years of age. There was no difference in AHI between African American and white females. Longitudinal analysis of mortality found that race and severity of OSA were not predictors of increased mortality in patient with sleep apnea.

DISCUSSION

Our study demonstrated the following novel findings: (1) Sleep apnea severity, expressed as AHI, was higher in African American males (age ≤ 39 years and 50-59 years), even after controlling for BMI. (2) Race and AHI were not identified as independent predictors of mortality in this cohort of patients with OSAHS.

Our study demonstrated higher AHI in African American patients relative to white patients with OSAHS. Our study corroborates previous epidemiologic studies addressing the relationship between race and AHI. Data from the Cleveland Cohort Study indicated that African Americans had a higher AHI at younger ages but a similar AHI between the ages of 50 and 60 years.[1] In a cohort of elderly patients, Ancoli-Israeli et al. found no difference in the overall AHI between African Americans and whites, though they did find that the AHI was higher in African Americans with severe OSAHS (AHI ≥ 30).[2] Both of these studies were community-based cohorts including subjects with and without OSAHS. Our study extended the previous findings by demonstrating that the severity of OSAHS is influenced by race, age, and gender.

Epidemiologic studies have shown significant cardiovascular mortality disparities between African American and white populations.[14–17] These disparities have been found to be associated with disparities in other chronic illnesses, such as diabetes and hypertension.[17] There is also evidence that the degree of disparity is greater in younger than older individuals.[16] OSAHS is an additional chronic illness that could contribute to mortality and, possibly, the racial disparities in cardiovascular mortality. Recent epidemiologic studies have shown that individuals with OSAHS have increased mortality compared to individuals without OSAHS.[18–20] These studies have generally shown that the increased mortality was seen in individuals with severe OSAHS, generally defined as an AHI ≥ 30/h, with one of the studies showing that the effect of mortality was primarily observed in men under the age of 70 years.[20] Thus, we were surprised that race and AHI did not predict mortality, even among younger African American men who had significantly higher AHI. Thus, while young and middle-aged African American men have a greater burden of disease, as measured by AHI, this burden does not translate into increased mortality when other demographic and comorbidities are considered.

We intended to study the influence of race on sleep apnea severity and mortality, we are cognizant that race is primarily a social construct. Therefore, considering racial differences in biological processes that influence OSAHS,[3,21] race may represent a marker

rather than a specific biologic risk factor for increased severity of AHI.[22] In addition, other relevant factors, such as socioeconomic status,[16,23] educational status,[15] degree of urbanization,[24] and access to care[25] are significant determinants of morbidity and mortality and contribute to the apparent racial disparities. For this cohort, we used median income data (based upon home address zip codes) as a surrogate for socioeconomic status, but did not find that socioeconomic status was a confounder or effect modifier in this population despite the clear difference in median income between the two groups. However, income may not be sufficient to detect disparities in access to care.[26] Finally, the use of race in this context could limit the generalizability to populations with different racial demographics or evolving and/or complex social settings.

Potential Mechanisms

Group differences in the prevalence and severity of OSAHS are generally attributed to group differences in either anatomic factors or neurochemical control of breathing during sleep.[27] Previous work has shown that there are differences in craniofacial structure, as indicated by cephalometrics[1] and anthropometric facial features,[28] between African American and white men. In particular, the evidence suggests that hard tissue anatomic risk associated with shape and size of the skeletal components of the upper airway may be relatively more important in whites, while soft tissue structures may be more important in African Americans.[28] We hypothesize that these anatomic differences may predispose to differences in upper airway mechanics and collapsibility between African Americans and white subjects. However, to our knowledge, there are no published reports to support this hypothesis.

Alternatively, the increased AHI in African Americans compared to whites could suggest that African Americans have an increased apneic threshold (are more susceptible to developing apnea) compared to white subjects; however, there is no experimental proof of such a difference, and preliminary data from our group does not indicate a difference in the apneic threshold.[29] However, it has been shown that African American individuals have a greater ventilatory response to hypoxia[21] and an increased peripheral response to hypercapnia compared to white individuals[30] during NREM sleep, suggesting that differences in neurochemical control of breathing could contribute to the increased AHI in African Americans.

Our study found a significant interaction between gender and race, with the increased in AHI being found only in African American men. The above discussion on the differences in the pathogenesis of OSA suggests a potential explanation for this finding. We speculate that an increased susceptibility to hypocapnic apnea (men)[31] in combination with differences in upper airway mechanics (African Americans) could result in a risk of OSA that is greater than either risk factor alone. This is, however, a hypothesis awaiting experimental proof.

In addition to pathophysiologic mechanisms, there could be cultural reasons for a difference in AHI. Specifically, reduced access to care or cultural differences in reporting symptoms of OSAHS could result in delayed presentation and higher AHI. However, in the Sleep Heart Health Study, African American women were more likely to report snoring than white women with no difference between African American and white men.[32] However, there is evidence that African Americans answer and interpret elements of the Epworth Sleepiness Scale differently than whites,[33] suggesting that cultural differences could exist in reporting of symptoms.

Epidemiologic studies have found an increased prevalence of OSA with increasing age.[2,8,34] Ware and colleagues found that age was a significant predictor of AHI in a clinical sample.[35] In this study, we found that the racial differences in AHI were most apparent in certain age groups, similar to other investigators who also found an increased AHI in younger African Americans.[1] The reasons for age being an influence on AHI in only certain age ranges are unclear. Several studies of the influence of age on upper airway mechanics and control of breathing do not show an aging effect[36–39] and of those that do, the decrement in function is present in an older age group, not younger.[40,41]

Limitations

We included comorbid conditions in the analysis because of known associations between several medical conditions and OSA, including heart disease[12] and hypertension.[10,11] While we did find associations for several of the comorbidities to AHI, the final regression models did not include any of these factors. There are several potential explanations. First, comorbidities other than hypertension were self-identified by the patients, and it is conceivable that patients did not disclose all relevant associated diagnoses. Second, the comorbidities could have been present but undiagnosed at the time of presentation to the sleep center. Third, the comorbidities analyzed could be either independent of or secondary to the OSA and therefore not predictive of OSA severity. For instance, comorbidities could be coexistent because of the common factor of obesity. Finally, it should be noted that we found that comorbidities such as heart disease and diabetes to be associated with a decreased risk of mortality; generally these comorbidities are associated with an increased risk of death. However, we note that those associations are generally from epidemiologic studies and ours is a clinical study. We speculate that the patients with these comorbidities were being actively treated, thus causing a potential protective effect.

Referral bias could result in our clinic population not being representative of patients with OSA. We note that in our clinic population the ratio of men to women is nearly 1:1, in contrast to the usual 3-5:1 reported in other clinic based population studies.[35,42,43] Our patients are also extremely obese (mean BMI > 35 kg/m^2), which also contrasts to previous clinic-based population studies. However, both of these demographic characteristics are consistent with the urban community our sleep center serves and previous studies from our center.[6,44]

We were unable to analyze the effect of neck circumference in this population because we only had this measurement in a subset of patients with disproportionate data collection between the gender and racial groups. Several previous studies have shown the importance of neck circumference in the prediction of sleep apnea,[44–46] and some have suggested that it is a better predictor of OSA severity than BMI. It is conceivable that substitution of neck circumference into our regression analyses could have changed the results. However, in a recent study from our center, we found that both neck circumference and BMI are independent predictors of AHI in a patient population very similar to that in this study.[44]

O'Connor and colleagues found that men were more likely to have supine dominant OSA.[42] Therefore, it is possible that the increased AHI in our study were secondary to the African American men spending more time in the supine position than white men. We do not have body position data for our patients so cannot disprove this hypothesis. However, we do not know of study that has shown that members of different races or cultures spend different amounts of time supine.

We limited our sample to patients with full-night sleep studies and those with an AHI ≥ 5/hour. We included only full-night studies so that we could compare sleep architecture between the two groups and so that all REM periods would be included in the analysis of sleep disordered breathing indices (important for patients with more mild REM-associated events). In theory, exclusion of patients with split-night studies removed patients with more severe OSAHS, thus minimizing differences between the two groups. However, split-night studies in our center can be performed for a wide range of AHI, thus minimizing this limitation. We excluded patients with AHI < 5/h, to better compare AHI in patients with sleep disordered breathing, not all patients presenting to a sleep center. However, limiting the population in this way could have introduced selection bias and favored the results showing a difference in AHI between the two races. In theory, the methodological design of a cross-sectional or longitudinal would be better suited to eliminate selection bias. In addition, that AHI was analyzed as a continuous variable, excluding patients with AHI < 5/h, could have contributed to the lack of significance in AHI predicting mortality. Finally, while the calculated power of the mortality data was 0.8, it should be noted that the sample size was determined not by a power calculation, as this was a convenience sample of patients with self-described race and sufficient follow-up.

In summary, we have extended previous findings by showing that African American men have a higher AHI than white men in certain age ranges, with no differences between African American and white women. The interaction between gender and race suggests that

increased severity of sleep disordered breathing may require both an increased susceptibility to hypocapnic apnea (men) and a smaller upper airway (African Americans).

DISCLOSURE STATEMENT

This was not an industry supported study. The authors have indicated no financial conflicts of interest.

REFERENCES

1 Redline S, Tishler PV, Hans MG, Tosteson TD, Strohl KP, Spry K, authors. Racial differences in sleep-disordered breathing in African-Americans and Caucasians. Am J Respir Crit Care Med. 1997;155:186–92. [PubMed]

2 Ancoli-Israel S, Klauber MR, Stepnowsky C, Estline E, Chinn A, Fell R, authors. Sleep-disordered breathing in African-American elderly. Am J Respir Crit Care Med. 1995;152:1946–9. [PubMed]

3 Cakirer B, Hans MG, Graham G, Aylor J, Tishler PV, Redline S, authors. The relationship between craniofacial morphology and obstructive sleep apnea in whites and in African-Americans. Am J Respir Crit Care Med. 2001;163:947–50. [PubMed]

4 Newman AB, Nieto FJ, Guidry U, et al., authors. Relation of sleep-disordered breathing to cardiovascular disease risk factors: the Sleep Heart Health Study. Am J Epidemiol. 2001;154:50–9. [PubMed]

5 Dempsey JA, Skatrud JB, Jacques AJ, et al., authors. Anatomic determinants of sleep-disordered breathing across the spectrum of clinical and nonclinical male subjects. Chest. 2002;122:840–51. [PubMed]

6 Rowley JA, Aboussouan LS, Badr MS, authors. The use of clinical prediction formulas in the evaluation of obstructive sleep apnea. Sleep. 2000;23:929–38. [PubMed]

7 Redline S, Kump K, Tishler PV, Browner I, Ferrette V, authors. Gender differences in sleep-disordered breathing in a community-based sample. Am J Respir Crit Care Med. 1994;149:722–6. [PubMed]

8 Bixler EO, Vgontzas AN, Ten Have T, Tyson K, Kales A, authors. Effects of age on sleep apnea in men: I. Prevalence and severity. Am J Respir Crit Care Med. 1998;157:144–8. [PubMed]

9 Bixler EO, Vgontzas AN, Lin HM, et al., authors. Prevalence of sleep-disordered breathing in women: effects of gender. Am J Respir Crit Care Med. 2001;163:608–13. [PubMed]

10 Peppard PE, Young T, Palta M, Skatrud J, authors. Prospective study of the association between sleep-disordered breathing and hypertension. N Engl J Med. 2000;342:1378–84. [PubMed]

11 Newman AB, Nieto FJ, Guidry U, et al., authors. Relation of sleep-disordered breathing to cardiovascular disease risk factors. Am J Epidemiol. 2001;154:50–9. [PubMed]

12 Shahar E, Whitney CW, Redline S, et al., authors. Sleep-disordered breathing and cardiovascular disease: cross-sectional results of the Sleep Heart Health Study. Am J Respir Crit Care Med. 2001;163:19–25. [PubMed]

13 Rechtschaffen A, Kales AA, authors. A manual of standardized terminology, techniques and scoring system for the sleep stages of human subjects. 1968. Washington, DC: National Institutes of Health;

14 Murray CJ, Kulkarni SC, Michaud C, et al., authors. Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. PLoS Med. 2006;3:e260[PubMed Central][PubMed]

15 Mensah GA, Mokdad AH, Ford ES, Greenlund KJ, Croft JB, authors. State of disparities in cardiovascular health in the United States. Circulation. 2005;111:1233–41. [PubMed]

16 Jolly S, Vittinghoff E, Chattopadhyay A, Bibbins-Domingo K, authors. Higher cardiovascular disease prevalence and mortality among younger blacks compared to whites. Am J Med. 2010;123:811–8. [PubMed]

17 Wong MD, Shapiro MF, Boscardin WJ, Ettner SL, authors. Contribution of major diseases to disparities in mortality. N Engl J Med. 2002;347:1585–92. [PubMed]

18 Young T, Finn L, Peppard PE, et al., authors. Sleep disordered breathing and mortality: eighteen-year follow-up of the Wisconsin sleep cohort. Sleep. 2008;31:1071–8. [PubMed Central] [PubMed]

19 Marin JM, Carrizo SJ, Vicente E, Agusti AG, authors. Long-term cardiovascular outcomes in men with obstructive sleep apnoea-hypopnoea with or without treatment with continuous positive airway pressure: an observational study. Lancet. 2005;365:1046–53. [PubMed]

20 Punjabi NM, Caffo BS, Goodwin JL, et al., authors. Sleep-disordered breathing and mortality: a prospective cohort study. PLoS Med. 2009;6:e1000132[PubMed Central][PubMed]

21 Crisostomo I, Zayyad A, Carley DW, et al., authors. Chemo- and baroresponses differ in African-Americans and Caucasians in sleep. J Appl Physiol. 1998;85:1413–20. [PubMed]

22 Kaplan JB, Bennett T, authors. Use of race and ethnicity in biomedical publication. JAMA. 2003;289:2709–16. [PubMed]

23 Kanjilal S, Gregg EW, Cheng YJ, et al., authors. Socioeconomic status and trends in disparities in 4 major risk factors for cardiovascular disease among US adults, 1971-2002. Arch Intern Med. 2006;166:2348–55. [PubMed]

24 Erwin PC, Fitzhugh EC, Brown KC, Looney S, Forde T, authors. Health disparities in rural areas: the interaction of race, socioeconomic status, and geography. J Health Care Poor Underserved. 2010;21:931–45. [PubMed]

25 Zhang X, Geiss LS, Cheng YJ, Beckles GL, Gregg EW, Kahn HS, authors. The missed patient with diabetes: how access to health care affects the detection of diabetes. Diabetes Care. 2008;31:1748–53. [PubMed Central][PubMed]

26 Moy E, Bartman BA, Weir MR, authors. Access to hypertensive care. Effects of income, insurance, and source of care. Arch Intern Med. 1995;155:1497–502. [PubMed]

27 Badr MS, author. Pathophysiology of upper airway obstruction during sleep. Clin Chest Med. 1998;19:21–32. [PubMed]

28 Cakirer B, Hans MG, Graham G, Aylor J, Tishler PV, Redline S, authors. The relationship between craniofacial morphology and obstructive sleep apnea in whites and in African-Americans. Am J Respir Crit Care Med. 2001;163:947–50. [PubMed]

29 Rowley JA, Badr MS, authors. Determinants of the hypocapnic apneic threshold: influence of race. Am J Respir Crit Care Med. 2007;175:A995

30 Bobat I, Mateika JH, Qureshi T, Badr MS, authors. Peripheral not central chemoreflex responsiveness is enhanced in African-Amercians compared to Caucasians during wakefulness. Am J Respir Crit Care Med. 2004;169:A60

31 Zhou XS, Shahabuddin S, Zahn BR, Babcock MA, Badr MS, authors. Effect of gender on the development of hypocapnic apnea/hypopnea during NREM sleep. J Appl Physiol. 2000;89:192–9. [PubMed]

32 O'Connor GT, Lind BK, Lee ET, et al., authors. Variation in symptoms of sleep-disordered breathing with race and ethnicity: the Sleep Heart Health Study. Sleep. 2003;26:74–9. [PubMed]

33 Hayes AL, Spilsbury JC, Patel SR, authors. The Epworth score in African American populations. J Clin Sleep Med. 2009;5:344–8.[PubMed Central][PubMed]

34 Ancoli-Israel S, Kripke DF, Klauber MR, Mason WJ, Fell R, Kaplan O, authors. Sleep-disordered breathing in community-dwelling elderly. Sleep. 1991;14:486–95. [PubMed Central][PubMed]

35 Ware JC, McBrayer RH, Scott JA, authors. Influence of sex and age on duration and frequency of sleep apnea events. Sleep. 2000;23:165–70. 15. [PubMed]

36 Browne HA, Adams L, Simonds AK, Morrell MJ, authors. Ageing does not influence the sleep-related decrease in the hypercapnic ventilatory response. Eur Respir J. 2003;21:523–9. [PubMed]

37 Browne HA, Adams L, Simonds AK, Morrell MJ, authors. Impact of age on breathing and resistive pressure in people with and without sleep apnea. J Appl Physiol. 2001;90:1074–82. [PubMed]

38 Rowley JA, Zhou X, Vergine I, Shkoukani MA, Badr MS, authors. Influence of gender on upper airway mechanics: upper airway resistance and Pcrit. J Appl Physiol. 2001;91:2248–54. [PubMed]

39 Pokorski M, Marczak M, authors. Ventilatory response to hypoxia in elderly women. Ann Hum Biol. 2003;30:53–64. [PubMed]

40 Fogel RB, White DP, Pierce RJ, et al., authors. Control of upper airway muscle activity in younger versus older men during sleep onset. J Physiol. 2003;553:533–44. [PubMed Central] [PubMed]

41 Worsnop C, Kay A, Kim Y, Trinder J, Pierce R, authors. Effect of age on sleep onset-related changes in respiratory pump and upper airway muscle function. J Appl Physiol. 2000;88:1831–9. [PubMed]

42 O'Connor C, Thornley KS, Hanly PJ, authors. Gender differences in the polysomnographic features of obstructive sleep apnea. Am J Respir Crit Care Med. 2000;161:1465–72. [PubMed]

43 Kushida CA, Efron B, Guilleminault C, authors. A predictive morphometric model for the obstructive sleep apnea syndrome. Ann Intern Med. 1997;127:581–7. [PubMed]

44 Tashkandi Y, Badr MS, Rowley JA, authors. Determinants of the apnea index in a sleep center population. Sleep Breath. 2005;9:181–6. [PubMed]

45 Young T, Palta M, Badr MS, authors. Sleep-disordered breathing (letter). N Engl J Med. 1993;329:1429–30

46 Stradling JR, Crosby JH, authors. Predictors and prevalence of obstructive sleep apnea and snoring in 1001 middle aged men. Thorax. 1991;46:85–90. [PubMed Central][PubMed]

* * * COMMUNICATION RESULT REPORT (APR. 16. 2014 2:43PM) * * *

FAX HEADER:

TRANSMITTED/STORED : APR. 16. 2014 2:38PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
235	MEMORY TX		912037413408	OK	32/32

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 12037413408

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 04/16/2014 **Time:** 2:45 pm

NUMBER OF PAGES: 32
(including transmittal sheet

Comments:
13-31884-CON
Attached is OHCA requested additional information from Local 34 Federation of University Employees in regards to Gaylord Hospital's CON Application.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 22, 2014

VIA FAX ONLY

Janine Epright
CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31883-CON, 13-31884-CON, 13-31885-Con, and 14-31902-CON
Gaylord Hospital
Additional Questions

Dear Ms. Epright:

Please complete the following two questions for Docket Number 13-31883-CON, Docket Number 13-31884-CON, Docket Number 13-31885-CON, and Docket Number 14-31902-CON:

1.

Table 1: Gaylord Sleep Medicine's Historical and Current Services Volume

Service	FY 2011	FY 2012	FY 2013	FY 2014*
Total				

*(October 1, 2013 – April 30, 2014)

2.**Table 2: Gaylord Sleep Medicine's Historical and Current Payer Mix by volume and by %**

Description	FY 2011		FY 2012		FY 2013		FY 2014**	
	Volume	%	Volume	%	Volume	%	Volume	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

*Includes managed care activity
**(October 1, 2013 – April 30, 2014)

Please respond by May 6, 2014. If you have any questions regarding the above, please contact me at (860) 418-7035..

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

* * * COMMUNICATION RESULT REPORT (APR. 22. 2014 2:39PM) * * *

FAX HEADER:

TRANSMITTED/STORED : APR. 22. 2014 2:38PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
240	MEMORY TX		912037413408	OK	3/3

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 12037413408

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 04/22/2014 **Time:** 2:45 pm

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Additional
Questions

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 21, 2014

Janine Epright, CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Services at Gaylord Sleep Medicine in North Haven

Dear Ms. Epright,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Gaylord Hospital ("Applicant") on March 10, 2014, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant: Gaylord Hospital

Docket Number: 13-31884-CON

Proposal: Termination of Gaylord Sleep Medicine in North Haven

Notice is hereby given of a public hearing to be held in this matter to commence on:

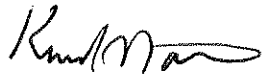
Date: June 18, 2014

Time: 3:00 p.m.

Place: Quinnipiac University
370 Bassett Rd., Room MNH 202
North Haven, CT 06473

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *New Haven Register* pursuant to General Statutes § 19a-639a (f).

Sincerely,



Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: PF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 21, 2014 Requisition # 45635

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 May 23, 2014**. 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 Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:PF:lmg

New Haven Register **May 21, 2014**
Notice of Public Hearing, Docket Number 13-31884-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Gaylord Hospital
Town:	Hamden
Docket Number:	13-31884-CON
Proposal:	Termination of Gaylord Sleep Medicine
Date:	June 18, 2014
Time:	3:00 p.m.
Place:	Quinnipiac University 370 Bassett Rd., Room MNH 202 North Haven, CT 06473

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 13, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

* * * COMMUNICATION RESULT REPORT (MAY. 21. 2014 3:50PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 21. 2014 3:49PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
320	MEMORY TX		912037413408	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: (203) 741-3408

AGENCY: GAYLORD HOSPITAL

FROM: OHCA

DATE: 5/21/14

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31884-CON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Thursday, May 22, 2014 2:45 PM
To: Olejarz, Barbara
Cc: Greer, Leslie
Subject: FW: Hearing notice
Attachments: 13-31884p NH Register.doc

Your legal notice is all set to run as follows:

New Haven Register, 5/23 issue - $419.89

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Olejarz>, Barbara <Barbara.Olejarz@ct.gov>
Date: Wednesday, May 21, 2014 1:43 PM
To: ads <ads@graystoneadv.com>
Cc: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: RE: Hearing notice

Attached is the hearing notice, please let me know if you received it Okay.

Barbara

From: ADS [mailto:ADS@graystoneadv.com]
Sent: Wednesday, May 21, 2014 1:01 PM
To: Olejarz, Barbara
Subject: Re: Hearing notice

The attachment you sent is blank, please resend…

From: <Olejarz>, Barbara <Barbara.Olejarz@ct.gov>
Date: Wednesday, May 21, 2014 12:45 PM
To: ads <ads@graystoneadv.com>
Cc: "Greer, Leslie" <Leslie.Greer@ct.gov>, "Martone, Kim" <Kimberly.Martone@ct.gov>, "Riggott, Kaila" <Kaila.Riggott@ct.gov>, "Fiducia, Paolo" <Paolo.Fiducia@ct.gov>
Subject: Hearing notice

5/21/14

Please run the attached hearing notice in the New Haven Register by 5/23/14. For billing purposes, refer to requisition 45635. In addition, please forward me a "proof of publication" when available.

Thank you,

Barbara K. Olejarz
Administrative Assistant
Office of Health Care Access
Division of The Department of Public Health
410 Capitol Ave., MS#13HCA
Hartford, CT 06134
Phone: 860 418-7005
Email: Barbara.olejarz@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: May 22, 2014

RE: Certificate of Need Application; Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Services at Gaylord Sleep Medicine in North Haven

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department
of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Olejarz, Barbara
Sent: Tuesday, May 27, 2014 2:41 PM
To: ads@graystoneadv.com
Cc: Greer, Leslie; Riggott, Kaila; Fiducia, Paolo; Hansted, Kevin; Martone, Kim
Subject: Hearing Notice
Attachments: 13-31884p NH Register revised.doc

5/27/14

Please run the attached hearing notice in the New Haven Register by 5/29/14. For billing purposes, refer to requisition 45665. In addition, please forward me a "proof of publication" when available.

Thank you,

Barbara K. Olejarz
Administrative Assistant
Office of Health Care Access
Division of The Department of Public Health
410 Capitol Ave., MS#13HCA
Hartford, CT 06134
Phone: 860 418-7005
Email: Barbara.olejarz@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 27, 2014

Janine Epright, CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Services at Gaylord Sleep Medicine in North Haven

Dear Ms. Epright,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Gaylord Hospital ("Applicant") on March 10, 2014, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	Gaylord Hospital
Docket Number:	13-31884-CON
Proposal:	Termination of Gaylord Sleep Medicine in North Haven

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 18, 2014

Time: 3:00 p.m.

Place: Gateway Community College **(revised)**
20 Church St. Community Room (N100)
New Haven, CT 06510

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *New Haven Register* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: PF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 27, 2014 Requisition #45665

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 **Thursday May 29, 2014**. 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 Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:PF:lmg

New Haven Register **May 27, 2014**
Notice of Public Hearing, Docket Number 13-31884-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Gaylord Hospital
Town:	North Haven
Docket Number:	13-31884-CON
Proposal:	Termination of Gaylord Sleep Medicine
Date:	June 18, 2014
Time:	3:00 p.m.
Place:	Gateway Community College **(revised)** 20 Church St. Community Room (N100) New Haven, CT 06510

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 13, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

* * * COMMUNICATION RESULT REPORT (MAY. 27. 2014 3:36PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 27. 2014 3:35PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
333	MEMORY TX		912037413408	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: (203) 741-3408

AGENCY: GAYLORD HOSPITAL

FROM: OHCA

DATE: 5/27/14

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: DN: 13-31884-CON Revised Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Wednesday, May 28, 2014 2:57 PM
To: Olejarz, Barbara
Cc: Greer, Leslie
Subject: FW: Hearing Notice
Attachments: 13-31884p NH Register revised.doc

Your legal notice is all set to run as follows:

New Haven Register, 5/29 issue - $419.89

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Olejarz>, Barbara <Barbara.Olejarz@ct.gov>
Date: Tuesday, May 27, 2014 2:41 PM
To: ads <ads@graystoneadv.com>
Cc: "Greer, Leslie" <Leslie.Greer@ct.gov>, "Riggott, Kaila" <Kaila.Riggott@ct.gov>, "Fiducia, Paolo" <Paolo.Fiducia@ct.gov>, "Hansted, Kevin" <Kevin.Hansted@ct.gov>, "Martone, Kim" <Kimberly.Martone@ct.gov>
Subject: Hearing Notice

5/27/14

Please run the attached hearing notice in the New Haven Register by 5/29/14. For billing purposes, refer to requisition 45665. In addition, please forward me a "proof of publication" when available.

Thank you,

Barbara K. Olejarz
Administrative Assistant
Office of Health Care Access
Division of The Department of Public Health
410 Capitol Ave., MS#13HCA
Hartford, CT 06134
Phone: 860 418-7005
Email: Barbara.olejarz@ct.gov

Greer, Leslie

From: Martone, Kim
Sent: Thursday, May 29, 2014 10:17 AM
To: Greer, Leslie; Riggott, Kaila
Subject: FW: Gaylord Hospital-Blair Appearance.pdf - Adobe Acrobat Professional
Attachments: Appearance.pdf

From: John D. Blair [mailto:john@blairlawllc.com]
Sent: Thursday, May 29, 2014 10:06 AM
To: Fiducia, Paolo
Cc: Martone, Kim; Lazarus, Steven
Subject: Gaylord Hospital-Blair Appearance.pdf - Adobe Acrobat Professional

Hi Paolo,

Please find enclosed Appearance on behalf of Gaylord Hospital. If you have any questions please contact me.

Thanks, John

John D. Blair
Counselor at Law

Blair Law LLC
P.O. Box 141
Rocky Hill, CT 06067
P: 860 280 4059
F: 860 760 6493
john@blairlawllc.com
www.blairlawllc.com

This electronic message contains information from Blair Law, LLC, or its attorneys, which may be confidential, privileged or otherwise protected from disclosure. The information is intended to be used solely by the recipient(s) named. If you are not an intended recipient, be aware that any review, disclosure, copying, distribution or use of this transmission or its contents is prohibited. If you have received this transmission in error, please notify us immediately at 860 280-4059 or at the reply email address. For more information about Blair Law, please go to http://www.blairlawllc.com.

BEFORE DEPARTMENT OF PUBLIC HEALTH DIVISION OFFICE OF HEALTH CARE ACCESS	DOCKET NO. 13-31884-CON
IN RE GAYLORD HOSPITAL TERMINATION OF SLEEP MEDICINE SERVICES	MARCH 29, 20014

APPEARANCE

In connection with the above referenced matter, please enter appearance on behalf of Gaylord Hospital:

John D. Blair, Esq.
Blair Law, LLC
PO Box 141
Rocky Hill, CT 06067
john@blairlawllc.com
Juris # 427940

Gaylord Hospital

John D. Blair, Esq.
Blair Law, LLC
PO Box 141
Rocky Hill, CT 06067
860.280.4059 (c)
john@blairlawllc.com

IN THE MATTER OF:

A Certificate of Need Application by
Gaylord Hospital

Docket Number: 13-31884-CON

Notice to Petitioner; re: Request for Status

RULING ON A PETITION FILED BY
UNITE HERE LOCAL 34
TO BE DESIGNATED AS AN INTERVENOR

By petition dated April 8, 2014, UNITE HERE Local 34 ("Petitioner") requested Party or Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of Gaylord Hospital ("Applicant") filed under Docket Number: 13-31884-CON. The CON application is for the termination of services at Gaylord Sleep Medicine in North Haven, Connecticut.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights for the hearing scheduled on June 18, 2014, 3:00 p.m., at Gateway Community College, 20 Church Street, Community Room (N100), New Haven, Connecticut. As an Intervenor with limited rights, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31884-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may make a short presentation. The Applicant may cross-examine the Petitioner. The Petitioner is not permitted to cross-examine the Applicant. The Petitioner shall submit its pre-filed testimony no later than June 11, 2014.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

5/29/14
Date

Kevin T. Hansted
Hearing Officer

* * * COMMUNICATION RESULT REPORT (MAY. 29. 2014 10:19AM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 29. 2014 10:18AM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
337	MEMORY TX		912037766438	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LAURIE KENNINGTON

FAX: 12037766438

AGENCY: UNITE HERE LOCAL 34

FROM: PAOLO FIDUCIA

DATE: 05/29/2014 **Time:** 10:15 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-CON
Ruling on a Petition filed by Unite Here Local 34

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (MAY. 29. 2014 10:20AM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 29. 2014 10:19AM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
338	MEMORY TX		918607606493	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOHN D. BLAIR, ESQ.

FAX: 18607606493

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 05/29/2014 **Time:** 10:15 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-CON
Ruling on a Petition filed by Unite Here Local 34

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: Fiducia, Paolo
Sent: Wednesday, June 04, 2014 11:39 AM
To: Olejarz, Barbara
Cc: Greer, Leslie
Subject: FW: Additional Questions
Attachments: Volumes and Services for CON Request-OCHA.xlsx

FYI

From: Sitler, Michele [mailto:msitler@gaylord.org]
Sent: Tuesday, May 27, 2014 4:19 PM
To: Riggott, Kaila
Cc: Fiducia, Paolo
Subject: RE: Additional Questions

Kaila,

Attached is the information you requested this morning.
Please let me know if you need anything else.

Regards,

Michele Sitler
Executive Assistant
Gaylord Hospital
Gaylord Farm Road, Box 400
Wallingford, Connecticut 06492
203-284-2741 -Phone
203-741-3408- Fax
Msitler@gaylord.org

Gaylord Specialty Healthcare
Care beyond the ordinary.

From: Riggott, Kaila [mailto:Kaila.Riggott@ct.gov]
Sent: Tuesday, May 27, 2014 9:56 AM
To: Sitler, Michele
Cc: Fiducia, Paolo
Subject: RE: Additional Questions

Thank you very much Michele.

From: Sitler, Michele [mailto:msitler@gaylord.org]
Sent: Tuesday, May 27, 2014 9:34 AM
To: Riggott, Kaila
Subject: RE: Additional Questions

Kaila,

I can see from the email address used below that Janine never received this email. The email address is incorrect. It was Janine.Epright@gaylord.org. I will need to see who can help with this information. I will get back to you to let you know when it will be done.

Regards,

Michele Sitler
Executive Assistant
Gaylord Hospital
Gaylord Farm Road, Box 400
Wallingford, Connecticut 06492
203-284-2741 -Phone
203-741-3408- Fax
Msitler@gaylord.org

Gaylord Specialty Healthcare
Care beyond the ordinary.

From: Riggott, Kaila [mailto:Kaila.Riggott@ct.gov]
Sent: Tuesday, May 27, 2014 9:23 AM
To: Sitler, Michele
Cc: Fiducia, Paolo
Subject: FW: Additional Questions

Here is the file that was sent to Janine on 4/22. Thanks very much for your help.

From: Fiducia, Paolo
Sent: Tuesday, April 22, 2014 2:25 PM
To: epright@gaylord.org
Cc: Riggott, Kaila; Carney, Brian
Subject: Additional Questions

Hi Janine,

Please complete the following two questions for Docket Number 13-31883-CON, Docket Number 13-31884-CON, Docket Number 13-31885-CON, and Docket Number 14-31902-CON:

1.

Table 1: Gaylord Sleep Medicine's Historical and Current Services Volume

Service	FY 2011	FY 2012	FY 2013	FY 2014*

Total				

*(October 1, 2013 – April 30, 2014)

2.**Table 2: Gaylord Sleep Medicine's Historical and Current Payer Mix by volume and by %**

Description	FY 2011		FY 2012		FY 2013		FY 2014**	
	Volume	**%**	**Volume**	**%**	**Volume**	**%**	**Volume**	**%**
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

*Includes managed care activity
**(October 1, 2013 – April 30, 2014)

Please respond by May 6, 2014. If you have any questions regarding the above please contact me.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst
Office of Health Care Access
A DIVISION OF DEPARTMENT OF PUBLIC HEALTH
paolo.fiducia@po.state.ct.us
860.418.7035 Direct Line
860.418.7053 Fax

Our Mission is to preserve and enhance a person's health and function. CONFIDENTIALITY NOTICE: This e-mail transmission, together with any attachments, is intended for the use of the individual or entity to which it is addressed and may contain personal information that is subject to federal, state and other regulatory agency privacy regulations. The authorized recipient of this information should refrain from further disclosure, unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, saving, printing, copying, or action taken in reliance on contents and/or attachment(s) of this message is strictly prohibited, and the original sender should be promptly notified.

Gaylord Hospital, Inc.
Sleep Volume Data - North Haven
FY 2011,2012,2013, FYTD 2014

Provided Services

Service	FY 2011	FY 2012	FY 2013	FY 2014
Study/Interp	2,627	2,343	1,951	1,078
Initial Eval	1,639	1,394	1,625	960
Follow Up	2,015	2,177	2,077	996
PAP NAP	-	62	69	34
CLINIC	2,076	2,546	2,538	1,268
Other	221	680	787	451
Total	8,578	9,202	9,047	4,787

Volume and Payor Mix	Volume FY 11	% FY 11	Volume FY 12	% FY 12	Volume FY 13	% FY 13	Volume FY 14	% FY 14
Medicare	1,943	23%	2,055	22%	2,070	23%	1,078	23%
Medicaid	2,069	24%	2,335	25%	2,080	23%	1,135	24%
Tricare	20	0%	13	0%	9	0%	12	0%
Total Government	4,032	47%	4,403	48%	4,159	46%	2,225	46%
Commercial	4,529	53%	4,791	52%	4,859	54%	2,549	53%
Uninsured	17	0%	8	0%	29	0%	13	0%
Worker's Comp	-	0%	-	0%	-	0%		0%
Total Non-Governement	4,546	53%	4,799	52%	4,888	54%	2,562	54%
Total All	8,578	100%	9,202	100%	9,047	100%	4,787	100%
	-		-		-			

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 10, 2014

VIA FAX ONLY

John D. Blair, Esq.
Blair Law, LLC
P.O. Box 141
Rocky Hill, CT 06067

RE: Certificate of Need Application; Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Services at Gaylord Hospital Sleep Medicine in North Haven

Dear Attorney Blair:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, June 18, 2014, at 3:00 p.m. at Gateway Community College, 20 Church Street, Community Room (N100), New Haven, Connecticut, regarding the Certificate of Need ("CON") application identified above. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. The Applicant's prefiled testimony must be submitted to OHCA on or before the close of business **on Friday, June 13, 2014.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Please contact Paolo Fiducia at (860) 418-7035, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

cc: Laurie Kennington, President, Unite Here Local 34

* * * COMMUNICATION RESULT REPORT (JUN. 10. 2014 8:54AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 10. 2014 8:53AM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
364	MEMORY TX		912037766438	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LAURIE KERRINGTON

FAX: 12037766438

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 06/10/2014 **Time:** 8:45 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-
CON
Applicant
Pre file
Letter

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUN. 10. 2014 8:53AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 10. 2014 8:52AM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
363	MEMORY TX		918607606493	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOHN D. BLAIR, ESQ.

FAX: 18607606493

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 06/10/2014 **Time:** 8:45 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-
CON
Applicant
Pre file
Letter

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

June 11, 2014

Mr. Kevin T. Hansted
Hearing Officer
Office of Healthcare Access
410 Capitol Ave.
Hartford CT 06134-0308

Ref: Docket 13-31884 CON

Dear Mr. Hansted:

Enclosed find pre-filed testimony for John Canham-Clyne, Melissa Dawkins-Doumbia and Gretchen Rose, who will be appearing as witnesses in the above-referenced docket, at the public hearing scheduled for June 18, 2014 at Gateway Community College, New Haven.

Sincerely,

John Canham-Clyne
Deputy Director of Research
UNITE HERE International Union

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Melissa Dawkins-Doumbia
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for hearing June 18, 2014

Good afternoon Mr Hansted. My name is Melissa Dawkins-Doumbia. I live at 24 Daisy St., New Haven CT. I am an administrative assistant in the Internal Medicine Department at Yale University. Throughout my time working at Yale Sleep Medicine, it became clear that Yale-New Haven Hospital was taking over the practice.

Before Christmas in 2013, I was temping at the Sleep Medicine lab at 40 Temple Street in New Haven. I then left the sleep lab when I got my new position in Internal Medicine. In the meantime, a few staff from the sleep lab had been laid off.

I returned to help the Sleep Medicine lab because it stayed open after the rest of the staff was laid off. However, the clinic moved over to 784 Howard Avenue in New Haven where they continued to see patients until Yale-New Haven Hospital opens its clinics in North Haven and Madison. We were told that the clinics will have Yale Medical Group doctors but Yale-New Haven Hospital administrators and staff.

The patients were told that they would be transitioned and that their care would be continued by the hospital. They were not told about any facility fees associated with being seen at the hospital, just that they could see the same doctor but at a different facility with different staff. I was instructed by management to tell patients:

> "Yale-New Haven Hospital will be opening up a sleep center. They will be taking over our practice. All of your charts and medical records will be switched over to the hospital."

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Gretchen Rose
Before the Office of Health Care Access
RE: Docket No. 12-31884 CON
Pre-filed for

My name is Gretchen Rose and I live at 1353 N. Stone St., W. Suffield, CT. I worked at the Yale University Sleep Lab at 40 Temple Street in New Haven until I was laid off last December.

I have worked for Yale University Sleep Medicine for 15 years, since 1998. When I started, I worked in the Guilford lab. In 1999, Yale opened a lab in Norwich which I was moved to, and a few years later, the lab in New Haven on Temple Street.

About 2 ½ to 3 years ago, the Norwich lab closed. One employee was laid off and the rest were consolidated into the Guilford and New Haven labs. In January 2013, the Guilford lab closed and we were all combined into the New Haven lab.

In October 2013, management conducted a mandatory meeting. They told us they were closing the sleep lab at 40 Temple Street effective January 6, 2014. We asked if the clinic was being purchased by Yale-New Haven Hospital. For a while, management denied that it was. Our manager told us that we could tell patients that we were moving and that they could be seen at the Yale Physicians Building on Howard Avenue. She said that we would no longer be conducting overnight studies. We saw our last patient right before Christmas.

The University denied that Yale-New Haven Hospital was taking control of the practice. They told us that it was not happening, that they didn't know where we were hearing that from. It is not an option. Yale-New Haven had talked to the University earlier but nothing came of it. It was denials everywhere.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of John Canham-Clyne
Deputy Director of Research, UNITE HERE International Union
On behalf of UNITE HERE Local 34
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for Hearing June 18, 2014

Good afternoon, Mr. Hansted. On behalf of the 3,700 members of UNITE HERE Local 34, thank you for holding this hearing, and, in particular, for ensuring that the citizens of New Haven, who will be most affected by this case, have an opportunity to be heard. This pre-filed testimony incorporates by reference the affidavits attached to our letter of April 8, 2014 requesting a hearing and status.

Local 34 sought status in this case for two reasons. First, we represent roughly 900 clerical and technical employees in the clinical practices of the Yale University School of Medicine. Among those are 11 employees of the Yale Medical Group's sleep laboratory who have been laid off as a result of the transactions in front of the Office.

Second, UNITE HERE Locals in Connecticut represent thousands of patients who are struggling to cope with the increasing costs and the access challenges of a rapidly transforming health care system. Those costs manifest themselves both as increased individual out of pocket costs at the point of service, and in increasingly contentious collective bargaining negotiations.

We believe that this hearing and the docket before you must address the following issues:

1. Yale-New Haven Hospital must file a Certificate of Need for the purchase of Gaylord's assets in North Haven.
2. The case must be reviewed in its entirety. This is a complex, three-sided transaction in which Yale-New Haven Hospital is taking over the practice of sleep medicine from Yale Medical School, purchasing Gaylord's North Haven assets and consolidating services in suburban locations as Gaylord closes its other facilities.
3. This consolidation presents challenges for at-risk populations. Former and potential patients from New Haven's low-income communities of color may struggle with the proposed geographic changes.
4. The transaction in its entirety may raise costs at the point of service, both to individual patients and institutional payers, with a demonstrated effect on access.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

5. The effect of the transactions has been to force highly experienced workers to choose between maintaining their salaries, job security, retirement and health care benefits, and continuing to work in the field of sleep medicine. This diminishes the pool of trained employees in the field.

Yale-New Haven Hospital Must File a Certificate of Need

The transaction as described to OHCA in the original Certificate of Need is fictitious. Gaylord is not "terminating" its sleep medicine operations in North Haven. It is closing its other sleep medicine facilities, but transferring its North Haven sleep medicine assets to Yale-New Haven Hospital, which will continue providing service at the North Haven location. There is voluminous evidence on the record for this fact.

The original CoN omitted any mention of an asset transfer. However, upon request for further information from OHCA, the Applicant submitted a letter that mentioned in passing a "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital...."[1] Similarly, the draft notice to patients attached to the completed CoN states "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations." [2]

The transfer of ownership of a health care facility requires a Certificate of Need. Additionally, by adding Applicant's North Haven assets, Yale-New Haven Hospital will create an "an increase of the licensed bed capacity of a health care facility," which also triggers a Certificate of Need.

The Transaction Must be Reviewed in its Entirety

The transfer of Gaylord Hospital's North Haven assets to Yale-New Haven Hospital is one part of a complex three-sided transaction. Yale-New Haven Hospital is assuming control of Yale University's sleep medicine practice, purchasing the assets of Gaylord's North Haven operations and consolidating services in suburban locations.

Prior to the filing of Gaylord's CoN, Yale University serially closed its sleep medicine laboratories in Norwich, Guilford and New Haven, beginning three years ago with the Norwich facility. By October 2013, Clerical and Technical employees at each site had been given layoff notices. In December, the Yale Medical Group mailed notices to patients informing them that YMG physicians would continue to see them at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[3]

---

[1] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

[2] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.

[3] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.

After YMG laid off its clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."[4] This directive from YMG management clearly suggests that YNHH is taking over YMG's practice.

The closure of the University's sleep labs, the "termination" of Gaylord's sleep services, and the opening of Yale-New Haven sleep facilities in North Haven and Madison are not unrelated, coincidentally timed transactions. For OHCA to proceed as if that were the case would be a disservice to the public. The transaction must be evaluated in its entirety to properly determine its full impact on the health care system.

Indeed, to fully understand what is happening in the market for sleep medicine, the closure of Gaylord Hospital's Trumbull, Glastonbury and Guilford operations must be evaluated in the context of the closure of Yale Medical Group's three facilities as well. Obviously, the development of home sleep testing is shrinking the need for site-based sleep labs. However, six closures in the space of 36 months, five of them within the last 18 months, constitutes dramatic change in the market.

For OHCA to discharge its responsibility to the public, the Office cannot view sweeping marketplace changes in a vacuum. Even viewing the closing of Gaylord's multiple sites likely would not give the Office sufficient scope to understand and review the impact of market changes on sleep medicine patients. Only by bringing the dominant market actor that is driving these changes, Yale-New Haven Hospital, under scrutiny for its impact on cost and access can the entire picture of the consolidation of sleep medicine services in Connecticut be explained to the public.

Regional Consolidation as Proposed Poses Threats to Access for At-Risk Populations

The consolidation of regional sleep medicine services in suburban locations poses a potential threat to at-risk populations. In the CoN deemed complete, the Applicant claims:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[5]

Further, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

---

[4] Affidavit by Melissa Dawkins, March 17, 2014.

[5] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[6] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

The Transaction in its Entirety May Raise Costs to Individual Patients and Institutional Payers

The Centers for Medicare and Medicaid Services (CMS) issued regulations in 2002 permitting hospitals to designate physician practices that they control as parts of an outpatient department, even when such facilities are miles from the hospital's core campus. Such a designation allows the hospital to bill for what were once physician office visits as if they were visits to the hospital itself. "Hospital-based," or "Provider-based" billing allows hospitals to charge much higher prices for services that are often indistinguishable from those provided at lower cost in a physician office setting – most commonly by the addition of "facility fees" on top of physicians' professional fees.

The Congressional Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare spends an additional $2 billion a year on provider-based services that cannot reasonably be distinguished from those provided in doctors' offices. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[7]

The trend toward provider-based billing for services that can be provided safely in doctor's offices has raised serious concerns among federal and state policymakers. MedPAC has been advising Congress to equalize billing for equivalent services for two years.[8] Connecticut Attorney General George Jepsen issued a report in April 2014, which concluded

> The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.[9]

---

[6] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.
[7] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[8] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[9] Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April, 2014, Pg. 2

Dramatic increases in billing for physician services – and especially the shift to hospital-based charges – have arrived in Connecticut at the worst possible moment. Patients are increasingly enrolled in plans with large copays and high deductibles. As the Attorney General notes:

> A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional hospital setting and specialty care and routine services were provided by primary care physicians
> and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.5Likewise, in 2006 10% of employer health plans had a deductible of at least $1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.6 It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

Thus, just as consumers are becoming responsible for more costs, and government and private payers are trying to shift care from higher cost settings to more appropriate venues, large numbers of physician practices are now "provider-based." A patient who might have paid a $40 specialist copay for an office visit may still pay that fee, but later receive a bill for a several hundred dollar copay for the facility, or worse, a $1,000+ deductible payment for outpatient hospital services. The consequences can be devastating for individuals.

OHCA should examine carefully the payment history for Sleep Medicine services, not only at Applicant's facilities, which are reportedly provider-based, but at the Yale Medical Group as well. The portion of the patients at Yale-New Haven's successor facility to the Applicant's that are transitioning from the Yale Medical Group sleep center may face facility fees and other increased costs for the first time.

Our members experience this phenomenon on a regular basis. Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[10]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors' visits or cease treatment all together.

Consolidation Diminishes the Pool of Skilled Workers

---

[10] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

11 technicians were laid off by Yale Medical Group's sleep center when it closed its three locations. The workers were told that they could take advantage of Local 34's layoff protections and seek employment in another occupation within the University.

To remain in their chosen field, the technicians were told that they could apply to work with Yale-New Haven Hospital as their employer, but with loss of seniority, lower wages, and poorer benefits.

In order to capture the financial rewards of "provider-based billing," Yale University and Yale-New Haven Hospital now share clinics. Ms. Timpko's transplant clinic, as noted above, is nominally managed by Yale-New Haven Hospital. But the clinic retains both University physicians and University workers.

When Yale-New Haven Hospital took over the University practice, it chose to push seasoned professionals out of the field, or require them to take pay and benefits cuts.

Conclusion

Applicant is not terminating services in North Haven, it is transferring assets to Yale-New Haven Hospital.

OHCA should:

- Deny Applicant's request for a Certificate of Need
- Require Yale-New Haven Hospital and Applicant to file a Certificate of Need for the transfer of Applicant's North Haven assets or;
- Consider the impact of the closures of all Gaylord facilities plus the Yale University sleep labs in determining the result of the new Certificate of need.

Whether OHCA formally chooses to bring these major changes in the sleep center market together in a single case or not, the following questions must be addressed:

- What impact will the takeover of YMG's clinic by Yale-New Haven Hospital have on individual out of pocket costs and institutional payer costs?
- What is Yale-New Haven Hospital's plan to ensure access to sleep medicine services for at-risk urban populations?
- Will there be adequate overall system capacity following the transactions.

WWW.BLAIRLAWLLC.COM

BLAIR | LAW

TEL: 860.280.4059
FAX: 860.760.6493
P.O. BOX 141
ROCKY HILL, CT 06067

VIA Hand Delivery

June 13, 2014

Lisa A. Davis, Deputy Commissioner
Department of Public Health - Office of Health Care Access
410 Capital Avenue MS # 13HCA
PO Box 340308
Hartford, CT 06134-0308

Docket No.: 13-31884-CON
Applicant: Gaylord Hospital
Proposal: Termination of Sleep Medicine Services

Dear Deputy Commissioner Davis:

Pursuant to Section 19a-9-29(e) of Regulations of Connecticut State Agencies, enclosed for filing in the above-captioned Docket are originals and two (2) copies of the pre-filed testimony of George Kyriacou, President and CEO of Gaylord Specialty Healthcare.

Thank you for consideration of this matter.

Respectfully,

John D. Blair

BEFORE DEPARTMENT OF PUBLIC HEALTH DIVISION OFFICE OF HEALTH CARE ACCESS	DOCKET NO. 13-31884-CON
IN RE GAYLORD HOSPITAL TERMINATION OF SLEEP MEDICINE SERVICES	JUNE 13, 2014

Pre-Filed Testimony of
George Kyriacou, President & CEO

Good Morning, Hearing Officer Hansted and Office of Health Care Access staff. My name is George Kyriacou; I am President and CEO of Gaylord Specialty Healthcare. I have served in this capacity since November 2011. Prior to becoming President and CEO at Gaylord, I was the CEO of a 106 bed Community Hospital in PA from 2008 – 2011. I also served as the COO of MidState Medical Center in Meriden, CT in 2008 and I was the VP of Network Development at Hartford HealthCare in Hartford, CT from 1996 to 2008, and was previously VP for Operations at MidState Medical Center from 1988 to 1996. I thank you for the opportunity to come before you today to share with you Gaylord Hospital's decision to discontinue sleep medicine services that we believe is in the best interest of our patients and our organization.

Gaylord Sleep Medicine-North Haven is a provider-based outpatient department of Gaylord Hospital. The Center, located in North Haven, is equipped for day and overnight sleep testing as well as CPAP therapy. The sleep service program at the North Haven location consists of 12 beds operating 7 nights a week. The services include diagnostic polysomnography, split-night polysomnography and therapeutic polysomnography.

Gaylord Hospital filed a certificate of need determination letter on August 1, 2006 to terminate sleep medicine services in Wallingford and New Haven and establish sleep medicine services in North Haven. On January 4, 2007, OHCA received the certificate of need application from Gaylord Hospital seeking authorization to discontinue two sleep laboratories located at Gaylord Farms Road, Wallingford, and 1 Long Wharf Drive, New Haven and to establish a sleep

laboratory at 8 Devine Street, North Haven, Connecticut, and increase the capacity from eleven to twelve beds. This CON was approved, and sleep medicine services continued to be provided in North Haven for the past 8 years. Subsequently, Gaylord Hospital filed a CON to discontinue sleep medicine services in North Haven and three other locations on December 30, 2013.

While the closure of the North Haven location is the subject of this hearing, I believe it should be viewed in the context of Gaylord's management decision to discontinue providing sleep medicine services in general. The decision to discontinue sleep medicine services at North Haven and 3 other sleep medicine locations was based on a variety of factors. As management of Gaylord Specialty Healthcare assessed the changing health care environment, during its strategic planning process, the decision was made to concentrate its limited resources on its core inpatient and outpatient health care services for complex rehabilitation and medically complex patients. Additional factors in the decision to discontinue sleep medicine services included diminished in-lab patient volume, changing models of delivery and unnecessary duplication of services since sleep medicine is provided by many other providers in the markets Gaylord serves. The enhanced technology and changes in the clinical practice of sleep medicine has resulted in a shift from in-lab studies to home studies with a much different reimbursement structure.

The table below is included in our application and shows that sleep study volume in North Haven has been declining over the course of the last 3 years. Physician referrals and direct patient referrals have also declined.

Table 1: Historical and Current Visits & Admissions (MSLT and Sleep Studies)

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***
	FY 2011	FY 2012	FY 2103	FY2014 YTD
Sleep Medicine	2627	2343	1951	1078
Total	**2627**	**2343**	**1951**	**1078**

Gaylord fiscal year (October 1-Septmmber 20)

*Oct – May 2014 YTD

Faced with the above, Gaylord management had to make a decision to assure continuity of care and continued access to high quality care (AASM-certified) for sleep medicine patients. Gaylord Sleep Medicine-North Haven, Yale New Haven Hospital and Connecticut Children's Medical Center worked collaboratively to ensure a seamless transition of the clinical service for our

patients. YNHH is able to assume care for adult patients and CCMC will assume care of pediatric population. CCMC has already opened their new center in Farmington and 50 percent of our pediatric population from our Glastonbury location has moved over. Gaylord Sleep Medicine-North Haven will notify patients of the availability of sleep medicine services provided by the sleep program affiliated with YNHH for adult patients and CCMC Sleep program for pediatric patients.

In closing, I want make it clear that Gaylord Hospital carefully arrived at decision to stop providing sleep medicine services and by collaborating with YNHH and CCMC who will assume responsibility for sleep services, will result in patients having continued access and to the highest quality of care. Thank you for the opportunity to come before you today. If you have any questions I would be glad to answer them.

Respectfully Submitted,

George Kyriacou, President & CEO
Gaylord Specialty Healthcare

* * * COMMUNICATION RESULT REPORT (JUN. 16. 2014 1:33PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 16. 2014 1:32PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
385	MEMORY TX		912037766438	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LAURIE KENNINGTON, PRESIDENT

FAX: (203) 776-6438

AGENCY: UNITE HERE LOCAL 34

FROM: OHCA

DATE: 6/16/14

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31884-CON Prefile Testimony of Applicant

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: Lazarus, Steven
Sent: Monday, June 16, 2014 1:58 PM
To: John Blair
Cc: Greer, Leslie
Subject: FW: Gaylord Hospital
Attachments: 31884_201406111638.pdf

John,

Since Paolo has been out and only in briefly, just wanted to make sure you received this.

Thanks,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Greer, Leslie
Sent: Monday, June 16, 2014 1:51 PM
To: Lazarus, Steven
Subject: Gaylord Hospital

Here you go & please cc me, thanks.

From: Greer, Leslie
Sent: Wednesday, June 11, 2014 4:43 PM
To: Fiducia, Paolo; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Gaylord Hospital

Attached are prefile testimonies for Gaylord Hospital.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Please consider the environment before printing this message

June 11, 2014

Mr. Kevin T. Hansted
Hearing Officer
Office of Healthcare Access
410 Capitol Ave.
Hartford CT 06134-0308

Ref: Docket 13-31884 CON

Dear Mr. Hansted:

Enclosed find pre-filed testimony for John Canham-Clyne, Melissa Dawkins-Doumbia and Gretchen Rose, who will be appearing as witnesses in the above-referenced docket, at the public hearing scheduled for June 18, 2014 at Gateway Community College, New Haven.

Sincerely,

John Canham-Clyne
Deputy Director of Research
UNITE HERE International Union

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Melissa Dawkins-Doumbia
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for hearing June 18, 2014

Good afternoon Mr Hansted. My name is Melissa Dawkins-Doumbia. I live at 24 Daisy St., New Haven CT. I am an administrative assistant in the Internal Medicine Department at Yale University. Throughout my time working at Yale Sleep Medicine, it became clear that Yale-New Haven Hospital was taking over the practice.

Before Christmas in 2013, I was temping at the Sleep Medicine lab at 40 Temple Street in New Haven. I then left the sleep lab when I got my new position in Internal Medicine. In the meantime, a few staff from the sleep lab had been laid off.

I returned to help the Sleep Medicine lab because it stayed open after the rest of the staff was laid off. However, the clinic moved over to 784 Howard Avenue in New Haven where they continued to see patients until Yale-New Haven Hospital opens its clinics in North Haven and Madison. We were told that the clinics will have Yale Medical Group doctors but Yale-New Haven Hospital administrators and staff.

The patients were told that they would be transitioned and that their care would be continued by the hospital. They were not told about any facility fees associated with being seen at the hospital, just that they could see the same doctor but at a different facility with different staff. I was instructed by management to tell patients:

> "Yale-New Haven Hospital will be opening up a sleep center. They will be taking over our practice. All of your charts and medical records will be switched over to the hospital."

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Gretchen Rose
Before the Office of Health Care Access
RE: Docket No. 12-31884 CON
Pre-filed for

My name is Gretchen Rose and I live at 1353 N. Stone St., W. Suffield, CT. I worked at the Yale University Sleep Lab at 40 Temple Street in New Haven until I was laid off last December.

I have worked for Yale University Sleep Medicine for 15 years, since 1998. When I started, I worked in the Guilford lab. In 1999, Yale opened a lab in Norwich which I was moved to, and a few years later, the lab in New Haven on Temple Street.

About 2 ½ to 3 years ago, the Norwich lab closed. One employee was laid off and the rest were consolidated into the Guilford and New Haven labs. In January 2013, the Guilford lab closed and we were all combined into the New Haven lab.

In October 2013, management conducted a mandatory meeting. They told us they were closing the sleep lab at 40 Temple Street effective January 6, 2014. We asked if the clinic was being purchased by Yale-New Haven Hospital. For a while, management denied that it was. Our manager told us that we could tell patients that we were moving and that they could be seen at the Yale Physicians Building on Howard Avenue. She said that we would no longer be conducting overnight studies. We saw our last patient right before Christmas.

The University denied that Yale-New Haven Hospital was taking control of the practice. They told us that it was not happening, that they didn't know where we were hearing that from. It is not an option. Yale-New Haven had talked to the University earlier but nothing came of it. It was denials everywhere.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of John Canham-Clyne
Deputy Director of Research, UNITE HERE International Union
On behalf of UNITE HERE Local 34
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for Hearing June 18, 2014

Good afternoon, Mr. Hansted. On behalf of the 3,700 members of UNITE HERE Local 34, thank you for holding this hearing, and, in particular, for ensuring that the citizens of New Haven, who will be most affected by this case, have an opportunity to be heard. This pre-filed testimony incorporates by reference the affidavits attached to our letter of April 8, 2014 requesting a hearing and status.

Local 34 sought status in this case for two reasons. First, we represent roughly 900 clerical and technical employees in the clinical practices of the Yale University School of Medicine. Among those are 11 employees of the Yale Medical Group's sleep laboratory who have been laid off as a result of the transactions in front of the Office.

Second, UNITE HERE Locals in Connecticut represent thousands of patients who are struggling to cope with the increasing costs and the access challenges of a rapidly transforming health care system. Those costs manifest themselves both as increased individual out of pocket costs at the point of service, and in increasingly contentious collective bargaining negotiations.

We believe that this hearing and the docket before you must address the following issues:

1. Yale-New Haven Hospital must file a Certificate of Need for the purchase of Gaylord's assets in North Haven.
2. The case must be reviewed in its entirety. This is a complex, three-sided transaction in which Yale-New Haven Hospital is taking over the practice of sleep medicine from Yale Medical School, purchasing Gaylord's North Haven assets and consolidating services in suburban locations as Gaylord closes its other facilities.
3. This consolidation presents challenges for at-risk populations. Former and potential patients from New Haven's low-income communities of color may struggle with the proposed geographic changes.
4. The transaction in its entirety may raise costs at the point of service, both to individual patients and institutional payers, with a demonstrated effect on access.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

5. The effect of the transactions has been to force highly experienced workers to choose between maintaining their salaries, job security, retirement and health care benefits, and continuing to work in the field of sleep medicine. This diminishes the pool of trained employees in the field.

Yale-New Haven Hospital Must File a Certificate of Need

The transaction as described to OHCA in the original Certificate of Need is fictitious. Gaylord is not "terminating" its sleep medicine operations in North Haven. It is closing its other sleep medicine facilities, but transferring its North Haven sleep medicine assets to Yale-New Haven Hospital, which will continue providing service at the North Haven location. There is voluminous evidence on the record for this fact.

The original CoN omitted any mention of an asset transfer. However, upon request for further information from OHCA, the Applicant submitted a letter that mentioned in passing a "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital...."[1] Similarly, the draft notice to patients attached to the completed CoN states "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations." [2]

The transfer of ownership of a health care facility requires a Certificate of Need. Additionally, by adding Applicant's North Haven assets, Yale-New Haven Hospital will create an "an increase of the licensed bed capacity of a health care facility," which also triggers a Certificate of Need.

The Transaction Must be Reviewed in its Entirety

The transfer of Gaylord Hospital's North Haven assets to Yale-New Haven Hospital is one part of a complex three-sided transaction. Yale-New Haven Hospital is assuming control of Yale University's sleep medicine practice, purchasing the assets of Gaylord's North Haven operations and consolidating services in suburban locations.

Prior to the filing of Gaylord's CoN, Yale University serially closed its sleep medicine laboratories in Norwich, Guilford and New Haven, beginning three years ago with the Norwich facility. By October 2013, Clerical and Technical employees at each site had been given layoff notices. In December, the Yale Medical Group mailed notices to patients informing them that YMG physicians would continue to see them at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[3]

---

[1] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

[2] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.

[3] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.

After YMG laid off its clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."[4] This directive from YMG management clearly suggests that YNHH is taking over YMG's practice.

The closure of the University's sleep labs, the "termination" of Gaylord's sleep services, and the opening of Yale-New Haven sleep facilities in North Haven and Madison are not unrelated, coincidentally timed transactions. For OHCA to proceed as if that were the case would be a disservice to the public. The transaction must be evaluated in its entirety to properly determine its full impact on the health care system.

Indeed, to fully understand what is happening in the market for sleep medicine, the closure of Gaylord Hospital's Trumbull, Glastonbury and Guilford operations must be evaluated in the context of the closure of Yale Medical Group's three facilities as well. Obviously, the development of home sleep testing is shrinking the need for site-based sleep labs. However, six closures in the space of 36 months, five of them within the last 18 months, constitutes dramatic change in the market.

For OHCA to discharge its responsibility to the public, the Office cannot view sweeping marketplace changes in a vacuum. Even viewing the closing of Gaylord's multiple sites likely would not give the Office sufficient scope to understand and review the impact of market changes on sleep medicine patients. Only by bringing the dominant market actor that is driving these changes, Yale-New Haven Hospital, under scrutiny for its impact on cost and access can the entire picture of the consolidation of sleep medicine services in Connecticut be explained to the public.

Regional Consolidation as Proposed Poses Threats to Access for At-Risk Populations

The consolidation of regional sleep medicine services in suburban locations poses a potential threat to at-risk populations. In the CoN deemed complete, the Applicant claims:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[5]

Further, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

---

[4] Affidavit by Melissa Dawkins, March 17, 2014.

[5] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[6] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

The Transaction in its Entirety May Raise Costs to Individual Patients and Institutional Payers

The Centers for Medicare and Medicaid Services (CMS) issued regulations in 2002 permitting hospitals to designate physician practices that they control as parts of an outpatient department, even when such facilities are miles from the hospital's core campus. Such a designation allows the hospital to bill for what were once physician office visits as if they were visits to the hospital itself. "Hospital-based," or "Provider-based" billing allows hospitals to charge much higher prices for services that are often indistinguishable from those provided at lower cost in a physician office setting – most commonly by the addition of "facility fees" on top of physicians' professional fees.

The Congressional Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare spends an additional $2 billion a year on provider-based services that cannot reasonably be distinguished from those provided in doctors' offices. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[7]

The trend toward provider-based billing for services that can be provided safely in doctor's offices has raised serious concerns among federal and state policymakers. MedPAC has been advising Congress to equalize billing for equivalent services for two years.[8] Connecticut Attorney General George Jepsen issued a report in April 2014, which concluded

> The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.[9]

---

[6] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.
[7] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[8] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[9] Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April, 2014, Pg. 2

Dramatic increases in billing for physician services – and especially the shift to hospital-based charges – have arrived in Connecticut at the worst possible moment. Patients are increasingly enrolled in plans with large copays and high deductibles. As the Attorney General notes:

> A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional hospital setting and specialty care and routine services were provided by primary care physicians
> and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.5Likewise, in 2006 10% of employer health plans had a deductible of at least $1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.6 It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

Thus, just as consumers are becoming responsible for more costs, and government and private payers are trying to shift care from higher cost settings to more appropriate venues, large numbers of physician practices are now "provider-based." A patient who might have paid a $40 specialist copay for an office visit may still pay that fee, but later receive a bill for a several hundred dollar copay for the facility, or worse, a $1,000+ deductible payment for outpatient hospital services. The consequences can be devastating for individuals.

OHCA should examine carefully the payment history for Sleep Medicine services, not only at Applicant's facilities, which are reportedly provider-based, but at the Yale Medical Group as well. The portion of the patients at Yale-New Haven's successor facility to the Applicant's that are transitioning from the Yale Medical Group sleep center may face facility fees and other increased costs for the first time.

Our members experience this phenomenon on a regular basis. Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[10]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors' visits or cease treatment all together.

Consolidation Diminishes the Pool of Skilled Workers

---

[10] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

11 technicians were laid off by Yale Medical Group's sleep center when it closed its three locations. The workers were told that they could take advantage of Local 34's layoff protections and seek employment in another occupation within the University.

To remain in their chosen field, the technicians were told that they could apply to work with Yale-New Haven Hospital as their employer, but with loss of seniority, lower wages, and poorer benefits.

In order to capture the financial rewards of "provider-based billing," Yale University and Yale-New Haven Hospital now share clinics. Ms. Timpko's transplant clinic, as noted above, is nominally managed by Yale-New Haven Hospital. But the clinic retains both University physicians and University workers.

When Yale-New Haven Hospital took over the University practice, it chose to push seasoned professionals out of the field, or require them to take pay and benefits cuts.

Conclusion

Applicant is not terminating services in North Haven, it is transferring assets to Yale-New Haven Hospital.

OHCA should:

- Deny Applicant's request for a Certificate of Need
- Require Yale-New Haven Hospital and Applicant to file a Certificate of Need for the transfer of Applicant's North Haven assets or;
- Consider the impact of the closures of all Gaylord facilities plus the Yale University sleep labs in determining the result of the new Certificate of need.

Whether OHCA formally chooses to bring these major changes in the sleep center market together in a single case or not, the following questions must be addressed:

- What impact will the takeover of YMG's clinic by Yale-New Haven Hospital have on individual out of pocket costs and institutional payer costs?
- What is Yale-New Haven Hospital's plan to ensure access to sleep medicine services for at-risk urban populations?
- Will there be adequate overall system capacity following the transactions.

Greer, Leslie

From: Greer, Leslie
Sent: Monday, June 16, 2014 5:15 PM
To: Fiducia, Paolo; Riggott, Kaila; Hansted, Kevin; Lazarus, Steven; Martone, Kim
Cc: john@blairlawllc.com
Subject: Gaylord Hospital Hearing
Attachments: 31884-9.pdf

Attached is a Notice of Appearance on behalf of the Intervenor.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

DANIEL E. LIVINGSTON
OREGO D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY E MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1933-2008

RECEIVED
JUN 16 2014
Office of HEALTHCARE ACCESS

DATE: 6/16/14 TIME:

TO: Office of Health Care Access FAX NO: 860-418-7053

FROM: Henry Murray

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET)

SPECIAL INSTRUCTIONS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL 2.

THIS MESSAGE IS ONLY FOR THE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. Any dissemination, distribution or copying of this communication other than by the intended recipient is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect), and destroy all copies of this communication. Thank you.

DEPARTMENT OF PUBLIC HEALTH
STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

Docket Number: **13-31884-CON**

APPEARANCE

Please enter my appearance before the Office of Health Care Access in the above captioned matter on behalf of intervenor, UNITE HERE Local 34.

Henry F. Murray, Esq.
LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821 (T)
860.232.7818 (F)
hfmurray@lapm.org

* * * COMMUNICATION RESULT REPORT (JUN. 17. 2014 11:19AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 17. 2014 11:18AM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
388 MEMORY TX		98602327818	OK	6/6

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: HENRY MURRY

FAX: (860) 232-7818

AGENCY: LIVINGSTON, ADLER, PULDA MEIKLEJOHN & KELLY, P.C.

FROM: OHCA

DATE: 6/17/14

NUMBER OF PAGES: 6
(including transmittal sheet

Comments: DN: 13-31884-CON Applicant Prefile Testimony

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

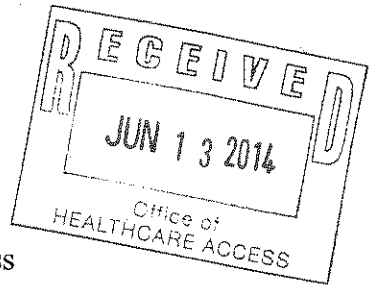
Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

WWW.BLAIRLAWLLC.COM

BLAIR | LAW

TEL: 860.280.4059
FAX: 860.760.6493
P.O. BOX 141
ROCKY HILL, CT 06067



VIA Hand Delivery

June 13, 2014

Lisa A. Davis, Deputy Commissioner
Department of Public Health - Office of Health Care Access
410 Capital Avenue MS # 13HCA
PO Box 340308
Hartford, CT 06134-0308

Docket No.: 13-31884-CON
Applicant: Gaylord Hospital
Proposal: Termination of Sleep Medicine Services

Dear Deputy Commissioner Davis:

Pursuant to Section 19a-9-29(e) of Regulations of Connecticut State Agencies, enclosed for filing in the above-captioned Docket are originals and two (2) copies of the pre-filed testimony of George Kyriacou, President and CEO of Gaylord Specialty Healthcare.

Thank you for consideration of this matter.

Respectfully,

John D. Blair

BEFORE DEPARTMENT OF PUBLIC HEALTH DIVISION OFFICE OF HEALTH CARE ACCESS	DOCKET NO. 13-31884-CON
IN RE GAYLORD HOSPITAL TERMINATION OF SLEEP MEDICINE SERVICES	JUNE 13, 2014

Pre-Filed Testimony of
George Kyriacou, President & CEO

Good Morning, Hearing Officer Hansted and Office of Health Care Access staff. My name is George Kyriacou; I am President and CEO of Gaylord Specialty Healthcare. I have served in this capacity since November 2011. Prior to becoming President and CEO at Gaylord, I was the CEO of a 106 bed Community Hospital in PA from 2008 – 2011. I also served as the COO of MidState Medical Center in Meriden, CT in 2008 and I was the VP of Network Development at Hartford HealthCare in Hartford, CT from 1996 to 2008, and was previously VP for Operations at MidState Medical Center from 1988 to 1996. I thank you for the opportunity to come before you today to share with you Gaylord Hospital's decision to discontinue sleep medicine services that we believe is in the best interest of our patients and our organization.

Gaylord Sleep Medicine-North Haven is a provider-based outpatient department of Gaylord Hospital. The Center, located in North Haven, is equipped for day and overnight sleep testing as well as CPAP therapy. The sleep service program at the North Haven location consists of 12 beds operating 7 nights a week. The services include diagnostic polysomnography, split-night polysomnography and therapeutic polysomnography.

Gaylord Hospital filed a certificate of need determination letter on August 1, 2006 to terminate sleep medicine services in Wallingford and New Haven and establish sleep medicine services in North Haven. On January 4, 2007, OHCA received the certificate of need application from Gaylord Hospital seeking authorization to discontinue two sleep laboratories located at Gaylord Farms Road, Wallingford, and 1 Long Wharf Drive, New Haven and to establish a sleep

laboratory at 8 Devine Street, North Haven, Connecticut, and increase the capacity from eleven to twelve beds. This CON was approved, and sleep medicine services continued to be provided in North Haven for the past 8 years. Subsequently, Gaylord Hospital filed a CON to discontinue sleep medicine services in North Haven and three other locations on December 30, 2013.

While the closure of the North Haven location is the subject of this hearing, I believe it should be viewed in the context of Gaylord's management decision to discontinue providing sleep medicine services in general. The decision to discontinue sleep medicine services at North Haven and 3 other sleep medicine locations was based on a variety of factors. As management of Gaylord Specialty Healthcare assessed the changing health care environment, during its strategic planning process, the decision was made to concentrate its limited resources on its core inpatient and outpatient health care services for complex rehabilitation and medically complex patients. Additional factors in the decision to discontinue sleep medicine services included diminished in-lab patient volume, changing models of delivery and unnecessary duplication of services since sleep medicine is provided by many other providers in the markets Gaylord serves. The enhanced technology and changes in the clinical practice of sleep medicine has resulted in a shift from in-lab studies to home studies with a much different reimbursement structure.

The table below is included in our application and shows that sleep study volume in North Haven has been declining over the course of the last 3 years. Physician referrals and direct patient referrals have also declined.

Table 1: Historical and Current Visits & Admissions (MSLT and Sleep Studies)

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2011	FY 2012	FY 2103	FY2014 YTD
Sleep Medicine	2627	2343	1951	1078
Total	**2627**	**2343**	**1951**	**1078**

Gaylord fiscal year (October 1-Septmmber 20)

*Oct – May 2014 YTD

Faced with the above, Gaylord management had to make a decision to assure continuity of care and continued access to high quality care (AASM-certified) for sleep medicine patients. Gaylord Sleep Medicine-North Haven, Yale New Haven Hospital and Connecticut Children's Medical Center worked collaboratively to ensure a seamless transition of the clinical service for our

patients. YNHH is able to assume care for adult patients and CCMC will assume care of pediatric population. CCMC has already opened their new center in Farmington and 50 percent of our pediatric population from our Glastonbury location has moved over. Gaylord Sleep Medicine-North Haven will notify patients of the availability of sleep medicine services provided by the sleep program affiliated with YNHH for adult patients and CCMC Sleep program for pediatric patients.

In closing, I want make it clear that Gaylord Hospital carefully arrived at decision to stop providing sleep medicine services and by collaborating with YNHH and CCMC who will assume responsibility for sleep services, will result in patients having continued access and to the highest quality of care. Thank you for the opportunity to come before you today. If you have any questions I would be glad to answer them.

Respectfully Submitted,

George Kyriacou, President & CEO
Gaylord Specialty Healthcare

* * * COMMUNICATION RESULT REPORT (JUN. 16. 2014 1:33PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 16. 2014 1:32PM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
05 MEMORY TX		912037766438	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LAURIE KENNINGTON, PRESIDENT

FAX: (203) 776-6438

AGENCY: UNITE HERE LOCAL 34

FROM: OHCA

DATE: 6/16/14

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31884-CON Prefile Testimony of Applicant

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

June 11, 2014

Mr. Kevin T. Hansted
Hearing Officer
Office of Healthcare Access
410 Capitol Ave.
Hartford CT 06134-0308

Ref: Docket 13-31884 CON

Dear Mr. Hansted:

Enclosed find pre-filed testimony for John Canham-Clyne, Melissa Dawkins-Doumbia and Gretchen Rose, who will be appearing as witnesses in the above-referenced docket, at the public hearing scheduled for June 18, 2014 at Gateway Community College, New Haven.

Sincerely,

John Canham-Clyne
Deputy Director of Research
UNITE HERE International Union

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Melissa Dawkins-Doumbia
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for hearing June 18, 2014

Good afternoon Mr Hansted. My name is Melissa Dawkins-Doumbia. I live at 24 Daisy St., New Haven CT. I am an administrative assistant in the Internal Medicine Department at Yale University. Throughout my time working at Yale Sleep Medicine, it became clear that Yale-New Haven Hospital was taking over the practice.

Before Christmas in 2013, I was temping at the Sleep Medicine lab at 40 Temple Street in New Haven. I then left the sleep lab when I got my new position in Internal Medicine. In the meantime, a few staff from the sleep lab had been laid off.

I returned to help the Sleep Medicine lab because it stayed open after the rest of the staff was laid off. However, the clinic moved over to 784 Howard Avenue in New Haven where they continued to see patients until Yale-New Haven Hospital opens its clinics in North Haven and Madison. We were told that the clinics will have Yale Medical Group doctors but Yale-New Haven Hospital administrators and staff.

The patients were told that they would be transitioned and that their care would be continued by the hospital. They were not told about any facility fees associated with being seen at the hospital, just that they could see the same doctor but at a different facility with different staff. I was instructed by management to tell patients:

> "Yale-New Haven Hospital will be opening up a sleep center. They will be taking over our practice. All of your charts and medical records will be switched over to the hospital."

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of Gretchen Rose
Before the Office of Health Care Access
RE: Docket No. 12-31884 CON
Pre-filed for

My name is Gretchen Rose and I live at 1353 N. Stone St., W. Suffield, CT. I worked at the Yale University Sleep Lab at 40 Temple Street in New Haven until I was laid off last December.

I have worked for Yale University Sleep Medicine for 15 years, since 1998. When I started, I worked in the Guilford lab. In 1999, Yale opened a lab in Norwich which I was moved to, and a few years later, the lab in New Haven on Temple Street.

About 2 ½ to 3 years ago, the Norwich lab closed. One employee was laid off and the rest were consolidated into the Guilford and New Haven labs. In January 2013, the Guilford lab closed and we were all combined into the New Haven lab.

In October 2013, management conducted a mandatory meeting. They told us they were closing the sleep lab at 40 Temple Street effective January 6, 2014. We asked if the clinic was being purchased by Yale-New Haven Hospital. For a while, management denied that it was. Our manager told us that we could tell patients that we were moving and that they could be seen at the Yale Physicians Building on Howard Avenue. She said that we would no longer be conducting overnight studies. We saw our last patient right before Christmas.

The University denied that Yale-New Haven Hospital was taking control of the practice. They told us that it was not happening, that they didn't know where we were hearing that from. It is not an option. Yale-New Haven had talked to the University earlier but nothing came of it. It was denials everywhere.

UNITE HERE International Union
425 College Street, New Haven, CT 06511 • Tel: (203) 624-5161, Fax: (203) 776-6438

Testimony of John Canham-Clyne
Deputy Director of Research, UNITE HERE International Union
On behalf of UNITE HERE Local 34
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for Hearing June 18, 2014

Good afternoon, Mr. Hansted. On behalf of the 3,700 members of UNITE HERE Local 34, thank you for holding this hearing, and, in particular, for ensuring that the citizens of New Haven, who will be most affected by this case, have an opportunity to be heard. This pre-filed testimony incorporates by reference the affidavits attached to our letter of April 8, 2014 requesting a hearing and status.

Local 34 sought status in this case for two reasons. First, we represent roughly 900 clerical and technical employees in the clinical practices of the Yale University School of Medicine. Among those are 11 employees of the Yale Medical Group's sleep laboratory who have been laid off as a result of the transactions in front of the Office.

Second, UNITE HERE Locals in Connecticut represent thousands of patients who are struggling to cope with the increasing costs and the access challenges of a rapidly transforming health care system. Those costs manifest themselves both as increased individual out of pocket costs at the point of service, and in increasingly contentious collective bargaining negotiations.

We believe that this hearing and the docket before you must address the following issues:

1. Yale-New Haven Hospital must file a Certificate of Need for the purchase of Gaylord's assets in North Haven.
2. The case must be reviewed in its entirety. This is a complex, three-sided transaction in which Yale-New Haven Hospital is taking over the practice of sleep medicine from Yale Medical School, purchasing Gaylord's North Haven assets and consolidating services in suburban locations as Gaylord closes its other facilities.
3. This consolidation presents challenges for at-risk populations. Former and potential patients from New Haven's low-income communities of color may struggle with the proposed geographic changes.
4. The transaction in its entirety may raise costs at the point of service, both to individual patients and institutional payers, with a demonstrated effect on access.

5. The effect of the transactions has been to force highly experienced workers to choose between maintaining their salaries, job security, retirement and health care benefits, and continuing to work in the field of sleep medicine. This diminishes the pool of trained employees in the field.

Yale-New Haven Hospital Must File a Certificate of Need

The transaction as described to OHCA in the original Certificate of Need is fictitious. Gaylord is not "terminating" its sleep medicine operations in North Haven. It is closing its other sleep medicine facilities, but transferring its North Haven sleep medicine assets to Yale-New Haven Hospital, which will continue providing service at the North Haven location. There is voluminous evidence on the record for this fact.

The original CoN omitted any mention of an asset transfer. However, upon request for further information from OHCA, the Applicant submitted a letter that mentioned in passing a "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital...."[1] Similarly, the draft notice to patients attached to the completed CoN states "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations." [2]

The transfer of ownership of a health care facility requires a Certificate of Need. Additionally, by adding Applicant's North Haven assets, Yale-New Haven Hospital will create an "an increase of the licensed bed capacity of a health care facility," which also triggers a Certificate of Need.

The Transaction Must be Reviewed in its Entirety

The transfer of Gaylord Hospital's North Haven assets to Yale-New Haven Hospital is one part of a complex three-sided transaction. Yale-New Haven Hospital is assuming control of Yale University's sleep medicine practice, purchasing the assets of Gaylord's North Haven operations and consolidating services in suburban locations.

Prior to the filing of Gaylord's CoN, Yale University serially closed its sleep medicine laboratories in Norwich, Guilford and New Haven, beginning three years ago with the Norwich facility. By October 2013, Clerical and Technical employees at each site had been given layoff notices. In December, the Yale Medical Group mailed notices to patients informing them that YMG physicians would continue to see them at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[3]

---

[1] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

[2] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.

[3] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.

After YMG laid off its clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts and medical records will be switched over to the hospital."[4] This directive from YMG management clearly suggests that YNHH is taking over YMG's practice.

The closure of the University's sleep labs, the "termination" of Gaylord's sleep services, and the opening of Yale-New Haven sleep facilities in North Haven and Madison are not unrelated, coincidentally timed transactions. For OHCA to proceed as if that were the case would be a disservice to the public. The transaction must be evaluated in its entirety to properly determine its full impact on the health care system.

Indeed, to fully understand what is happening in the market for sleep medicine, the closure of Gaylord Hospital's Trumbull, Glastonbury and Guilford operations must be evaluated in the context of the closure of Yale Medical Group's three facilities as well. Obviously, the development of home sleep testing is shrinking the need for site-based sleep labs. However, six closures in the space of 36 months, five of them within the last 18 months, constitutes dramatic change in the market.

For OHCA to discharge its responsibility to the public, the Office cannot view sweeping marketplace changes in a vacuum. Even viewing the closing of Gaylord's multiple sites likely would not give the Office sufficient scope to understand and review the impact of market changes on sleep medicine patients. Only by bringing the dominant market actor that is driving these changes, Yale-New Haven Hospital, under scrutiny for its impact on cost and access can the entire picture of the consolidation of sleep medicine services in Connecticut be explained to the public.

Regional Consolidation as Proposed Poses Threats to Access for At-Risk Populations

The consolidation of regional sleep medicine services in suburban locations poses a potential threat to at-risk populations. In the CoN deemed complete, the Applicant claims:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[5]

Further, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

---

[4] Affidavit by Melissa Dawkins, March 17, 2014.
[5] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[6] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

The Transaction in its Entirety May Raise Costs to Individual Patients and Institutional Payers

The Centers for Medicare and Medicaid Services (CMS) issued regulations in 2002 permitting hospitals to designate physician practices that they control as parts of an outpatient department, even when such facilities are miles from the hospital's core campus. Such a designation allows the hospital to bill for what were once physician office visits as if they were visits to the hospital itself. "Hospital-based," or "Provider-based" billing allows hospitals to charge much higher prices for services that are often indistinguishable from those provided at lower cost in a physician office setting – most commonly by the addition of "facility fees" on top of physicians' professional fees.

The Congressional Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare spends an additional $2 billion a year on provider-based services that cannot reasonably be distinguished from those provided in doctors' offices. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[7]

The trend toward provider-based billing for services that can be provided safely in doctor's offices has raised serious concerns among federal and state policymakers. MedPAC has been advising Congress to equalize billing for equivalent services for two years.[8] Connecticut Attorney General George Jepsen issued a report in April 2014, which concluded

> The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.[9]

---

[6] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.
[7] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[8] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.
[9] Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April, 2014, Pg. 2

Dramatic increases in billing for physician services – and especially the shift to hospital-based charges – have arrived in Connecticut at the worst possible moment. Patients are increasingly enrolled in plans with large copays and high deductibles. As the Attorney General notes:

> A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional hospital setting and specialty care and routine services were provided by primary care physicians
> and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.5Likewise, in 2006 10% of employer health plans had a deductible of at least $1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.6 It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

Thus, just as consumers are becoming responsible for more costs, and government and private payers are trying to shift care from higher cost settings to more appropriate venues, large numbers of physician practices are now "provider-based." A patient who might have paid a $40 specialist copay for an office visit may still pay that fee, but later receive a bill for a several hundred dollar copay for the facility, or worse, a $1,000+ deductible payment for outpatient hospital services. The consequences can be devastating for individuals.

OHCA should examine carefully the payment history for Sleep Medicine services, not only at Applicant's facilities, which are reportedly provider-based, but at the Yale Medical Group as well. The portion of the patients at Yale-New Haven's successor facility to the Applicant's that are transitioning from the Yale Medical Group sleep center may face facility fees and other increased costs for the first time.

Our members experience this phenomenon on a regular basis. Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[10]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors' visits or cease treatment all together.

Consolidation Diminishes the Pool of Skilled Workers

---

[10] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, June 17, 2014 1:18 PM
To: hfmurray@lamp.org
Cc: Greer, Leslie
Subject: FW: Gaylord Hospital Objection
Attachments: Objection.pdf

Please see the attached Objection filed by the Applicant in the hearing scheduled tomorrow.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: John D. Blair [mailto:john@blairlawllc.com]
Sent: Tuesday, June 17, 2014 12:10 PM
To: Greer, Leslie; Fiducia, Paolo; Riggott, Kaila; Hansted, Kevin; Lazarus, Steven; Martone, Kim
Subject: Gaylord Hospital Objection

To Whom it May Concern,

Enclosed is Gaylord Hospital's Objection to Unite Here 34 status as intervenor.

If you should have any questions please contact me.

Sincerely, John

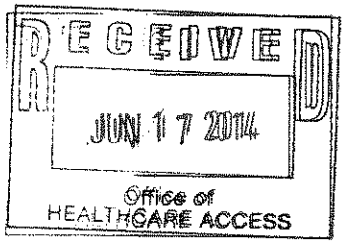
John D. Blair
Counselor at Law

Blair Law LLC
P.O. Box 141
Rocky Hill, CT 06067
P: 860 280 4059
F: 860 760 6493
john@blairlawllc.com
www.blairlawllc.com

WWW.BLAIRLAWLLC.COM

BLAIR | LAW

TEL: 860.280.4059
FAX: 860.760.8480
P.O. BOX 141
ROCKY HILL, CT 06067



Via Hand Delivery

June 17, 2014

Lisa A. Davis, Deputy Commissioner
Department of Public Health - Office of Health Care Access
410 Capital Avenue MS # 13HCA
PO Box 340308
Hartford, CT 06134-0308

Docket No.: 13-31884-CON
Applicant: Gaylord Hospital
Proposal: Termination of Sleep Medicine Services

Dear Deputy Commissioner Davis:

Enclosed on behalf of Gaylord Hospital, Inc. is an Objection to Unite Here Local 34 being designated as an Intervenor.

Thank you for your consideration.

Sincerely,

John D. Blair

cc: Henry F. Murray, Esq.

BEFORE DEPARTMENT OF PUBLIC HEALTH DIVISION OFFICE OF HEALTH CARE ACCESS	DOCKET NO. 13-31884-CON
IN RE GAYLORD HOSPITAL TERMINATION OF SLEEP MEDICINE SERVICES	JUNE 17, 2014

OBJECTION TO PETITION BY THE UNITE HERE LOCAL 34 TO BE DESIGNATED AS AN INTERVERNOR

I. Introduction

Gaylord Hospital (GH) files objection to the Unite Here Local 34 (Petitioner) to be designated as an intervenor. Neither the Petitioner nor individual members demonstrated the requisite legal interests or satisfied the necessary criteria to participate as an intervenor. The issues the Petitioner proposes to interject in this proceeding are not relevant to the Certificate of Need (CON) application, and any interests represented by the Petitioner are no different from, or greater than, the interests of the public in general. Accordingly, GH requests that the Department of Public Health, Division of Office of Health Care Access (OHCA) should revoke the Petitioner's intervenor status.

The petition essentially accuses OHCA of not properly enforcing their legal jurisdiction. The petition makes erroneous assertions that GH's decision to discontinue sleep medicine services will limit access to care and increase costs to the State. These incorrect claims appear to be presented as a vehicle for the Petitioner to address labor issues which are wholly independent of GH and not within the scope of this CON proceeding. For reasons

that follow, the Petitioner qualifies as neither a party nor an intervenor, and GH respectfully requests that any participation be limited to the public comment portion of the contested case.

II. Response to Petition

1. The issues on which the Petitioner proposes to present evidence are both inaccurate and irrelevant to OHCA's CON review of GH proposal to discontinue sleep medicine services.

The Petitioner suggests GH's decision to discontinue sleep medicine services is part of "complex three-way transaction, only a small percentage of which has come under OHCA scrutiny…" (April 8, 2014, Union Here Letter)

First, the assertion that GH was involved in a "complex three-way transaction" mischaracterizes the facts and creates a vast conspiracy where no such conspiring occurred. It was GH's management alone that decided to discontinue providing sleep medicine services, as far back as 2011. The decision to discontinue sleep medicine services at North Haven and three other sleep medicine locations was based on a variety of factors. As management of Gaylord Specialty Healthcare assessed the changing health care environment, during its strategic planning process, the decision was made to concentrate its limited resources on its core inpatient and outpatient health care services for complex rehabilitation and medically complex patients. Additional factors in the decision to discontinue sleep medicine services included diminished in-lab patient volume, changing models of delivery and unnecessary duplication of services since sleep medicine is provided by many other providers in the markets Gaylord serves. The enhanced technology and changes in the clinical practice of sleep medicine has resulted

in a shift from in-lab studies to home studies with a much different reimbursement structure.

GH management arrived at the decision to close a full line of sleep medicine services, including locations as far away as Glastonbury, CT. Once the decision was reached to discontinue sleep medicine services, GH explored transactions with several potential providers who could help assure a smooth transition for its patients. The transaction with Yale-New Haven Hospital for the North Haven site involves only the sale of GH's sleep medicine assets at that site, so that GH had some comfort that its patients would continue to be served, and Yale University is not a party to that transaction in any way. To suggest that GH's decision is part of a "complex three way transaction" is wholly inaccurate.

Second, even a cursory review of the OHCA statutes reveal why "only a small percentage of"...the sleep medicine closures..."come under OHCA scrutiny". Under current law, Connecticut General Statutes, 19a-638, a CON is not required for the opening or closure of sleep medicine services.

Unlike the current law, 2006 CON laws required GH to obtain CON approval to open or close sleep medicine services. A subsequent Order approving GH to offer services in North Haven (Docket No. 06-30811-CON) stipulated;

> "Gaylord Hospital, Inc. shall hereafter notify OHCA of any and all proposed termination of services prior to finalizing any decision to terminate any

> services or programs. Failure to notify OHCA in advance of any proposed termination of services may be considered as not filing required information and subject Gaylord Hospital, Inc. to civil penalties pursuant to Section 19a-653, C.G.S."

The above stipulation, not current law, is the sole legal basis for why GH is required to obtain CON approval to discontinue sleep medicine services. Even assuming that GH's decision to discontinue sleep medicine services constituted a "termination" of an outpatient hospital service for which a CON would be required under CGS 19a-638(4), OHCA would be presented with the same issues – whether the statutory criteria for terminating GH's sleep medicine services have been met. The Petitioner's attempts to muddy the water with extraneous allegations and misinterpretations of the applicable legal standard add nothing to OHCA's consideration of these criteria.

Thus, the Petitioner's claims that GH's decision to discontinue sleep medicine services as part of "complex three way transaction" or is improperly before the agency takes away from the relevant issues of the CON application before the OHCA.

2. <u>The Petitioner's interests are no different from, or greater than, the interests of the general public and make unfounded claims regarding diminished access and increased cost for services.</u>

The Petitioner attempts to raise concerns that the decision to close sleep medicine services by GH will reduce access to sleep medicine services and increase cost to the State.

a. Access was of paramount concern in Gaylord Hospital's assessment of closing sleep medicine services.

GH considered access to care based on availability of services, as well as, accessibility to those services. Gaylord Sleep Medicine-North Haven, Yale New Haven Hospital (YNHH) and Connecticut Children's Medical Center (CCMC) worked collaboratively to ensure a seamless transition of the clinical service for our patients. YNHH is able to assume care for adult patients and CCMC will assume care of the pediatric population. CCMC has already opened their new sleep center in Farmington and 50 percent of our pediatric population from our Glastonbury location has already moved to that Center. Gaylord Sleep Medicine-North Haven will notify patients of the availability of sleep medicine services provided by the sleep program affiliated with YNHH for adult patients and CCMC Sleep program for pediatric patients once a decision is rendered from OHCA.

In terms of accessibility to sleep services, it should be made clear, transportation to North Haven has been provided by GH to the North Haven sleep medicine location for the past eight years, at no direct cost to the patient. GH has provided transportation via taxi to patients from New Haven, in need of transportation to ensure access to care. Also, LogistiCare provides no cost transportation to Medicaid patients for day and evening appointments In addition, the North Haven site is on a bus line and service is available. YNHH has committed to maintaining similar transportation services to this patient population.

b. The claim that there is an increased cost to the State is unfounded.

There is no additional cost to the State. Sleep medicine services have been a provider-based hospital outpatient service for GH, and they will continue to be a provider based hospital outpatient service for the Yale-New Haven facility, with both facility and professional fees being billed. Nothing will change as a result of GH's sale of assets.

3. <u>The Petitioner should not be permitted to participate in the proceedings as a party or an intervenor</u>

The Petitioner has no legal rights, duties or privileges that will be specifically affected by OHCA's decision on GH's termination of sleep medicine services, and thus is not entitled to participate as a party to in this proceeding. Conn. Agencies Regs. Sec. 19a-643-37. The Petitioner's attempt to connect GH's closure of sleep medicine services to the financial hardship experienced by Yale University employees in closures effectuated through business transactions involving completely independent parties is too attenuated to substitute for the requisite showing of specific legal interests that will be affected by the decision. The issues and evidence proposed to be presented by the Petitioner bear no connection to the questions before OHCA and are not relevant to OHCA's consideration of the CON, and thus the Petitioner's request to participate as intervenor should have been denied. Conn. Agencies Reg. Sec. 19a-643-38(c). Allowing participation as an intervenor of every potentially affected patient, organization or member of the public, without regard to the relevance of the proposed evidence, would most

certainly "impair the orderly conduct of the proceedings." Conn. Agencies Regs. 19a-643-38(d). Federal labor issues are beyond the purview of OHCA's jurisdiction, and should be addressed in their proper forum, rather than burdening GH with the disputes involving third parties. Since the interests of the Petitioner in this proceeding are not different from or greater than the interests of the public at large, its participation in this public hearing should be limited to offering of relevant comments, presented in the public comment portion of the hearing.

4. Formal participation by Petitioner would impair the orderly conduct of the proceedings.

The Petitioner has been granted intervenor status with limited rights and to make a short presentation based on OHCA's ruling dated May 29, 2014. To date, the Petitioner has made inaccurate legal assumptions, provided only anecdotal evidence of unrelated transactions and baseless claims with regards to continued access and increased cost relating to GH's decision to discontinue sleep medicine services. Despite the rhetoric with which it is cloaked, Petitioner's petition and proposed testimony contain no information that would assist OHCA in its inquiry of whether the statutory and regulatory criteria have been met. It appears that Petitioner is primarily interested in a platform on which to express its views about labor relations at Yale University and Yale-New Haven Hospital, a subject on which GH has no knowledge and that is irrelevant to OHCA's consideration, as neither Yale University nor Yale-New Haven Hospital are parties to this proceeding (nor need they be, as sleep medicine beds are not licensed beds, an increase in

which requires a CON). Allowing the CON proceeding to be diverted in this matter will impair the orderly conduct of the proceedings without any corresponding benefit.

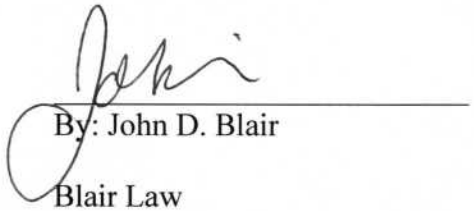
GH respectfully requests that if the Petitioner's status is not revoked that OHCA excludes from the record for decision the extensive allegations, citations and quotations contained in the petition. Should OHCA decide to admit any of the allegations and information contained in the petition into the record for decision making, GH would request an opportunity to submit additional testimony and briefing regarding such allegations.

II. Conclusion

For all the reasons stated above, Applicant GH respectfully requests that the Petitioner's intervernor status be revoked and that its contents not be included in the record or decision.

Respectfully submitted,

GAYLORD HOSPITAL



By: John D. Blair

Blair Law
PO Box 141
Rocky Hill, CT 06607
Ph: 860 280-4059
john@blairlawllc.com
It's Counsel

CERTIFICATION

This is to certify that a true and correct copy of the foregoing was sent via email on this 17th day of June, 2014 to the following:

Henry F. Murray
LIVINGSTON, ADLER, PULDA, MEIKLEJOHN
& KELLY, P.C.
557 Prospect Street Avenue
Hartford, CT 06105
860.233.9821 (T)
860.232.7818 (F)

John D. Blair

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31884-CON

Gaylord Hospital

Termination of Services at Gaylord Sleep Medicine in North Haven

June 18, 2014 at 3:00 p.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

III. OHCA's Questions-Applicant

IV. Intervenor's Testimony (15 minutes)

V. Applicant's Questions- Intervenor

VI. OHCA's Questions-Intervenor

VII. Public Comment

VIII. Closing Remarks

VI. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Gaylord Hospital**

DOCKET NUMBER: **13-31884-CON**

PUBLIC HEARING: **June 18, 2014 at 3:00 p.m.**

PLACE: **Gateway Community College**
20 Church St. Community Room (N100)
New Haven, CT 06510

EXHIBIT	DESCRIPTION
A	Letter from Gaylord Hospital ("Applicant") dated December 30, 2013, enclosing the CON application for the termination of services at sleep medicine in North Haven under Docket Number 13-31884, received by OHCA on December 30, 2013. (79 pages)
B	OHCA's letter to the Applicant dated January 29, 2014, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31884. (3 pages)
C	Applicant's responses to OHCA's letter of January 29, 2014, dated February 6, 2014, in the matter of the CON application under Docket Number 13-31884, received by OHCA on February 19, 2014. (18 pages)
D	Letter from UNITE HERE International Union, Local 34 dated April 8, 2014 noticing their concerns, requesting a hearing and requesting status as a party or in the alternative an intervenor in the matter of the CON application under Docket Number 13-31884, received by OHCA on April 8, 2014. (7 pages)
E	Letter from UNITE HERE International Union, Local 34 dated April 15, 2014 enclosing supporting material related to their letter requesting a public hearing in the matter of the CON application under Docket Number 13-31884, received by OHCA on April 16, 2014. (31 pages)
F	OHCA's letter to the Applicant dated April 22, 2014, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31884. (2 pages)

G	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for June 18, 2014, in the matter of the CON application under Docket Number 13-31884, dated May 21, 2014. (4 pages)
H	Designation letter dated May 22, 2014 of Hearing Officer in the matter of the CON application under Docket Number 13-31884. (1 page)
I	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the **revised** location for the public hearing scheduled for June 18, 2014, in the matter of the CON application under Docket Number 13-31884, dated May 27, 2014. (4 pages)
J	Applicant's responses to OHCA's letter of April 22, 2014, dated May 27, 2014, in the matter of the CON application under Docket Number 13-31884, received by OHCA on May 27, 2014.
K	Email from the Applicant to OHCA dated May 29, 2014 noticing the appearance of Attorney John Blair in the matter of the CON application under Docket Number 13-31884, received by OHCA on May 29, 2014. (2 pages)
L	OHCA's Ruling on the Petition of UNITE HERE International Union, Local 34 to be granted intervenor status with limited rights in the matter of the CON application under Docket Number 13-31884, dated May 29, 2014. (1 page)
M	OHCA's letter to the Applicant dated June 10, 2014, requesting prefile testimony in the matter of the CON application under Docket Number 13-31884. (1 page)
N	Letter from the Intervenor enclosing Prefile Testimony dated June 11, 2014 in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 11, 2014. (9 pages)
O	Letter from the Applicant enclosing Prefile Testimony dated June 13, 2014 in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 31, 2014. (4 pages)
P	Intervenor's letter to OHCA dated June 16, 2014 enclosing a notice of appearance for Livingston, Adler, Pulda, Meiklejohn and Kelly P.C. in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 16, 2014. (1 page)
Q	Letter from the Applicant to OHCA datedJune 17, 2014 objecting to UNITE HERE Local 34 being designated as an Intervenor in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 17, 2014. (10 pages)

* * * COMMUNICATION RESULT REPORT (JUN. 17. 2014 2:29PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 17. 2014 2:28PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
390	MEMORY TX		912037766438	OK	4/4

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LAURIE KENNINGTON

FAX: 1 (203) 776 6438

AGENCY:

FROM: OHCA

DATE: 6/17/14 **Time:**

NUMBER OF PAGES:
(including transmittal sheet

Comments:

Information regarding the hearing being held on June 18, 2014 at Gateway College regarding Gaylord Hospital.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUN. 17. 2014 2:53PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 17. 2014 2:52PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
394	MEMORY TX		912037413408	OK	4/4

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 1-203-741-3408

AGENCY:

FROM: OHCA

DATE: 6/17/14 **Time:**

NUMBER OF PAGES:
(including transmittal sheet

Comments:

Information regarding the hearing being held on June 18, 2014 at Gateway College regarding Gaylord Hospital

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: John D. Blair <john@blairlawllc.com>
Sent: Wednesday, June 25, 2014 11:25 AM
To: Hansted, Kevin
Cc: Riggott, Kaila; Martone, Kim; Lazarus, Steven; hfmurray@lapm.org; Greer, Leslie; Fiducia, Paolo
Subject: Gaylord Late Files - DOCKET NO. 13-31884-CON
Attachments: APALateFile.pdf; SCHEDULE 2 1(a) - List of Personal Property Included in the Acquired Ass .pdf; North Have Volume thru May 2014 Late File.xlsx; CAB RIDES.xlsx

Dear Attorney Hansted,

Enclosed are the requested late files from Gaylord Hospital Termination of Sleep Medicine Services in North Haven Public Hearing held Wednesday, June 18, 2014:

1. Asset Purchase Agreement and List of Included Assets
2. North Haven Volume thru May 2014
3. Cab Rides Provided

The Transportation Agreement is forthcoming.

Thank you for your consideration of this matter.

Sincerely, John

John D. Blair
Counselor at Law

Blair Law LLC
P.O. Box 141
Rocky Hill, CT 06067
P: 860 280 4059
F: 860 760 6493
john@blairlawllc.com
www.blairlawllc.com

This electronic message contains information from Blair Law, LLC, or its attorneys, which may be confidential, privileged or otherwise protected from disclosure. The information is intended to be used solely by the recipient(s) named. If you are not an intended recipient, be aware that any review, disclosure, copying, distribution or use of this transmission or its contents is prohibited. If you have received this transmission in error, please notify us immediately at 860 280-4059 or at the reply email address. For more information about Blair Law, please go to http://www.blairlawllc.com.

EXECUTION VERSION

ASSET PURCHASE AGREEMENT

THIS ASSET PURCHASE AGREEMENT (the "***Agreement***"), is made and entered into as of November 1, 2013 ("***Execution Date***"), by and between **Yale-New Haven Hospital, Inc.,** a Connecticut nonstock corporation ("***Buyer***"), and **Gaylord Hospital, Inc.**, a Connecticut nonstock corporation ("***Seller***"). Buyer and Seller are collectively referred to herein as the "parties" and individually as a "party."

RECITALS

WHEREAS, Buyer owns and operates a 1541-bed tertiary medical center in New Haven, Connecticut that provides a full range of high quality, cost effective health care services to residents of Connecticut, and its surrounding area, including comprehensive sleep medicine services;

WHEREAS, Seller owns certain tangible and intangible assets utilized in its provision of technical sleep medicine services at four (4) sleep centers owned and operated by Seller and located in Glastonbury, Guilford, North Haven, and Trumbull, Connecticut; and

WHEREAS, Buyer desires to purchase, and Seller desires to sell substantially all of the assets used in connection with the provision of technical sleep medicine services by Seller at its North Haven facility only (the "***Sleep Center Business***") on the terms and subject to the conditions set forth in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties hereto, Seller and Buyer agree as follows:

ARTICLE 1

DEFINITIONS

In addition to the words and terms elsewhere defined in this Agreement, the following words and terms shall have the following meanings unless the context or use indicates another or different meaning or intent:

1.1 "***Acquired Assets***" has the meaning set forth in Section 2.1.

1.2 "***Active Patients***" means all patients who have been seen at the Facility within the eighteen (18) month period prior to the Closing Date.

1.3 "***Affiliate***" means, with respect to any Person, any Person directly or indirectly Controlling, Controlled by or under common Control with such Person.

1.4 "***Agreement***" has the meaning set forth in the introductory paragraph hereto.

1.5 "***Assignment and Assumption Agreement***" means the Assignment and Assumption Agreement in the form set forth in Exhibit A attached hereto.

1.6 "***Assumed Contracts***" has the meaning set forth in Section 2.1(d).

1.7 "***Assumed Contracts and Leases***" has the meaning set forth in Section 2.1(d).

1.8 ***"Assumed Contract Obligations"*** has the meaning set forth in Section 2.8.

1.9 "***Bill of Sale***" means the Bill of Sale in the form set forth in Exhibit B attached hereto.

1.10 "***Buyer Employed Personnel***" has the meaning set forth in Section 6.4(a).

1.11 "***Buyer Indemnified Persons***" has the meaning set forth in Section 11.2.

1.12 "***Buyer's Deliveries***" has the meaning set forth in Section 7.4.

1.13 "***Claim Notice***" has the meaning set forth in Section 11.1.

1.14 "***Closing***" has the meaning set forth in ARTICLE 9.

1.15 "***Closing Date***" has the meaning set forth in ARTICLE 9.

1.16 "***Code***" means the Internal Revenue Code of 1986, as amended.

1.17 "***Control***" (and variations thereon) means the possession, directly or indirectly, of the power to direct the management and policies of a Person whether through the ownership of voting securities, by contract or otherwise; and control shall be presumed if a Person owns more than fifty percent (50%) of the voting equity in any other Person.

1.18 "***Damages***" has the meaning set forth in Section 11.2.

1.19 "***ECW Equipment***" has the meaning set forth in Section 2.2.

1.20 "***ERISA***" means the Employee Retirement Income Security Act of 1974, as amended.

1.21 "***Effective Time***" has the meaning set forth in ARTICLE 9.

1.22 "***Encumbrances***" has the meaning set forth in Section 2.4.

1.23 "***Excluded Assets***" has the meaning set forth in Section 2.2.

1.24 "***Excluded Contracts***" has the meaning set forth in Section 2.3.

1.25 "***Execution Date***" has the meaning set forth in the Recitals of this Agreement.

1.26 *"Facility"* means the sleep center facility operated by Seller in North Haven.

1.27 "***Fundamental Rep***." has the meaning set forth in Section 11.1.

1.28 "***Governmental Authority***" means any foreign, federal, state, local or municipal court, legislature, quasi-governmental, executive or regulatory authority, agency, licensing or accrediting body or commission, or other governmental entity, authority or instrumentality.

1.29 "***Inventories***" has the meaning set forth in Section 2.1(e).

1.30 "***IRCA***" means the Immigration Reform and Control Act of 1986, as amended.

1.31 "***knowledge***" has the meaning set forth in Section 13.3

1.32 "***Licenses***" has the meaning set forth in Section 2.1(e).

1.33 "***Marks and Copyrights***" has the meaning set forth in Section 2.1(j).

1.34 "***material adverse effect***" has the meaning set forth in Section 12.3.

1.35 "***Material Contracts***" has the meaning set forth in Section 4.10.

1.36 "***Necessary Consent***" has the meaning set forth in Section 2.5.

1.37 "***Non-Assignable Assets***" has the meaning set forth in Section 2.5.

1.38 "***Patient Record***" has the meaning set forth in Section 2.1(g).

1.39 "***Permitted Encumbrances***" means (a) personal property and ad valorem taxes for the year of the Closing which are not yet due and payable, and which shall be prorated between Buyer and Seller as of the Effective Time; (b) any interest of a lessor in an Acquired Asset that is the subject of a lease which is an Assumed Contract and Lease as of the Effective Time; and (c) any other Encumbrances of record.

1.40 "***Person***" means any individual, partnership, limited partnership, corporation, business trust, limited liability company, limited liability partnership, joint stock company, trust, unincorporated association, joint venture, Governmental Authority or other entity.

1.41 "***Personal Property***" has the meaning set forth in Section 2.1(a).

1.42 "***Personal Property Leases***" has the meaning set forth in Section 2.1(b).

1.43 "***Plan***" means any employee benefit plan within the meaning of Section 3(3) of ERISA that is in effect as of the Effective Time.

1.44 "***Prepaid Expenses***" has the meaning set forth in Section 2.1(f).

1.45 "***Proceedings***" has the meaning set forth in Section 4.9.

1.46 "***Purchase Price***" has the meaning set forth in Section 3.1.

1.47 "***Real Property Lease***" has the meaning set forth in Section 2.1(c).

1.48 "***Restricted Area***" has the meaning set forth in Section 2.1(c).

1.49 "***Seller's Deliveries***" has the meaning set forth in Section 8.3.

1.50 "***Seller Indemnified Persons***" has the meaning set forth in Section 11.3.

1.51 "***Sleep Center Business***" has the meaning set forth in the Recitals of this Agreement.

1.52 "***Sleep Center Personnel***" means all employees of Seller who provide services for or on behalf of the Sleep Center Business conducted at or for the Facility.

1.53 "***SHC***" the meaning set forth in Section 2.1(i).

1.54 "***Survival Period*** " has the meaning set forth in Section 11.1.

1.55 "***Transferred Records***" has the meaning set forth in Section 2.1(i).

ARTICLE 2

TRANSFER OF THE ASSETS

2.1 Transfer of Assets. At the Closing and subject to the terms and conditions set forth in this Agreement, Seller shall sell, transfer, convey, assign and deliver to Buyer, and Buyer shall purchase from Seller, all of Seller's right, title and interest in, and arising under, the following, other than the Excluded Assets (collectively, the "***Acquired Assets***"):

(a) All tangible personal property, including all equipment, furniture, fixtures, office furnishings, instruments, and leasehold improvements, used or held for use in connection with the Sleep Center Business and located at the Facility and, to the extent transferable or assignable, all rights in all warranties of any manufacturer or vendor with respect thereto, as described on Schedule 2.1(a) (collectively, the "***Personal Property***");

(b) All of Seller's rights under the equipment leases and other contracts described on Schedule 2.1(b) relating to the Personal Property (the "***Personal Property Leases***");

(c) All of Seller's rights under that certain Lease Agreement, dated as of May 23, 2005, by and between Gaylord Wellness Associates LLC, as landlord, and Seller, as tenant, with respect to the Facility (the "***Real Property Lease***");

(d) All of Seller's rights under the contracts, agreements, licenses, commitments and purchase orders listed on Schedule 2.1(d) (all such assigned contracts, agreements, licenses, commitments and purchase orders are referred to herein as the

"***Assumed Contracts***" and together with the Real Property Leases and Personal Property Leases, the "***Assumed Contracts and Leases***");

(e) All inventory and supplies located at the Facility at the Effective Time, including pharmaceuticals and medications, janitorial supplies, office supplies, forms, consumables, disposables, and medical supplies, other than durable medical equipment (the "***Inventories***");

(f) The prepaid expenses of the Sleep Center Business of the types described on Schedule 2.1(f) (the "***Prepaid Expenses***");

(g) All documents, books, records, operating and policy manuals and files owned by Seller and related directly to the operation of the Sleep Center Business at the Facility, whether in hard copy or other form, located at the Facility and all medical records for Active Patients (each a "***Patient Record***"), patient lists, and equipment records, whether in hard copy or other form (collectively, the "***Transferred Records***");

(h) All claims of Seller against third parties, choate or inchoate, known or unknown, contingent or otherwise, relating to any Acquired Asset.

Seller shall deliver possession and/or control of the Acquired Assets to Buyer as of the Effective Time. Seller shall cease using the Acquired Assets from and after the Effective Time.

2.2 Transitional Use of ECW Equipment. Seller shall provide Buyer and its employees, agents and representatives with full access to and continuous, uninterrupted use of the eClinical Works (ECW) software and related computer hardware located at the Facility (the "***ECW Equipment***"), for up to four (4) months after the Closing Date without charge.

2.3 Excluded Assets. Notwithstanding anything to the contrary, Seller is not selling and Buyer is not purchasing or assuming any obligations with respect to, the following assets which shall remain the property of Seller on and after the Effective Time (the "***Excluded Assets***"): (a) cash, cash equivalents and refunds of Seller on hand as of the Effective Time; (b) accounts receivables of Seller as of the Effective Time; (c) Seller's corporate seals, minute books, charter documents, income and franchise tax returns, corporate stock record books and other books and records pertaining to the organization, existence or share capitalization of Seller and such books and records as are necessary to enable Seller to file its tax returns; (d) employee benefit plans or employee records; (e) Seller's Medicare, Medicaid, TRICARE and other payor provider agreements and identifier numbers; (f) all contracts, leases, agreements, licenses, commitments, purchase orders and other contractual rights which are not Assumed Contracts and Leases (the "***Excluded Contracts***"); (g) artwork, decorations and other personal assets of Physicians located on the premises of Seller but in which Seller has no ownership interest; (h) Seller's membership interest in Sleep HealthCenters of Connecticut, LLC, a Delaware limited liability company ("***SHC***"), and all right, title and interest of Seller therein and all of the properties and assets of Seller and SHC exclusively used by SHC in the durable medical equipment business conducted by SHC and Seller; (i) the ECW Equipment, including the Hewlett Packard server and server rack and the software supporting the Seller's ECW users; (j)

the assets of the Sleep Center Business at any other facility or location of Seller other than the Facility; and (k) those assets described on Schedule 2.3(k).

2.4 Assets Free and Clear. The Acquired Assets shall be sold and free and clear of all liabilities, liens, charges, claims, encumbrances, mortgages, security interests, adverse claims, and restrictive covenants of any nature whatsoever ("***Encumbrances***"), other than Permitted Encumbrances. Buyer shall not assume nor in any way become liable for any liability or obligation of Seller or the Sleep Center Business, fixed or contingent, disclosed or undisclosed, at the Closing or any time prior to or after the Effective Time, including any obligation of Seller to its employees or leased employees or in connection with any Proceeding, other than the Assumed Contract Obligations. Seller agrees to satisfy, on or before the Closing, all Encumbrances (other than Permitted Encumbrances), and to deliver to Buyer evidence of satisfaction of same and all appropriate UCC termination statements and lien releases at the Closing.

2.5 Non-Assignable Assets. Nothing in this Agreement shall be construed as an attempt or agreement to assign any Acquired Asset, including any contract, license, permit, certificate, patient records, approval, authorization or other right, if an attempted assignment thereof, without the approval, authorization or consent of, or granting or issuance of any license or permit by, any third party thereto (each such action, a "***Necessary Consent***"), would constitute a breach thereof or in any way adversely affect the rights of Buyer thereunder ("***Non-Assignable Assets***"). In such event, Seller and Buyer will use their reasonable best efforts to obtain the Necessary Consents with respect to any such Non-Assignable Asset, or any claim or right or any benefit arising thereunder, for the assignment thereof to Buyer as Buyer may reasonably request. To the extent permitted by applicable law, in the event consents to the assignment thereof cannot be obtained, such Non-Assignable Assets shall be held, as of and from the Closing Date, by Seller, in trust for Buyer, and the covenants and obligations thereunder shall be performed by Buyer in Seller's name and all benefits and obligations existing thereunder shall be for Buyer's account (except for any Excluded Assets which the parties agree herein shall belong to Seller). Seller shall take or cause to be taken at Buyer's expense such actions in its name or otherwise as Buyer may reasonably request so as to provide Buyer with the benefits of the Non-Assignable Assets and to effect collection of money or other consideration that becomes due and payable under the Non-Assignable Assets (except for any Excluded Assets, which the parties agree herein shall belong to Seller). As of and from the Closing Date, Seller authorizes Buyer, to the extent permitted by applicable law and the terms of the Non-Assignable Assets, at Buyer's expense, to perform all the obligations and receive all the benefits of Seller under the Non-Assignable Assets (except for any Excluded Assets, which the parties agree herein shall belong to Seller) and appoints Buyer or its attorney-in-fact to act in its name on its behalf with respect thereto. Without limiting the foregoing, with respect to intellectual property licenses, if Seller is permitted to sublicense only in exchange for a one-time fixed payment or an ongoing fee, Seller shall notify Buyer thereof and, only if Buyer agrees in writing to be responsible to such payment or fee, as applicable, Seller shall sublicense whatever rights it is permitted to sublicense under the respective intellectual property licenses, subject to the payment or fee being paid by Buyer.

2.6 Risk of Loss. Seller shall bear the risk of loss for damage to the Acquired Assets at all times prior to the Effective Time. Seller agrees to maintain Seller's existing insurance policies on the Acquired Assets through the Closing Date and shall name Buyer as an additional

insured on such existing insurance policies during the period between the Execution Date and the Closing Date. Seller shall provide evidence of the foregoing insurance coverage upon request of Buyer. In the event of substantial damage or destruction to any Acquired Asset after the Execution Date and prior to the Effective Time, Buyer shall be entitled to receive the net proceeds of any insurance proceeds payable with respect to such Acquired Asset(s) upon Closing and in lieu of the Acquired Assets, which shall be Seller's sole and exclusive remedy for any substantial damage or destruction of the Acquired Assets after the Execution Date and prior to the Effective Time.

2.7 Condition of Acquired Assets. THE REPRESENTATIONS AND WARRANTIES OF SELLER SET FORTH IN ARTICLE 4 ARE EXCLUSIVE AND IN LIEU OF ALL OTHER REPRESENTATIONS OR WARRANTIES OF SELLER WHETHER STATUTORY, WRITTEN, ORAL OR IMPLIED AND, EXCEPT FOR SUCH REPRESENTATIONS AND WARRANTIES SET FORTH HEREIN, SELLER HAS NOT MADE AND DOES NOT HEREBY MAKE, NOR SHALL IT BE DEEMED BY VIRTUE OF HAVING SOLD AND CONVEYED THE ACQUIRED ASSETS PURSUANT TO THIS AGREEMENT TO HAVE MADE, ANY REPRESENTATION OR WARRANTY AS TO THE MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, DESIGN OR CONDITION OF, OR AS TO THE QUALITY OF THE WORKMANSHIP OF, THE ACQUIRED ASSETS.

2.8 Assumed Contract Liabilities. Buyer shall not assume any liabilities or obligations of Seller or the Sleep Center Business other than those liabilities and obligations under the Assumed Contracts and Leases which are to be performed after the Effective Time ("***Assumed Contract Obligations***"); provided, that Buyer will not assume any obligation or liability arising under the Assumed Contracts and Leases prior to the Effective Time or any such liability or obligation arising out of Seller's performance, breach or failure to perform any Assumed Contract or Lease prior to Effective Time.

ARTICLE 3

ARTICLE 4

REPRESENTATIONS AND WARRANTIES OF SELLER

Seller represents and warrants to Buyer, which representations and warranties shall be true and correct as of the Execution Date and as of the Closing Date, as follows:

4.1 Duly Organized. Seller is a nonstock corporation duly incorporated and validly existing under the laws of the State of Connecticut and has full power and authority to own or lease the Acquired Assets and to conduct the Sleep Center Business as heretofore conducted.

4.2 Authorization. Seller has the requisite power and authority to execute and deliver this Agreement, to perform its obligations hereunder and to consummate the transactions contemplated hereby and has taken all action required to be taken by or on the part of Seller to authorize the execution, delivery and performance of this Agreement.

4.3 Delivery of Agreement. This Agreement has been duly and validly executed and delivered on Seller's behalf, constitutes a valid and binding obligation of Seller, enforceable against Seller in accordance with its terms (except as enforceability may be limited by bankruptcy and similar laws affecting the enforcement of creditors' rights generally or equitable considerations which may affect a court's exercise of its equitable powers).

4.4 No Violation or Conflict. Neither the execution and delivery of this Agreement, nor the performance of its obligations hereunder, by Seller is a violation of any provision of Seller's certificate of incorporation or bylaws, or any law, rule, regulation, order, writ, injunction, judgment or decree to which Seller is a party or to which Seller or the Acquired Assets is/are subject or bound, subject to receipt of the consents and approvals listed on Schedule 4.4. Further, the consummation of the transactions contemplated by this Agreement shall not constitute a violation of or a default under any contract, commitment, lease or other agreement or any other restriction of any kind to which Seller is a party or by which Seller is bound, nor cause an acceleration or increase in liability owed by Seller pursuant to any such contract, commitment, lease or other agreement, subject to receipt of the consents and approvals listed on Schedule 4.4.

4.5 Consents. No consent or approval by, or filing with, any Governmental Authority or any other Person is required in connection with the execution and delivery by Seller of this Agreement or for consummation of the transactions contemplated hereby, except as set forth on Schedule 4.5.

4.6 Title to and Condition and Extent of the Acquired Assets. Upon consummation of the transactions contemplated by this Agreement, Buyer shall be the sole owner of the Acquired Assets free and clear of all Encumbrances, other than Permitted Encumbrances and Encumbrances created by Buyer. The Acquired Assets are each in substantially the same condition as they were in upon Buyer's inspection of such Acquired Assets on September 10, 2013, ordinary wear and tear excepted.

4.7 Taxes. All federal, state and other tax returns of Seller have been timely filed, and Seller has paid or provided for all taxes (including taxes on properties (real and personal), income, franchises, licenses, sales and payrolls) that have become due pursuant to such returns or that the amount, applicability or validity is currently being contested in good faith by appropriate proceedings and with respect to which Seller has set aside and shall maintain adequate reserves. There are no tax liens on the Acquired Assets except those with respect to taxes not yet due and payable.

4.8 Material Contracts. Schedule 4.8 lists each contract, agreement or other written or oral arrangement that is binding on Seller and relates to any of the Acquired Assets or the Sleep Center Business at the Facility, including vendor agreements and independent contractor agreements, requiring payments of greater than $10,000 in any single twelve-month period (collectively, the "***Material Contracts***"). Each Material Contract: (a) is valid and legally binding on Seller and, to the knowledge of Seller, the other parties thereto, is in full force and effect; (b) if validly assigned to, and assumed by, Buyer or its successor or designee, will continue to be in full force and effect immediately after such assignment to, and assumption by,

Buyer as of the Effective Time; and (c) is being complied with by Buyer and, to the knowledge of Buyer, the other parties thereto.

4.9 Litigation. Schedule 4.9 is an accurate list and summary description of all actions, suits, claims, litigation, arbitration, judgments, orders, decrees, or proceedings (collectively, the "***Proceedings***") with respect to which Seller or any Physician is a party and that relate to the Sleep Center Business at the Facility or the Acquired Assets. Except as set forth on Schedule 4.9, there are no Proceedings (public or private) or governmental investigations that have been brought by or against any Governmental Authority or any other Person pending or, to the knowledge of Seller, threatened against the Seller or any Physician and that relate to the Sleep Center Business at the Facility or the Acquired Assets, or that would affect the consummation of the transactions contemplated herein. Except as set forth on Schedule 4.9, there are no existing or, to the knowledge of Seller, threatened orders, judgments or decrees (other than those of general application) of any Governmental Authority to which Seller or an Physician is subject or a party which would have an adverse effect on the Sleep Center Business at the Facility, the Acquired Assets or the consummation of the transactions contemplated herein.

4.10 Employee Benefit Plans. The Acquired Assets are not and shall not become subject to a lien imposed under Section 162 of the Code or under Title I or Title IV of ERISA.

4.11 Labor and Employment Matters.

(a) Labor Matters; Union and Employee Contracts. Except as set forth on Schedule 4.11(a), with respect to the Sleep Center Business at the Facility: (i) Seller is not a party to or bound by any union contract, collective bargaining agreement, employment contract, independent contractor agreement, consultation agreement or other similar type of contract; (ii) Seller has not agreed to recognize any union or other collective bargaining unit; (iii) no union or collective bargaining unit has been certified as representing the employees of Seller and no organizational attempt has been made or threatened by or on behalf of any labor union or collective bargaining unit; and (iv) Seller has not experienced any labor strike, dispute, slowdown or stoppage or any other material labor difficulty during the past five (5) years and, to the knowledge of Seller, there are no facts or circumstances that may reasonably lead to any such labor dispute.

(b) Employee List. Seller has previously furnished Buyer with a list of all employees of, and all employees leased by, Seller who are employed in connection with the Sleep Center Business at the Facility, their respective positions, locations, exempt or non-exempt status, the rate of all regular and special compensation payable to each such employee in any and all capacities, and any other compensation that will be payable to each such employee in any and all capacities as of the Closing Date other than the then-current accrual of regular payroll compensation. Except as set forth on Schedule 4.11(b), all employees of Seller are employed on an "at will" basis. To the knowledge of Seller, except as otherwise set forth on Schedule 4.11(b), no employee intends to terminate his or her employment either currently or as a result of the transactions contemplated by this Agreement.

(c) WARN Act. With respect to the employees of Seller, during the last twelve (12) months, there has been no mass layoff, plant closing, or shutdown that implicates the

Worker Adjustment & Retraining Notification Act of 1988, as amended, or any similar Law that could result in similar liability to an employer.

(d) Former Employment Arrangements. To the knowledge of Seller, no current employee or current officer or director of Seller (who is employed in connection with the Sleep Center Business at the Facility) is a party to, or is otherwise bound by, any agreement or arrangement, including any confidentiality, non competition or proprietary rights agreement, between such employee, officer or director and any other Person that in any way materially and adversely affects the performance of his or her duties as an employee, officer, director or manager with respect to the Sleep Center Business at the Facility.

4.12 Legal and Regulatory Compliance. To the best of Seller's knowledge, Seller is in compliance with all applicable laws of federal, state and local authorities, and all applicable rules, regulations and requirements of all federal, state and local commissions, boards, bureaus and agencies having jurisdiction over the Sleep Center Business at the Facility or the Acquired Assets, including the Internal Revenue Service and the U.S. Department of Health and Human Services, the violation of which would have a material adverse effect on the Sleep Center Business at the Facility or the Acquired Assets. Seller has timely filed all material reports, data and other information required to be filed with such commissions, boards, bureaus and agencies. Except as set forth in Schedule 4.12, neither Seller nor any Affiliate thereof have, with respect to the operation of the Sleep Center Business at the Facility or on the Acquired Assets, received written notice of, and to Seller's knowledge, neither Seller nor any Affiliate thereof is under investigation with respect to, any violation or alleged violation of, or any obligation to take remedial action under, any applicable (a) law, statute, ordinance, rule, regulation, policy or guideline promulgated; (b) license, certificate or certificate of need issued; or (c) order, judgment or decree entered, by any federal, state or local court or Governmental Authority.

4.13 No Finders or Brokers. Seller has not engaged any finder or broker in connection with the transactions contemplated hereunder.

4.14 Real Property Leases. As of the Closing Date, Seller shall have provided to Buyer a true and complete copy of all Real Property Leases with all such amendments, subleases, modifications, supplements and guaranties thereto and each Real Property Lease shall be in full force and effect. Neither Seller nor the landlord under any Real Property Lease shall be in default of any kind under any Real Property Lease and no event has occurred and no circumstances exists which, if not remedied, and whether with or without notice or the passage of time or both, would result in a default.

4.15 Accuracy and Completeness of Information. No representation or warranty made by Seller in this Agreement contains any untrue statement of material fact or omits to state a fact necessary to make the statements therein not misleading.

ARTICLE 5

REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to Seller, which representations and warranties shall be true and correct as of the Execution Date and as of the Closing Date, as follows:

5.1 Duly Organized. Buyer is a nonstock corporation duly organized and validly existing under the laws of the State of Connecticut.

5.2 Authorization. Buyer has the requisite power and authority to execute and deliver this Agreement, to perform its obligations hereunder and to consummate the transactions contemplated hereby and has taken all action required to be taken by or on the part of Buyer to authorize the execution, delivery and performance of this Agreement.

5.3 Delivery of Agreement. This Agreement has been duly and validly executed and delivered on Buyer's behalf, constitutes a valid and binding obligation of Buyer, enforceable in accordance with its terms (except as enforceability may be limited by bankruptcy and similar laws affecting the enforcement of creditors' rights generally or equitable considerations which may affect a court's exercise of its equitable powers).

5.4 No Violation or Conflict. Neither the execution and delivery of this Agreement, nor the performance of its obligations hereunder, by Buyer is a violation of any provision of its certificate of incorporation or bylaws, or any law, rule, regulation, order, writ, injunction, judgment or decree to which it is a party. Further, the consummation of the transactions contemplated by this Agreement shall not constitute a violation of or a default under any contract, commitment, lease or other agreement or any other restriction of any kind to which Buyer is a party or by which Buyer is bound, nor cause an acceleration or increase in liability owed by Buyer pursuant to any such contract, commitment, lease or other agreement.

5.5 Consents. No consent or approval by, or filing with, any Governmental Authority or any other Person is required in connection with the execution and delivery by Buyer of this Agreement or for consummation of the transactions contemplated hereby.

5.6 No Finders or Brokers. Buyer has not engaged any finder or broker in connection with the transactions contemplated hereunder.

5.7 Sufficient Funds. Buyer has sufficient funds to purchase the Acquired Assets. The purchase of the Acquired Assets is not subject to a financing contingency.

5.8 Accuracy and Completeness of Information. No representation or warranty made by Buyer in this Agreement contains any untrue statement of material fact or omits to state a fact necessary to make the statements therein not misleading.

ARTICLE 6

CERTAIN AGREEMENTS AND COVENANTS OF THE PARTIES

The parties covenant and agree that, except as otherwise consented to in writing by the other party, after the Execution Date:

6.1 Further Assurances; Execution of Further Documents. Each party shall execute and deliver such additional instruments and other documents and shall take such further actions as may be necessary or appropriate to effectuate, carry out, and comply with all of the terms of this Agreement and the transactions contemplated hereby, and to satisfy the conditions set forth in ARTICLE 7 and ARTICLE 8, as applicable. Upon the reasonable request of Buyer, the Seller shall execute, acknowledge, and deliver all such further deeds, bills of sale, assignments, transfers, conveyances, powers of attorney, and assurances as may be required or appropriate to convey and transfer to and vest in Buyer and protect its right, title, and interest in all of the Acquired Assets and to carry out the transactions contemplated by this Agreement.

6.2 Consents and Approvals. Each party shall take all necessary corporate action and shall use its reasonable best efforts to take all other action and to obtain all consents, approvals and amendments of agreements required of it to carry out the transactions contemplated by this Agreement and to satisfy the conditions specified herein.

6.3 Disclosures. Each party shall immediately inform the other party of the occurrence or non-occurrence of any event which would likely cause any representation or warranty contained in ARTICLE 4 or ARTICLE 5, as applicable, to be untrue or inaccurate, or any covenant or condition, or agreement contained herein not to be complied with or satisfied.

6.4 Employee Obligations.

(a) Buyer may, in its sole discretion, without obligation to any person, on or before the Closing Date, offer employment (to be effective as of the Effective Time) to those Sleep Center Personnel that Buyer determines satisfy its credentialing and employment eligibility standards and are necessary for the positions it determines are available to be filled, in its sole discretion (such persons, the "***Buyer Employed Personnel***"). If Buyer makes an offer to any Sleep Center Personnel prior to the Effective Time it shall give prompt written notice thereof to Seller. Notwithstanding the foregoing, nothing in this Agreement shall obligate Buyer to employ any Buyer Employed Personnel for any period of time or continue any term or condition of employment or any employment benefits or policies for any period of time after the Closing Date.

(b) With respect to all employees and leased employees of Seller (including Sleep Center Personnel), Seller shall be and shall at all times remain solely liable for all employer obligations and any employment or benefit related payments with respect to such persons for periods prior to the Closing Date, including: (i) accrued paid time off expense, vacation, sick leave or other pay; (ii) employer contributions accrued or committed under each Plan or similar arrangement of Seller (provided that, with the consent of Buyer, which shall not be unreasonably withheld, and whom shall be held harmless from liability by Seller, these

amounts may be paid on the date on which such contributions would otherwise be due in the absence of this Agreement); (iii) any severance payments or other obligations arising under existing employment agreements or similar arrangements; and (iv) any other accrued benefits to which employee or leased employee may be entitled. Seller acknowledges and agrees that (w) Buyer assumes no obligation under any existing Plan of Seller, (x) there shall be no merger of any Plan of Seller with any existing Plan(s) of Buyer, (y) Buyer shall not be deemed to be a successor operator or employer of Seller for purposes of ERISA and the regulations thereunder, and (z) Seller shall be responsible for any Plan benefits or other benefits or contributions up to the Closing Date in respect of the Buyer Employed Personnel. With respect to all Sleep Center Personnel and all other employees of Seller who do not become Buyer Employed Personnel, Seller shall be and shall at all times remain solely liable for all employer obligations and all employment and benefit related payments with respect to such persons for periods on and before the Closing Date.

6.5 Operation in the Ordinary Course. Except as expressly authorized by this Agreement, Seller shall conduct, during the time period from the Execution Date through the Effective Time, the business and operations of the Sleep Center Business at the Facility only in the ordinary course in all material respects. Seller agrees to maintain the Acquired Assets between the Execution Date and the Effective Time in good operating condition and repair (ordinary wear and tear excepted) and otherwise as Seller would maintain such assets in the ordinary course of its business.

6.6 Space for DME Company. Buyer shall enter into good faith negotiations with Seller for the sublease of at least 500 square feet of office space at one of Buyer's facilities located in North Haven, Connecticut.

6.7 Wind-Up Costs. Seller shall be solely responsible for any and all costs associated with winding up its operation of the Sleep Center Business, including legal and accounting fees.

ARTICLE 7

CONDITIONS TO THE OBLIGATIONS OF SELLER

The duties and obligations of Seller under this Agreement to consummate the Closing shall be subject to the fulfillment, prior to or at Closing of each of the following conditions (unless waived in writing by the Seller):

7.1 Buyer's Representations and Warranties to be True and Correct. The representations and warranties made by Buyer contained in ARTICLE 5 that are qualified by materiality shall be true, complete and correct in all respects as of the Closing Date, and all representations and warranties made by Buyer that are not so qualified shall be true, complete and correct in all material respects as of the Closing Date, and an authorized officer of Buyer shall have certified the foregoing to Seller in writing.

7.2 No Action or Proceeding. No order of any Governmental Authority restraining, enjoining or otherwise preventing or delaying the consummation of this Agreement or the transactions contemplated hereby shall be outstanding, and no proceeding or investigations by or

before, or otherwise involving, any Governmental Authority shall be threatened or pending against any party which seeks to enjoin or prevent the consummation of the transactions contemplated under this Agreement or which seeks material damages in connection with the transactions contemplated hereby.

7.3 Payments on the Closing Date. Buyer shall have made the payments required of it on the Closing Date in accordance with Section 3.1.

7.4 Buyer's Deliveries. Buyer shall have delivered the documents and other items referred to below (the "***Buyer's Deliveries***"):

(a) Certificates. A certificate executed by a duly authorized officer of Buyer, dated as of the Closing Date and reasonably satisfactory in form and substance to Seller, certifying (i) the accuracy of the matters set forth Section 7.1 on and as of the Closing Date; and (ii) Buyer has in all material respects performed and complied with all of its covenants set forth in this Agreement which are to be performed or complied with before or as of the Closing Date, except as may have been waived by Seller.

(b) Certificate of Legal Existence. A certificate of legal existence for Buyer from the Connecticut Secretary of the State dated no earlier than ten (10) days prior to the Closing Date.

(c) Secretary's Certificate. A certificate of the Secretary or an Assistant Secretary for Buyer dated as of the Closing Date and certifying: (i) that attached thereto is a true and complete copy of all resolutions adopted by the appropriate governing body authorizing the execution, delivery and performance of this Agreement, and all transactions contemplated hereto and that all such resolutions are in full force and effect and are all the resolutions adopted in connection with the transactions contemplated by this Agreement; and (ii) to the incumbency and specimen signature of the officer of Buyer executing this Agreement or the other documents to be delivered by Buyer.

(d) Assignment and Assumption. Seller shall assign its rights and obligations under, and Buyer shall accept such rights and assume such obligations under, the Assignment and Assumption Agreement.

(e) Other Documents. Buyer shall deliver to Seller such other documents or instruments as may be reasonably required to consummate the purchase of the Acquired Assets as contemplated by this Agreement.

ARTICLE 8

CONDITIONS TO THE OBLIGATIONS OF BUYER

The duties and obligations of Buyer under this Agreement to consummate the Closing shall be subject to the fulfillment, prior to or at Closing of each of the following conditions (unless waived in writing by the Buyer):

8.1 Representations and Warranties to be True and Correct. The representations and warranties made by Seller contained in ARTICLE 4 that are qualified by materiality shall be true, complete and correct in all respects as of the Closing Date, and all representations and warranties made by Seller that are not so qualified shall be true, complete and correct in all material respects as of the Closing Date, and an authorized officer of Seller shall have certified the foregoing to Buyer in writing.

8.2 No Action or Proceeding. No order of any Governmental Authority restraining, enjoining or otherwise preventing or delaying the consummation of this Agreement or the transactions contemplated hereby shall be outstanding, and no proceeding or investigations by or before, or otherwise involving, any Governmental Authority shall be threatened or pending against any party which seeks to enjoin or prevent the consummation of the transactions contemplated under this Agreement or which seeks material damages in connection with the transactions contemplated hereby.

8.3 Seller's Deliveries. Seller shall have delivered the documents and other items referred to below (the "***Seller's Deliveries***"):

(a) Certificates. A certificate executed by a duly authorized officer of Seller, dated as of the Closing Date and reasonably satisfactory in form and substance to Buyer, certifying (i) the accuracy of the matters set forth Section 8.1 on and as of the Closing Date; and (ii) Seller has in all material respects performed and complied with all of its covenants set forth in this Agreement which are to be performed or complied with before or as of the Closing Date, except as may have been waived by Buyer.

(b) Certificate of Legal Existence. A certificate of legal existence for Seller from the Connecticut Secretary of the State dated no earlier than ten (10) days prior to the Closing Date.

(c) Secretary's Certificate. A certificate of the Secretary or an Assistant Secretary for Seller dated as of the Closing Date and certifying: (i) that attached thereto is a true and complete copy of all resolutions adopted by the appropriate governing body authorizing the execution, delivery and performance of this Agreement and all transactions contemplated hereto and that all such resolutions are in full force and effect and are all the resolutions adopted in connection with the transactions contemplated by this Agreement; and (ii) to the incumbency and specimen signature of the officer of Seller executing this Agreement or the other documents to be delivered by Seller.

(d) Bill of Sale. Seller shall execute and deliver the Bill of Sale for the transfer of the Acquired Assets to Buyer.

(e) Assignment and Assumption. Seller shall assign its rights and obligations under, and Buyer shall accept such rights and assume such obligations under, the Assignment and Assumption Agreement.

(f) Release of Encumbrances. Seller shall have filed copies of appropriately completed UCC-3 termination statements, and Seller shall deliver to Buyer such other evidence as Buyer determines necessary to evidence the affirmative releases of all other Encumbrances

relating to the Acquired Assets, including, the release of any Encumbrance arising from Seller's financing arrangements through the Connecticut Health and Education Facilities Authority.

(g) FIRPTA. A certificate, duly completed and executed by Seller, pursuant to Section 1.1445-2(b)(2) of the Treasury Regulations, certifying that Seller is not a "foreign person" within the meaning of Section 1445 of the Code.

(h) Other Documents. Seller shall deliver to Buyer such other documents or instruments as may be reasonably required to consummate the purchase of the Acquired Assets as contemplated by this Agreement, including the proof of satisfaction of liabilities as required by Section 2.4.

ARTICLE 9

CLOSING

Subject to satisfaction or waiver of the conditions set forth in ARTICLE 7 and ARTICLE 8, the closing of the transactions contemplated by this Agreement (the "***Closing***") shall take place at 20 York Street, New Haven, Connecticut on the earlier of: March 1, 2014 or a date that is as soon as practicable after the satisfaction or waiver of the conditions set forth in ARTICLE 7 and ARTICLE 8 but in no event more than thirty (30) days thereafter or such other date as mutually agreed by the parties (the "***Closing Date***"). The Closing shall be effective on the Closing Date; however, transfer of possession of the Acquired Assets shall be effective as of 12:01 a.m. on the Closing Date (the "***Effective Time***").

ARTICLE 10

POST-CLOSING COVENANTS

10.1 Seller Claims. Seller represents, warrants and agrees with Buyer that Seller is responsible for, and shall pay when due:

(a) All liabilities or obligations of and claims against Seller, including all liabilities or obligations of and claims against Seller resulting from or related to Seller's operation of the Sleep Center Business or the Acquired Assets prior to the Effective Time;

(b) Any and all losses, damages, costs or deficiencies resulting from any and all misrepresentations or breaches of warranty or failures to perform undertakings by Seller contained in or made pursuant to this Agreement;

(c) All claims and litigation and potential claims and litigation against Seller with respect to incidents or other matters which occurred prior to the Effective Time related to the Sleep Center Business or the Acquired Assets;

(d) All sales and transfer taxes which may be due as a result of the sale of the Acquired Assets taking place pursuant to this Agreement; and

(e) Any and all actions, suits, proceedings, claims, demands, assessments, judgments, costs and expenses incident to any of the foregoing.

10.2 Buyer Claims. Buyer represents, warrants and agrees with Seller that Buyer is responsible for, and shall pay when due:

(a) All liabilities or obligations of and claims against Buyer, including all liabilities or obligations of and claims against Seller resulting from or related to Buyer's operation of the Acquired Assets from and after the Effective Time;

(b) Any and all losses, damages, costs or deficiencies resulting from any and all misrepresentations or breaches of warranty or failures to perform undertakings by Buyer contained in or made pursuant to this Agreement;

(c) All claims and litigation and potential claims and litigation against Buyer with respect to incidents or other matters which occurred on or after the Effective Time related to the Acquired Assets; and

(d) Any and all actions, suits, proceedings, claims, demands, assessments, judgments, costs and expenses incident to any of the foregoing.

ARTICLE 11

INDEMNIFICATION

11.1 Survival. The representations and warranties set forth in this Agreement shall each survive the Closing for a period of twelve (12) months, except for the representations and warranties set forth in Sections 4.2, 4.3 and 4.13 (collectively, the "***Fundamental Reps***") which shall each survive the Closing indefinitely and those set forth in Sections 4.7 and 4.12 which shall survive the Closing for the applicable statute of limitations plus 30 days (each applicable period, the "***Survival Period***"). All covenants and agreements contained in this Agreement shall survive the Closing for the period of performance or survival stated therein or, if no period is stated, for a period of twelve (12) months. Claims for indemnification under this ARTICLE 11 shall be asserted by the party seeking indemnification prior to the expiration of the applicable Survival Period by giving written notice to the indemnifying party describing in reasonable detail the basis for such claim ("***Claim Notice***"). No person shall have any obligation to indemnify any other persons hereunder with respect to any Losses asserted in a Claim Notice that is not given prior to the expiration of the applicable Survival Period.

11.2 Indemnification by Seller. Seller will indemnify and hold harmless Buyer and its representatives, members, managers, officers, agents, subsidiaries and Affiliates (collectively, the "***Buyer Indemnified Persons***"), and will reimburse Buyer Indemnified Person for any loss, liability, claim, damage (other than incidental and consequential damages that are reasonably foreseeable), expense (including costs of investigation and defense and reasonable attorneys' fees and expenses) or diminution of value (collectively, "***Damages***"), whether or not involving a claim by a third party, arising from or in connection with any of the items below: (a) any breach of any representation or warranty made by Seller in this Agreement or any other certificate, document, writing or instrument delivered by Seller pursuant to this Agreement; (b) any breach of any covenant or obligation of Seller in this Agreement or in any other certificate, document, writing or instrument delivered by Seller pursuant to this Agreement; (c) any liability arising out of the ownership or operation of the Sleep Center Business or the Acquired Assets with respect to the period prior to the Effective Time other than the Assumed Contract Obligations (if any); or (d) any liability relating to any Plan maintained by Seller or any Affiliate.

11.3 Indemnification by Buyer. Buyer will indemnify and hold harmless Seller and its representatives, members, managers, officers, agents, subsidiaries and Affiliates (collectively, the "***Seller Indemnified Persons***"), and will reimburse Seller Indemnified Persons for any Damages arising from or in connection with: (a) any breach of any representation or warranty made by Buyer in this Agreement or in any certificate, document, writing or instrument delivered by Buyer pursuant to this Agreement; (b) any breach of any covenant or obligation of Buyer in this Agreement or in any other certificate, document, writing or instrument delivered by Buyer pursuant to this Agreement; (c) any liability arising out of the ownership or operation of the Acquired Assets with respect to the period after the Effective Time; and (d) any Assumed Contract Obligations.

11.4 Notice of Claims.

(a) Claims by Third Parties. Promptly after receipt by a Seller Indemnified Person or a Buyer Indemnified Person of written notice of the commencement of any investigation, claim, proceeding or other action by a third party in respect of which indemnification may be sought from the Buyer or Seller under Section 11.2 or 11.3, respectively (each, an "***Action***"), such indemnified party shall promptly provide a Claim Notice to the indemnitor; but the failure to so notify the indemnitor shall not relieve it from any liability that it may otherwise have to such indemnified party, except to the extent that the indemnitor is materially prejudiced or forfeits substantive rights or defenses as a result of such failure. The indemnitor shall be entitled to participate in, and, upon prior written notice to the indemnified party, may promptly, upon receipt of a Claim Notice, assume the defense of, any Action, at its own cost and expense. Notwithstanding the assumption of the defense of any such Action by the indemnitor, each indemnified party shall have the right to employ separate counsel and to participate in the defense of such Action. The indemnitor shall bear the reasonable fees, costs and expenses of such separate counsel to such indemnified party if: (i) the indemnitor shall have agreed to the retention of such separate counsel, (ii) the defendants in, or target of, any such Action include more than one indemnified party or both an indemnified party and the indemnitor shall have concluded that representation of such indemnified party by the same counsel would be inappropriate due to actual or, as reasonably determined by such indemnified party's counsel, potential differing interests between them in the conduct of the defense of such Action, or if there may be legal defenses available to such indemnified party that are different from or additional to those available to the other indemnified party or to the indemnitor, or (iii) the indemnitor shall have failed to employ counsel reasonably satisfactory to such indemnified party within a reasonable period of time after notice of the institution of such Action. If such indemnified party retains separate counsel in cases other than as described in clauses (i), (ii), or (iii) above, such counsel shall be retained at the expense of such indemnified party. Except as provided above, it is hereby agreed and understood that the indemnitor shall not, in connection with any Action in the same jurisdiction, be liable for the fees and expenses of more than one counsel for all such indemnified parties (together with appropriate local counsel). The indemnitor shall not, without the written consent of the indemnified party (which consent shall not be unreasonably withheld), settle or compromise any Action or consent to entry of any judgment that (A) relates to Taxes, (B) has a material adverse effect on the indemnified party, (C) provides for injunctive or non-monetary relief, or (D) does not include an (x) unconditional release of each indemnified party from all liabilities with respect to such Action and (y) agreement by indemnitor to pay all of the costs of any such settlement or judgment.

(b) Other Claims. In the event one party hereunder should have a claim for indemnification that does not involve a claim or demand being asserted by a third party, the party seeking indemnification shall promptly send a Claim Notice to the party from whom indemnification is sought, but in no event later than the expiration of the applicable Survival Period applicable to such claim.

11.5 Limitations. Neither party shall have any obligation to indemnify the other pursuant to Section 11.2 or 11.3 unless and until total Damages asserted by Buyer Indemnified Persons or Seller Indemnified Persons, as the case may be, exceed Ten Thousand Dollars ($10,000), in which case, Buyer or Seller, as the case may be, shall be liable for the full amount

of all such Damages. Neither party shall be required to indemnify any person for an aggregate amount of Damages exceeding One Hundred Thousand Dollars ($100,000). All references in this Agreement to "material," "material respects," and "material adverse effect" and similar qualifications will be disregarded when determining the amount of damages resulting from a breach of a representation or warranty for which a Buyer Indemnified Person or Seller Indemnified Person is entitled to indemnification under this ARTICLE 11 and the amount of any Damages related thereto.

ARTICLE 12

TERMINATION

12.1 Termination. This Agreement may be terminated at any time prior to the Closing:

(a) by mutual written consent of Buyer and Seller;

(b) by Buyer or Seller if:

(i) the Closing does not occur on or before March 1, 2014; provided that the right to terminate this Agreement under this clause (b)(i) shall not be available to any party whose breach of a representation, warranty, covenant or agreement under this Agreement has been the cause of or resulted in the failure of the Closing to occur on or before such date; or

(ii) a Governmental Authority shall have issued an order or taken any other action, in any case having the effect of permanently restraining, enjoining or otherwise prohibiting the transactions contemplated by this Agreement, which order or other action is final and non-appealable; provided, that the right to terminate this Agreement under this clause b(ii) shall not be available to any party whose breach of any provision of this Agreement has been the cause of or resulted in such order or action being taken by such Governmental Authority, including noncompliance with its obligations under Sections 6.1 or 6.2;

(c) by Buyer if:

(i) any condition to the obligations of Buyer hereunder becomes incapable of fulfillment other than as a result of a breach by Buyer of any covenant or agreement contained in this Agreement, and such condition is not waived by Buyer; or

(ii) there has been a breach by Seller of any representation, warranty, covenant or agreement contained in this Agreement, or if any representation or warranty of Seller shall have become untrue, in either case such that the conditions set forth in Section 8.3 would not be satisfied and such breach is not curable, or, if curable, is not cured within fifteen (15) business days after written notice of such breach is given to Seller by Buyer; or

(iii) there is loss or damage to the Acquired Assets not covered in full by Seller's insurance policies and not otherwise paid by Seller to Buyer as of Closing.

(d) by Seller if

(i) any condition to the obligations of Seller hereunder becomes incapable of fulfillment other than as a result of a breach by Seller of any covenant or agreement contained in this Agreement, and such condition is not waived by Seller; or

(ii) there has been a breach by Buyer of any representation, warranty, covenant or agreement contained in this Agreement or Schedules, or if any representation or warranty of Buyer shall have become untrue, in either case such that the conditions set forth in Section 7.4 would not be satisfied and, in either case, such breach is not curable, or, if curable, is not cured within fifteen (15) business days after written notice of such breach is given to Buyer by Seller.

The party desiring to terminate this Agreement pursuant to clause (b), (c) or (d) shall give prior written notice of such termination to the other party hereto.

12.2 Effect of Termination. In the event of termination of this Agreement as provided in Section 12.1, this Agreement shall immediately become null and void and there shall be no liability or obligation on the part of Seller or Buyer or their respective officers, directors, stockholders or affiliates, except as set forth in Section 12.3; provided, however, Section 12.3 of this Agreement shall remain in full force and effect and survive any termination of this Agreement.

12.3 Remedies. Any party terminating this Agreement pursuant to Section 12.1 shall have the right to seek recovery of breach of contract damages sustained by such party as a result of any breach by the other party of any representation, warranty, covenant or agreement contained in this Agreement or fraud or willful misrepresentation; provided, however, that the party seeking relief is not in breach of any representation, warranty, covenant or agreement contained in this Agreement under circumstances which would have permitted the other party to terminate the Agreement under Section 12.1.

ARTICLE 13

MISCELLANEOUS

13.1 Expenses. All expenses of the preparation of this Agreement and of the transaction provided for hereby shall be borne by the respective parties incurring such expense, whether or not such transactions are consummated.

13.2 Compliance with Law. In the event that any party to this Agreement determines, in good faith, or receives general or specific notice from the Internal Revenue Service or any other Governmental Authority that all or any provision of this Agreement: (a) violates or fails to comply with any state or federal law, regulation, rule or administrative policy or would result in

the prohibition of a referral under 42 U.S.C. § 1395nn, as amended; (b) jeopardizes its participation in any federal or state health care program; (c) jeopardizes the tax-exempt status of Buyer or any of its Affiliates or the tax-exempt status of any bonds issued on behalf of Buyer or any of its Affiliates; or (d) exposes any Person employed by or affiliated with Buyer or any of its Affiliates to the imposition of excise taxes under Section 4958 of the Code or any other sanction imposed by a Governmental Authority, the parties agree to undertake good faith negotiations to create and execute a modification that is as close as possible in terms, conditions and substance to this Agreement, but without the provision that causes the concern. If the parties are unable to renegotiate the terms of this Agreement on a mutually acceptable basis, any party may terminate this Agreement.

13.3 Knowledge and Material Adverse Effect. For purposes of this Agreement, "***knowledge***" of a particular fact or other matter will be imputed to a party if any of its shareholders, officers or directors: (a) is actually aware of the fact or matter; or (b) could reasonably be expected to discover or otherwise become aware of that fact or matter in the course of conducting his or her responsibilities as a shareholder, officer or director of the subject party. Notwithstanding the foregoing, Seller will be deemed to have "knowledge" of a particular fact or other matter only if George Kyriacou (Chief Executive Officer), Janine Epright (Chief Financial Officer), Sonja Labarbera (Director of Inpatient Therapy), Susan Hostage (Chief Compliance Officer) and Wally Harper (Vice President of Human Resources) is actually aware of that fact or other matter after making a reasonable inquiry into the fact or matter. For purposes of this Agreement, "***material adverse effect***" means any circumstance, change or effect, individually or in the aggregate with all other circumstances, changes or effects, that is materially adverse to the ability of the Seller to consummate the transactions contemplated by this Agreement.

13.4 Press Releases and Public Announcements. Neither party shall issue any press release or make any public announcement relating to the subject matter of this Agreement without the prior written approval of the other party; provided, however, that after the Closing Date, any party may make any public disclosure it believes in good faith is required by applicable law.

13.5 No Third Party Beneficiaries. This Agreement shall not confer any rights or remedies upon any Person other than the parties and their respective successors and permitted assigns, except as otherwise expressly provided for herein.

13.6 Waiver. The failure of any party to insist on performance of any of the terms or conditions of this Agreement shall not be construed as a waiver or relinquishment of any rights granted hereunder or of the future performance of any such term or condition, and the obligations of the parties with respect thereto shall continue in full force and effect.

13.7 Notices. Except as provided otherwise in this Agreement, any and all notices necessary or desirable to be served hereunder shall be in writing and shall be delivered personally, sent by certified mail or overnight delivery service to the intended recipient at the address for such intended recipient set forth below, or sent by facsimile to the fax number for such intended recipient set forth below, or to such other address or facsimile number as the party may designate in writing.

If to Buyer: Yale-New Haven Hospital, Inc.
20 York Street
New Haven, Connecticut 06510
Attention: Executive Vice President and COO

with a copy to: Yale-New Haven Hospital, Inc.
20 York Street
New Haven, Connecticut 06510
Attention: General Counsel

If to Seller: Gaylord Hospital, Inc.
Gaylord Farm Road
P.O. Box 400
Wallingford, Connecticut 06492

with a copy to:
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103

Any notice sent by mail as provided above shall be deemed delivered on the second (2nd) business day next following the postmark date which it bears. Any notice sent by facsimile or hand delivery as provided above shall be deemed delivered when sent. Any notice sent by a nationally recognized overnight carrier shall be deemed delivered on the next business day next following the postmarked date which it bears.

13.8 Exhibits. All exhibits, schedules and documents referred to in or attached to this Agreement are integral parts of this Agreement if fully set forth herein and all statements appearing therein shall be deemed to be representations.

13.9 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall comprise one and the same instrument. Any signature page counterpart executed and delivered by a party by means of facsimile transmission or electronic mail as a .PDF file shall be deemed for all purposes of this Agreement as an original counterpart.

13.10 Severability. If any provision of this Agreement is held to be illegal, invalid or unenforceable under any present or future law, and if the rights or obligations of Seller or Buyer under this Agreement will not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part hereof; (c) the remaining provisions of this Agreement will remain in full force and effect and will not be affected by the

illegal, invalid or unenforceable provision or by its severance herefrom; and (d) in lieu of such illegal, invalid or unenforceable provision, there will be added automatically as a part of this agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

13.11 Governing Law. The validity and construction of this Agreement shall be governed by the laws of the State of Connecticut.

13.12 Construction. The parties have hereto participated jointly in the negotiation and drafting of this Agreement. In the event an ambiguity or question of intent or interpretation arises, this Agreement will be construed as if drafted jointly by the parties hereto and no presumption or burden of proof will arise favoring or disfavoring any party hereto by virtue of the authorship of any of the provisions of this Agreement. Any reference to any federal, state, local or foreign statute or law will be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise. The word "including" means including without limitation. Any reference to the singular in this Agreement shall also include the plural and vice versa.

13.13 Entire Agreement. This Agreement and the exhibits attached hereto constitute the entire agreement between the parties with respect to the subject matter hereof, and no amendment or modification of this Agreement shall be valid unless such amendment or modification is expressed in a written instrument duly executed on behalf of the party or parties making such amendment or modification.

**** * * * Remainder of Page Blank / Signature Page Follows * * * ****

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date first written above.

SELLER:

GAYLORD HOSPITAL, INC.

By: Janine L Enright

Its: CFO

BUYER:

YALE-NEW HAVEN HOSPITAL, INC.

By:_____

Its:_____

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date first written above.

SELLER:

GAYLORD HOSPITAL, INC.

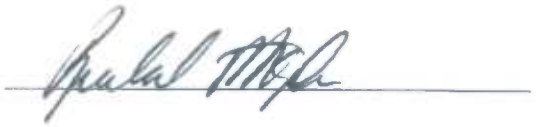
_____

By:_____

Its:_____

BUYER:

YALE-NEW HAVEN HOSPITAL, INC.



By: Richard D'Aquila

Its: President & Chief Operating Officer

Exhibit A

Form of Assignment and Assumption

THIS ASSIGNMENT AND ASSUMPTION AGREEMENT (the "***Assignment***"), is made and entered into as of _____, 2013, by and between Gaylord Hospital, Inc., a Connecticut nonstock corporation ("***Assignor***"), and Yale-New Haven Hospital, Inc., a Connecticut nonstock corporation ("***Assignee***"). Assignor and Assignee are collectively referred to herein as the "parties" and, individually, as a "party." Capitalized terms used in this Agreement and not defined herein shall have the same meanings as assigned to them in the Asset Purchase Agreement (as that term is defined below).

RECITALS

WHEREAS, Assignor and Assignee have entered into an Asset Purchase Agreement dated as of November 1, 2013 (the "***Asset Purchase Agreement***"); and

WHEREAS, the terms of the Asset Purchase Agreement require Assignor and Assignee to execute this Assignment.

AGREEMENT

NOW, THEREFORE, for and in consideration of the sum of One Dollar ($1.00) in hand paid to Assignor, the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. ASSIGNMENT OF CONTRACTS. As of the Effective Time, Assignor hereby assigns, conveys, transfers, and sets over unto Assignee any and all of Assignor's rights, interest and privileges, if any, in the Assumed Contracts, and Assignee hereby assumes Assignor's obligations under the Assumed Contracts which accrue from and after the Effective Time. Assignor shall remain liable for all claims, demands, causes of action, losses, damages, costs and expenses arising under the Assumed Contracts prior to the Effective Time.

2. ASSIGNMENT OF LEASES. As of the Effective Time, Assignor hereby assigns, conveys, transfers, and sets over unto Assignee any and all of Assignor's rights, interest and privileges, if any, in the Personal Property Leases and Real Property Leases (collectively, the "***Leases***"), and Assignee hereby assumes Assignor's obligations under the Leases which accrue from and after the Effective Time. Assignor shall remain liable for all claims, demands, causes of action, losses, damages, costs and expenses arising under the Leases prior to the Effective Time.

3. BINDING EFFECT. This Assignment applies to and binds the parties hereto and their respective heirs, administrators, executors, successors and assigns.

4. GOVERNING LAW. This Assignment shall be governed by, construed and enforced in accordance with the laws of the State of Connecticut.

IN WITNESS WHEREOF, Assignor and Assignee have duly executed this Assignment as of the ___ day of _____, 2013.

ASSIGNOR:

GAYLORD HOSPITAL, INC.

By:_____

Its:_____

ASSIGNEE:

YALE-NEW HAVEN HOSPITAL, INC.

By:_____

Its:_____

Exhibit B

Form of Bill of Sale

KNOW ALL MEN BY THESE PRESENTS, that Gaylord Hospital, Inc., a Connecticut nonstock corporation having, an address at _____ ("***Seller***"), pursuant to that certain Asset Purchase Agreement (the "***Agreement***") dated as of _____, 2013, by and between Seller and Yale-New Haven Hospital, a Connecticut nonprofit corporation ("***Buyer***"), for and in consideration of One Dollar ($1.00) and other good and valuable consideration paid to Seller by Buyer as set forth in the Agreement, has granted, bargained, sold and delivered and by these presents does grant, bargain, sell to Buyer all of Seller's right, title and interest in and to the Acquired Assets (as that term is defined in the Agreement) effective as of the Effective Time (as that term is defined in the Agreement).

TO HAVE AND TO HOLD the Assets unto Buyer, its heirs and assigns, to and for its own use and benefit forever.

IN WITNESS WHEREOF, the Seller has executed this Bill of Sale as of the ___ day of _____, 2013.

GAYLORD HOSPITAL, INC.

By:_____

Its:_____

Schedule 2.1(a)

List of Personal Property included in the Acquired Assets

Schedule 2.1(b)

List of Personal Property Leases

None

Schedule 2.1(d)

List of Contracts and Leases to be Assigned to Buyer

Real Property Lease

Schedule 2.1(f)

List of Prepaid Expenses

None

Schedule 2.3(k)

List of Additional Excluded Assets

None

Schedule 3.1

Allocation of Purchase Allocation

The Purchase Price shall be allocated among the Acquired Assets in accordance with Section 1060 of the Code and the regulations thereunder.

Schedule 4.4

List of Consents and Approvals Required under Contracts and Leases

Schedule 4.5

List of Governmental Consents and Approvals Required to Sell the Acquired Assets

Approval of the Connecticut Office of Health Care Access

Schedule 4.8

List of all Material Contracts

None

Schedule 4.9

List of Pending Litigation and Other Proceedings

None.

Schedule 4.11(a)

Labor and Employment Matters

None.

Schedule 4.11(b)

Labor and Employment Matters

None.

Schedule 4.12

Legal and Regulatory Compliance

None.

Gaylord Specialty Healthcare
Care beyond the ordinary.

Gaylord Specialty Healthcare

P.O. Box 400
Gaylord Farm Road
Wallingford, CT
06492
203 284-2800 tel
203 284-2894 fax
www.gaylord.org

May 6, 2014

VIA FACSIMILE (203) 688-3162 AND ELECTRONIC MAIL

Yale-New Haven Hospital, Inc.
20 York Street
New Haven, CT 06510

Attention: Richard D'Aquila
President and COO

Dear Mr. D'Aquila:

Reference is hereby made to that certain Asset Purchase Agreement, dated January 27, 2014 (the "*Purchase Agreement*"), by and between Yale-New-Haven Hospital, Inc. (the "*Buyer*") and Gaylord Hospital, Inc. (the "*Seller*"), which sets forth the principal terms and conditions on which the Buyer agreed to purchase certain tangible and intangible assets of the Seller utilized in the provision of technical sleep medicine services at four sleep centers owned and operated by the Seller. The Purchase Agreement provides in Article 9 that the outside closing date is March 1, 2014, and Section 12.1(b)(1) provides that either party may terminate the Purchase Agreement if the closing does not occur on or before March 1, 2014.

In view of the fact that the Seller has not received final approval of its application for a Certificate of Need from the Connecticut Office of Health Care Access, the parties have agreed to amend the Purchase Agreement to provide that the outside closing date under Article 9 and Section 12.1(b)(1) of the Purchase Agreement shall be extended from March 1, 2014 to October 1, 2014. Otherwise, the Purchase Agreement is hereby ratified and confirmed, as so amended.

[Signature page follows]

If the foregoing accurately reflects our understanding, please confirm the agreement of the Buyer to amend the Purchase Agreement by signing this letter in the space provided below.

Very truly yours,

GAYLORD HOSPITAL, INC.

By: Janine L. Epright
Janine L. Epright
Chief Financial Officer

cc: Willam Aseltyne, Esq.
General Counsel
Marc C. Lombardi, Esq.
Deputy General Counsel

ACCEPTED AND AGREED TO:

Dated: May 14, 2014

YALE-NEW HAVEN HOSPITAL, INC.

By: _____

Sleep Listed Assets – SCHEDULE 2.1(a) List of Personal Property Included in the Acquired Assets

Description	Location
Bedroom Furniture	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
Heater/Humidifier	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
Pressure Transducer	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
Sleep Room / Facility Furniture	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
EMG System	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
COMPUTER CENTRAL PROCESSING UNIT	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
MEDICATION & TRANSFER CARTS	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
MID-BACK,PNEUMATIC CHAIR ARMS	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
CHAIRS/CONCORDE 24H/HIGH BACK MULTI-TILTER	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
CHAIRS/CONCORDE 24H/HIGH BACK MULTI-TILTER	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
CHAIRS/CONCORDE 24H/HIGH BACK MULTI-	Equipt. From Wlfd Campus. Some disposed Some went to other facilities.
Neurologic diagnostic system	North Haven
Electric Beds	North Haven
Pulse Oximeter Finger Unit	North Haven
Bed Rails	North Haven
Notebook Laptop (1)	North Haven
Shelving	North Haven
Sleep Furniture No Haven	North Haven
Equipment	North Haven
Monitors	North Haven
Art For North Haven	North Haven
Otoscopes	North Haven
Voice IP System	North Haven
LCD TV/DVD	North Haven
Window Treatments	North Haven
Shelving	North Haven
Power Edge 2850 Server/ Comp. Equip.	North Haven
Computer equipment/Licences Includes later Adj's	North Haven
Art For North Haven	North Haven
Intelifax High Speed Fax Machine (2)	North Haven
Sleep Furniture No Haven	North Haven
Optiplex GX520 (2), Notebook Laptop (3)	North Haven
Mobile pedestall, Chair, File, Lamps	North Haven
Refrigerator, microwave	North Haven
Blackout Shades for N. Haven Sleep	North Haven
Laptop computers, Desktop computer	North Haven
Recliner Chairs	North Haven
Physician Scales	North Haven
Heavy Duty Bed Frames	North Haven
Equipment Drying Unit	North Haven
Exterior Sign (No. Haven)	North Haven
Blackout Shades	North Haven
Wiring for No. Haven Sleep	North Haven
Access Control for No. Haven Sleep	North Haven
Contruction On Sleep Lab	North Haven
Access Control for No. Haven Sleep	North Haven
Sleep Lab Construction	North Haven
monitors (62) for new system, 24"	North Haven
Back-UPS	North Haven
PCs	North Haven
Fax, printer, monitor	North Haven
chairs for St. Vincent's	North Haven
otoscopes, B/Ps for St. Vincent's	North Haven
Fax, printer, monitor	North Haven
Fujitsu Sheet-fed Scanner	North Haven
Software	North Haven
Nomad Recorder	North Haven
High back chair	North Haven
Interpretative EKG	North Haven
Respiratory Sensors/Modules	North Haven -Also System wide
Chair Bariatric	North Haven
Latitude D620 Computer	Should Be in North Haven (was Wlfd)
Desktop Computer	Should Be in North Haven (was Wlfd)
Latitude D620 Computer	Should Be in North Haven (was Wlfd)
Laptop computer	Should Be in North Haven (was Wlfd)
Sterilizers and Driers	Should Be in North Haven (was Wlfd)
Software for SLP Medicine	System Wide Software
REPLACE WALK-BEHIND FLOOR CARE UNIT	Unsure of location. Most likely North Haven

$

© Regents Health Resources, Inc. 2013

Gaylord Hospital, Inc.
Sleep Volume Data - North Haven
FY 2011,2012,2013, FYTD May 2014

Provided Services

Service	FY 2011	FY 2012	FY 2013	FY 2014	
Study/Interp	2,627	2,343	1,951	1,302	Full Service Sleep Study Including Physician Interpretatic
Initial Eval	1,639	1,394	1,625	1,044	Patient initial Consultation with Medical Staff
Follow Up	2,015	2,177	2,077	1,141	Follow up visit to review study results and plan of care
PAP NAP	-	62	69	40	3-4 hour Day time visit to help patients learn to use mas
CLINIC	2,076	2,546	2,538	1,402	Cpap Set up, Working with patients on compliance issue
Other	221	680	787	531	HST rental, Psychology visits for insomnia management
Total	8,578	9,202	9,047	5,460	

Volume and Payor Mix	Volume FY 11	% FY 11	Volume FY 12	% FY 12	Volume FY 13	% FY 13	Volume FY 14	% FY 14	Thru May FY 14
Medicare	1,943	23%	2,055	22%	2,070	23%	1,078	22.5%	28.7%
Medicaid	2,069	24%	2,335	25%	2,080	23%	1,135	23.7%	26.1%
Tricare	20	0%	13	0%	9	0%	12	0.3%	0.3%
Total Government	4,032	47%	4,403	48%	4,159	46%	2,225	46.5%	55.1%
Commercial	4,529	53%	4,791	52%	4,859	54%	2,549	53.2%	44.5%
Uninsured	17	0%	8	0%	29	0%	13	0.3%	0.4%
Worker's Comp	-	0%	-	0%	-	0%		0.0%	0.0%
Total Non-Governement	4,546	53%	4,799	52%	4,888	54%	2,562	53.5%	44.9%
Total All	8,578	100%	9,202	100%	9,047	100%	4,787	100.0%	100.0%

-

on

sks and inprove patient compliance
e or Mask issues etc…

Gaylord Hospital
Cab Usage 10/01/10-05/31/14
North Haven Sleep Center only

		$	# Trips	Patients
10/1/2010	$	268.70	12	7
11/1/2010	$	165.57	6	4
12/1/2010	$	279.15	10	7
1/1/2011	$	351.74	12	8
2/1/2011	$	256.32	8	6
4/1/2011	$	314.78	11	8
5/1/2011	$	511.00	15	8
5/1/2011	$	252.09	9	6
6/1/2011	$	541.85	16	12
7/1/2011	$	78.30	3	3
7/1/2011	$	1,040.24	22	14
8/1/2011	$	691.00	18	10
9/1/2011	$	441.93	13	9
10/1/2011	$	357.51	8	6
11/1/2011	$	314.06	12	8
1/1/2012	$	787.28	20	15
2/1/2012	$	675.95	19	14
3/1/2012	$	467.94	13	10
4/1/2012	$	647.90	17	9
5/1/2012	$	218.13	6	4
6/1/2012	$	79.80	3	3
7/1/2012	$	779.57	14	10
8/1/2012	$	118.80	4	3
9/1/2012	$	325.06	7	4
10/1/2012	$	294.87	12	8
12/1/2012	$	300.52	8	5
1/1/2013	$	300.63	6	8
2/1/2013	$	773.20	21	16
4/1/2013	$	314.71	10	7
6/1/2013	$	1,205.94	27	17
7/1/2013	$	666.66	10	6
8/1/2013	$	1,637.35	33	23
9/1/2013	$	330.33	10	7
11/1/2013	$	370.59	12	7
12/1/2013	$	898.38	23	15
1/1/2014	$	847.50	19	10
2/1/2014	$	370.92	10	8
3/1/2014	$	347.82	12	9
4/1/2014	$	346.39	11	10
5/1/2014	$	275.55	8	6
5/1/2014	$	479.16	13	10
	$	19,725.19	523	360

Greer, Leslie

From: Henry F. Murray <hfmurray@lapm.org>
Sent: Thursday, June 26, 2014 1:30 PM
To: 'John D. Blair'; Hansted, Kevin
Cc: Riggott, Kaila; Martone, Kim; Lazarus, Steven; Greer, Leslie; Fiducia, Paolo
Subject: RE: Gaylord Late Files - DOCKET NO. 13-31884-CON

Dear Attorney Hansted and Attorney Blair:

In reviewing the Late Filing #1 supplied yesterday by Gaylord, I noticed that Article Three of the Purchase Sale Agreement (P/SA) is blank. Without a table of contents to the P/SA I was unable to determine the subject matter of what Article Three. Can Gaylord please tell us what Article Three is and provide a copy to the Commission and to us? Thank you.

Hank Murray

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

_____
This Transmittal is intended for a particular addressee(s). It may contain confidential attorney-client communication. If it is not clear you are the intended recipient, you are hereby notified that you have received this transmittal in error. Any review, copying, distribution or dissemination of this communication is strictly prohibited. If you suspect that you have received this transmittal in error, please notify the sender at the telephone numbers and email addresses above and delete the transmittal and any attachments. THANK YOU

Please think about the environment before deciding to print this email.

From: John D. Blair [mailto:john@blairlawllc.com]
Sent: Wednesday, June 25, 2014 11:25 AM
To: Hansted, Kevin
Cc: Riggott, Kaila; Martone, Kim; Lazarus, Steven; hfmurray@lapm.org; Greer, Leslie; Fiducia, Paolo
Subject: Gaylord Late Files - DOCKET NO. 13-31884-CON

Dear Attorney Hansted,

Enclosed are the requested late files from Gaylord Hospital Termination of Sleep Medicine Services in North Haven Public Hearing held Wednesday, June 18, 2014:

1. Asset Purchase Agreement and List of Included Assets

2. North Haven Volume thru May 2014
3. Cab Rides Provided

The Transportation Agreement is forthcoming.

Thank you for your consideration of this matter.

Sincerely, John

John D. Blair
Counselor at Law

Blair Law LLC
P.O. Box 141
Rocky Hill, CT 06067
P: 860 280 4059
F: 860 760 6493
john@blairlawllc.com
www.blairlawllc.com

This electronic message contains information from Blair Law, LLC, or its attorneys, which may be confidential, privileged or otherwise protected from disclosure. The information is intended to be used solely by the recipient(s) named. If you are not an intended recipient, be aware that any review, disclosure, copying, distribution or use of this transmission or its contents is prohibited. If you have received this transmission in error, please notify us immediately at 860 280-4059 or at the reply email address. For more information about Blair Law, please go to http://www.blairlawllc.com.

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

RECEIVED
JUN 26 2014
Office of
HEALTHCARE ACCESS

GAYLORD HOSPITAL

TERMINATION OF SERVICES AT GAYLORD SLEEP MEDICINE
IN NORTH HAVEN

DOCKET NO. 13-31884-CON

JUNE 18, 2014

3:05 P.M.

20 CHURCH STREET
NEW HAVEN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

1 . . .Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Public
3 Health, Office of Health Care Access, in the matter of
4 Termination of Services at Gaylord Sleep Medicine in
5 North Haven, held at Gateway Community College, 20 Church
6 Street, New Haven, Connecticut, on June 18, 2014 at 3:05
7 p.m. . . .
8
9
10
11 HEARING OFFICER KEVIN HANSTED: Good
12 afternoon, everyone. We're going to get started here
13 shortly, so if everyone could take a seat, please? Thank
14 you.
15 And we're here today for a public hearing
16 before the Office of Health Care Access, identified by
17 Docket No. 13-31884-CON, and it's being held on June 18,
18 2014 to consider Gaylord Hospital's application for the
19 termination of services at Gaylord Sleep Center in North
20 Haven, Connecticut.
21 This public hearing is being held pursuant
22 to Connecticut General Statutes, Section 19a-19a-639a,
23 and will be conducted as a contested case, in accordance
24 with the provisions of Chapter 54 of the Connecticut

1 General Statutes.

2 My name is Kevin Hansted, and I've been
3 designated by Commissioner Jewel Mullen of the Department
4 of Public Health to act as the Hearing Officer here
5 today.

6 The staff member assigned to assist me
7 today is Kaila Riggott, and it is being recorded by Post
8 Reporting Services.

9 In making its decision, OHCA will consider
10 and make written findings concerning the principles and
11 guidelines set forth in Section 19a-639 of the
12 Connecticut General Statutes.

13 Gaylord Hospital has been designated as a
14 party in this proceeding and Unite Here Local 34 has been
15 designated as an Intervenor, with limited rights of
16 participation.

17 At this time, I will ask staff to read
18 into the record those documents already appearing in
19 OHCA's Table of the Record.

20 MS. KAILA RIGGOTT: Kaila Riggott, OHCA
21 staff. OHCA would like to enter into the record Exhibits
22 A through Q, as listed in OHCA's Table of the Record.

23 HEARING OFFICER HANSTED: Thank you, Ms.
24 Riggott. And does counsel have any objections to any of

1 the exhibits? Can you turn your microphone on? It's
2 right on the back there. Oh, they're on the bottom?
3 MR. HENRY MURRAY: They're on the bottom.
4 HEARING OFFICER HANSTED: Thank you.
5 MR. MURRAY: Yes. Henry Murray, counsel
6 for Local 34. No objections.
7 MR. JOHN BLAIR: John Blair, counsel for
8 Gaylord Hospital. No objections.
9 HEARING OFFICER HANSTED: Thank you. And
10 we handed out an agenda. It was on the table outside,
11 and I know counsel has it. I'm going to deviate from
12 that a bit.
13 What I want to do is I want to have the
14 Applicant give its presentation, followed directly by the
15 Intervenor, and then I will permit the Applicant to
16 Cross-Examine the Intervenor, if they choose to do so,
17 and then OHCA will ask its questions.
18 After that is completed, we will, then, go
19 to the public portion of tonight's hearing. At that
20 time, any members of the public, who have signed up to do
21 so, may present a brief comment on the application and
22 their direct position regarding the same.
23 I'm going to ask you to limit your
24 comments to three minutes. We have a lot of folks here

1 that want to speak on this application, and I want to
2 make sure everyone gets heard today.
3 At this time, I would ask all the
4 individuals, who are going to testify on behalf of the
5 Applicant and the Intervenor, to please stand, raise your
6 right hand, and be sworn in by the court reporter.
7 (Whereupon, the parties were duly sworn
8 in.)
9 HEARING OFFICER HANSTED: Thank you, all.
10 And just a bit of housekeeping. Attorney Blair, you had
11 filed an objection to the Intervenor being designated as
12 an Intervenor in this case, and I just wanted to address
13 it.
14 I have not made a written ruling on that
15 yet. Attorney Murray, do you have any response to that?
16 Have you had an opportunity to review it?
17 MR. MURRAY: Yes, I have. As you know,
18 I've been in this case about 36 hours. I did have an
19 opportunity to review Attorney Blair's written objection
20 to the previous ruling by OHCA, and if the Hearing
21 Officer will permit me an opportunity to file a
22 subsequent written response, I will.
23 I do have some brief comments to make at
24 this point, if you'd permit me.

1 HEARING OFFICER HANSTED: You may do so.
2 MR. MURRAY: Okay. We object, obviously,
3 to the petitioner's attempt to forestall our opportunity
4 to intervene in these proceedings, but, first, I wanted
5 to comment that, in fact, this is not the first time,
6 under almost identical circumstances, that this agency
7 has granted this Local Union Intervenor status on a
8 Certificate of Need application.
9 I'll call your attention to Docket 99-
10 0550. In that, even though it's a 1999 number, it was in
11 January of 2000 that this agency granted Intervenor
12 status to Local 34 under almost identical circumstances
13 in the following sense.
14 At that time, the application before the
15 agency was for Yale-New Haven Hospital to acquire Yale
16 Psychiatric Institute, which was a facility of Yale
17 University, and, at that time, the agency granted
18 Intervenor status to this local Union for almost the
19 identical reasons.
20 The Local made the case to OHCA and
21 subsequently had testified on at least three different
22 occasions during the spring of 2000 in front of Ray
23 Gorman, that it was putting the acquisition by Yale-New
24 Haven Hospital of the University's facility put in

1 jeopardy and in question potential psychiatric care to
2 at-risk population in this city, and people, who accessed
3 the Yale Psychiatric Institute and accessed it at the
4 University, may not have had the similar access once that
5 was acquired by Yale-New Haven Hospital.
6 The Commission ruled against, ruled in
7 favor of that acquisition subsequently, but it did not
8 deny Local 34 from its interest in both its own members'
9 interest, in terms of members losing jobs, but, more
10 importantly, what would happen to that at-risk population
11 permitted Local 34 to raise those questions about that
12 particular acquisition, so this is not the first time.
13 Fourteen years ago, the agency did the
14 exact same thing under almost identical circumstances,
15 and we would simply request, and I'll put this in our
16 subsequent written comments, that the agency not deviate
17 from the practice it had 14 years ago, when it granted us
18 Intervenor status under almost the identical situation,
19 at least from our point of view of an acquisition.
20 I understand that the Petitioner views it
21 quite differently, but we've argued and we'll through our
22 witnesses argue that this particular application of the
23 Petitioner has to be viewed in a more global context of
24 what's happening with the acquisition by Yale-New Haven

1 Hospital.

2 So 14 years ago, this agency, in its

3 infinite wisdom, granted us Intervenor status, and we

4 request that you do so and continue the agency's ruling

5 in this particular case.

6 HEARING OFFICER HANSTED: Thank you,

7 Attorney Murray. Attorney Blair, do you have anything to

8 follow-up?

9 MR. BLAIR: Hearing Officer Hansted, we

10 have no further testimony, other than what we filed in

11 the written testimony.

12 HEARING OFFICER HANSTED: Okay, thank you.

13 Attorney Murray, I've reviewed the objection at length,

14 and it's compelling to me, because several of the items

15 that you are prepared to speak about tonight are not

16 under OHCA's jurisdiction.

17 First and foremost, any employment issues

18 are not under OHCA's jurisdiction. The purported

19 transfer of the health care facility is not under OHCA's

20 jurisdiction as we see it, and, furthermore, with respect

21 to the sale of a physician practice, which I think is

22 being argued on behalf of the Intervenor, that's not yet

23 under OHCA's jurisdiction.

24 As you probably are aware, the legislature

1 and the Governor passed a Public Act, which will put that
2 under OHCA's jurisdiction, but it's not for purposes of
3 this application.
4 Nonetheless, I'm not going to bar you from
5 participating in this hearing, so your Intervenor status
6 will stand, as I originally ordered it, and, in that
7 respect, I'm going to deny the, I'm sorry, overrule the
8 objection on the part of the Applicant.
9 MR. MURRAY: Thank you.
10 HEARING OFFICER HANSTED: You're welcome.
11 Attorney Blair, you may proceed with the Applicant's
12 presentation.
13 MR. GEORGE KYRIACOU: Hello. I'm George
14 Kyriacou, and I hereby adopt my pre-filed testimony.
15 HEARING OFFICER HANSTED: Thank you.
16 MR. KYRIACOU: Good afternoon, Hearing
17 Officer Hansted and Office of Health Care Access staff.
18 I'm George Kyriacou. I'm President and CEO of Gaylord
19 Specialty Health Care. I've served in this capacity
20 since November of 2011.
21 Prior to becoming President and CEO at
22 Gaylord, I was the CEO of a 106-bed community hospital in
23 Pennsylvania from 2008 to 2011. I have also served as
24 Chief Operating Officer of MidState Medical Center in

1 Meriden, Connecticut in 2008, while also serving as the
2 Vice President of Network Development at Hartford Health
3 Care in Hartford, Connecticut from 1996 through 2008, and
4 I was previously Vice President for Operations at
5 MidState Medical Center from 1988 to 1996.
6 I thank you for the opportunity to come
7 before you today to share with you Gaylord Hospital's
8 decision to discontinue sleep medicine services that we
9 believe is in the best interest of our patients and our
10 organization.
11 Gaylord Sleep Medicine North Haven is a
12 provider-based outpatient department of Gaylord Hospital.
13 The center, located in North Haven, is equipped for day
14 and overnight sleep testing, as well as CPAP therapy.
15 The sleep service program at the North
16 Haven location consists of 12 beds operating seven days
17 and nights. The services include diagnostic
18 polysomnography, split night polysomnography, and
19 therapeutic polysomnography.
20 Gaylord Hospital filed a Certificate of
21 Need determination letter on August 1, 2006 to terminate
22 sleep medicine services in Wallingford and New Haven and
23 establish sleep medicine services in North Haven.
24 On January 4, 2007, OHCA received the

1 Certification of Need application from Gaylord Hospital
2 seeking authorization to discontinue two sleep
3 laboratories located at Gaylord Farms Road, Wallingford,
4 and One Long Wharf Drive in New Haven, and to establish a
5 sleep laboratory at 8 Devine Street in North Haven, and
6 increase the capacity of that lab from 11 to 12 beds.
7 This Certificate of Need was approved, and
8 sleep medicine services continued to be provided in North
9 Haven for the past eight years.
10 Subsequently, Gaylord Hospital filed a
11 Certificate of Need to discontinue sleep medicine
12 services in North Haven and three other locations on
13 December 30, 2013.
14 While the closure of the North Haven
15 location is the subject of this hearing, I believe it
16 should be viewed in the context of Gaylord's management
17 decision to discontinue providing sleep medicine services
18 in general.
19 The decision to discontinue sleep medicine
20 services at North Haven and three other sleep locations
21 was based on a variety of factors.
22 As management of Gaylord Specialty Health
23 Care assessed the changing health care environment during
24 its strategic planning process, the decision was made to

1 concentrate its limited resources on core inpatient and
2 outpatient health care services for complex rehab and
3 medically-complex patients.
4 Additional factors in the decision to
5 discontinue sleep medicine services included diminished
6 inpatient lab volume, changing models of delivery, and
7 unnecessary duplication of services, since sleep medicine
8 is provided by many other providers in the markets
9 Gaylord serves.
10 The enhanced technology and changes in the
11 clinical practice of sleep medicine has resulted in a
12 shift from in-lab studies to home studies, with a much
13 different reimbursement structure.
14 The table below is included in our
15 application and shows that sleep study volume in North
16 Haven has been declining over the course of the last
17 three years. Physician referrals and direct patient
18 referrals have also declined, and I reference Table 1.
19 Faced with the above, Gaylord management
20 had to make a decision to assure continuity of care and
21 continued access to high-quality care for sleep medicine
22 patients.
23 Gaylord Sleep Medicine North Haven, Yale-
24 New Haven Hospital and Connecticut Children's Medical

1 Center work collaboratively to insure a seamless
2 transition of the clinical service for our patients.
3 Yale-New Haven Hospital is able to assume care for adult
4 patients, and Connecticut Children's Medical Center will
5 assume care of the pediatric population.
6 CCMC has already opened their new center
7 in Farmington, and we have experienced a 50 percent drop
8 in our pediatric population from our Glastonbury
9 location, as it has moved over to that new Farmington
10 location.
11 Gaylord Sleep Medicine North Haven will
12 notify patients of the availability of sleep medicine
13 services provided by the sleep program affiliated with
14 Yale-New Haven Hospital for adult patients and CCMC sleep
15 program for pediatric patients.
16 In closing, I want to make it clear that
17 Gaylord Hospital carefully arrived at a decision to stop
18 providing sleep medicine services and by collaborating
19 with Yale-New Haven Hospital and the Connecticut
20 Children's Medical Center, who will assume responsibility
21 for sleep services. This will result in patients having
22 continued access for the highest level of care.
23 Thank you for the opportunity to come
24 before you today. If you have any questions, I would be

1 glad to answer them.
2 HEARING OFFICER HANSTED: Thank you.
3 Attorney Blair, do you have anything further?
4 MR. BLAIR: Nothing further.
5 HEARING OFFICER HANSTED: Thank you.
6 Attorney Murray, you may proceed.
7 MR. MURRAY: Mr. Hearing Officer, I'd like
8 to call up our speakers at this time, our witnesses.
9 Thank you. John?
10 MR. JOHN CANHAM-CLYNE: Good afternoon,
11 Hearing Officer Hansted, Ms. Riggott and other OHCA
12 staff. My name is John Canham-Clyne. I hereby adopt my
13 pre-filed testimony.
14 HEARING OFFICER HANSTED: Thank you.
15 MR. CANHAM-CLYNE: I am the Deputy
16 Director of Research for Unite Here International Union.
17 We're the parent Union of Unite Here Local 34, and I'm
18 here on behalf of the members, the 3,700 members of Unite
19 Here Local 34.
20 I will not read my entire testimony, but
21 summarize the relevant points, given that it was long,
22 and let me first say that we appreciate the holding of
23 this hearing in the City of New Haven, where we expect
24 the citizenry is most likely to feel the impact of the

1 current changes in the market for sleep medicine, and,
2 second, I also want to recognize the point that you made
3 earlier, which is that the regulation of the purchase of
4 physician office practices by hospitals is not currently
5 under OHCA's jurisdiction.
6 I will say, however, that the two women
7 with me and many others in this room were vocal advocates
8 for that change during the course of the last legislative
9 session, and we're looking forward to working with the
10 office on those issues in the future.
11 We believe this hearing and the docket in
12 front of you must address the following key issues.
13 First and foremost, Yale-New Haven Hospital must file a
14 CON for the purchase of Gaylord's assets in North Haven.
15 This is the transfer of facility. It's
16 not the termination of services. Secondly, it almost
17 certainly includes an increase in licensed bed capacity
18 of Yale-New Haven Hospital, and, under either of those
19 circumstances, we believe that the hospital, itself, must
20 be here to answer for its future plans for sleep medicine
21 in the State of Connecticut.
22 Secondly, this is, in fact, if not from
23 the perspective of the current Applicant, it is, from the
24 perspective of Yale-New Haven Hospital, a three-sided

1 transaction, in which a large volume of services are
2 going to be consolidated in North Haven and Madison,
3 ultimately. Third, that the consolidation does present
4 challenges for at-risk populations. You'll hear more
5 from the other witnesses about that.
6 And, finally and perhaps most importantly,
7 the transaction, as structured, is part of a trend in the
8 industry, in which patients, who have in the past been
9 able to access care in a physician's office for
10 reasonable out-of-pocket costs, are now being charged
11 under hospital fee structures, with a dramatic increase
12 in cost out-of-pocket, and, also, in cost to
13 institutional payers, which is having a significant
14 impact on the access to health care services, and, again,
15 you'll hear more about that from the other witnesses.
16 For the first point, Local 34 represents
17 3,700 workers here in Greater New Haven. Included in
18 that are 900 folks, who are employed in the clinical
19 practices of Yale University School of Medicine. That
20 included, until recently, the Sleep Center.
21 When the Sleep Center was closed, it was
22 clear to us that it was part of a move by Yale-New Haven
23 Hospital to take control of a large chunk of the Sleep
24 Center market. It had a significant impact on our

1 members' lives, obviously.
2 We would argue it also has an impact on
3 the pool of well-qualified staff, who are able to take
4 care of the patients in Yale-New Haven, and, most
5 importantly, it will have an impact on access first.
6 We believe the regional consolidation, as
7 is currently proposed and currently taking place in the
8 larger context of the various transactions happening at
9 the moment, does pose a threat to access for at-risk
10 populations, certainly for those, who had been accessing
11 care prior to the closure of the Yale-University Sleep
12 Laboratory on Temple Street.
13 Secondly, by moving to North Haven, which
14 has significantly reduced bus access and is much more
15 difficult to reach, particularly for patients, who often
16 have significant co-morbidities, the actual access,
17 physical access to care will be challenging.
18 Secondly, it is also clear to us that, as
19 the -- we shouldn't say it's clear to us. We believe
20 that, as part of a Certification of Need from Yale-New
21 Haven Hospital, the office should investigate
22 aggressively the impact of changing from physician-based
23 fee structures to hospital-based fee structures for those
24 patients, who had previously been accessing care

1 elsewhere, because we also believe that that will
2 increase their out-of-pocket costs and cause very
3 significant and very difficult choices to be made by
4 patients.
5 We are hearing from patients regularly
6 that, in other disciplines, that they are choosing not to
7 access health care, because of the dramatic increase in
8 their out-of-pocket costs.
9 That, I think, is ultimately the reason
10 that Local 34 is here today. Those 900 members, who work
11 in the clinical practices, are hearing literally every
12 day from their patients about the increasing difficulties
13 they face, even those, who are well-insured, in trying to
14 access care in other disciplines, and we believe that the
15 same circumstances ought not happen to patients in sleep
16 medicine.
17 Finally, just to close and resummarize, we
18 believe that the issues of access and cost, as they
19 relate to access, are vital to the community in New
20 Haven, and our request here is that you deny the
21 Applicant's current request for a Certificate of Need,
22 require Yale-New Haven Hospital and the Applicant to file
23 a CON for the transfer of the Applicant's North Haven
24 access, and, in doing so, consider the impact both of the

1 closures of Gaylord's other facilities, plus the Yale
2 University Sleep Labs, in determining the result of the
3 new Certificate of Need.
4 Regardless of the formal outcome, we
5 believe that this proceeding should address critical
6 questions, including the impact of facility fees and
7 other hospital-based reimbursement on individual out-of-
8 pocket costs when those patients are accessing what is
9 essentially physician care, rather than hospital care, in
10 the coming Yale-New Haven Hospital facilities, and, also,
11 to investigate aggressively what Yale-New Haven's plan to
12 insure geographic access for the sleep medicine
13 population in New Haven will be, and, then, finally, to
14 look at the overall system capacity.
15 Given the fact that there is significant
16 change in the way that sleep medicine is administered
17 with the growth of home testing, we're still talking
18 about five facilities that have closed in the last 18
19 months, and that's a significant change in the
20 marketplace.
21 With that, I'll turn it over to the other
22 witnesses.
23 HEARING OFFICER HANSTED: Thank you.
24 MS. GRETCHEN ROSE: Hi. My name is

1 Gretchen Rose, and I hereby adopt my pre-filed testimony.
2 HEARING OFFICER HANSTED: Thank you.
3 MS. ROSE: And I'm going to read it
4 anyway, so everyone can hear.
5 HEARING OFFICER HANSTED: That's fine.
6 MS. ROSE: I worked for Yale University
7 Sleep Medicine for 15 years, up until the time I was laid
8 off in January. When I started, I worked in our Guilford
9 facility. In 1999, Yale opened a lab in Norwich, which I
10 moved to, and, a few years later, our lab down here in
11 New Haven at Temple Street was opened.
12 About two and a half to three years ago,
13 our Norwich lab closed. I was moved into our Guilford
14 facility, and then, in January of 2013, our Guilford lab
15 closed, whereupon we all combined into our New Haven lab.
16 There were layoffs during that time, and,
17 finally, in October of 2013, our management conducted a
18 mandatory staff meeting, where we were all told the sleep
19 lab at 40 Temple Street was closing, effective January
20 6th of 2014.
21 We asked at that time if the lab was being
22 purchased by Yale-New Haven Hospital, and, for awhile,
23 management denied that it was. Our manager at that time
24 told us that we could tell our patients that we were

1 moving, that they would no longer be seen at Temple
2 Street, but they would be seen at the Yale Physician's
3 Building on Howard Avenue, but that we would no longer be
4 conducting overnight studies, and we did see our last
5 night patients right before Christmas of 2013, and, then,
6 on January 6th, the lab was closed at the Temple Street
7 building.
8 Our patients are still being seen by our
9 doctors, but, during the closure time, it was very
10 confusing, as to who was going to see them, where they
11 would get an overnight study, and, right now, it's still
12 confusing.
13 Our patients are still calling and don't
14 know where to go. Phone numbers are not in service. I'd
15 like you to take into consideration that our patient base
16 here in New Haven is very diversified.
17 We have professors, faculty, students, and
18 all of our low-income residents of New Haven with
19 significant medical issues, co-morbidities. Many of our
20 patients came in wheelchairs. They had to take a taxi,
21 public access. They had to get to their sleep study with
22 a bus.
23 I feel being shipped out to North Haven at
24 some future date is going to be difficult for many of our

1 patients, and I'd like you to take that into
2 consideration in the future as Yale-New Haven is
3 expanding. Thank you.
4 HEARING OFFICER HANSTED: Thank you.
5 MS. MELISSA DAWKINS-DOUMBIA: Good
6 afternoon.
7 HEARING OFFICER HANSTED: Good afternoon.
8 MS. DAWKINS-DOUMBIA: My name is Melissa
9 Dawkins-Doumbia, and I hereby adopt my pre-filed
10 testimony.
11 HEARING OFFICER HANSTED: Thank you.
12 MS. DAWKINS-DOUMBIA: I am currently an
13 administrative assistant in the Department of Internal
14 Medicine at Yale University.
15 Throughout my time working on a temporary
16 assignment at Yale Sleep Medicine, it had became clear
17 that Yale-New Haven Hospital was taking over the
18 practice.
19 Before Christmas in 2013, I was on
20 temporary assignment at the Sleep Medicine Lab on 40
21 Temple Street in New Haven. I, then, left the sleep lab
22 when I accepted a new position in internal medicine.
23 In the meantime, a few staff in the sleep
24 lab had already been laid off. I returned to sleep

1 medicine lab, because it stayed open after the rest of
2 the staff had been laid off, however, the clinic part of
3 the practice was moved over to 784 Howard Avenue in New
4 Haven, where they continued to see patients until Yale-
5 New Haven Hospital opened its clinic in North Haven and,
6 as well, in Madison.
7 We were told that the clinics will have
8 Yale Medical Group doctors, but Yale-New Haven Hospital
9 administrators and staff. The patients were told that
10 they would be transitioned and that their care would be
11 continued by the hospital.
12 They were told -- they were not told about
13 any facility fees associated with being seen at the
14 hospital, just that they could see the same doctor, but
15 at a different facility with different staff.
16 I was instructed by management to tell
17 patients Yale-New Haven Hospital will be opening up a
18 sleep center. They will be taking over our practice.
19 All of your charts and medical records will be switched
20 over to the hospital.
21 I just want to say that this will and has
22 caused an inconvenience for all patients, many who are
23 Medicare/Medicaid and cannot afford higher bills and
24 convenient transportation option by these changes. It

1 also affects the workers and the taxpayer.
2 I'm just asking that you please call Yale-
3 New Haven Hospital to the table, and, you know, there's a
4 lot of things going on, and we haven't heard from them.
5 And, myself, I am a resident and, also, a
6 patient. We are all patients, and we should hear from
7 this large hospital. Thank you.
8 HEARING OFFICER HANSTED: Thank you.
9 MR. MURRAY: We have nothing else at this
10 time. Thank you.
11 HEARING OFFICER HANSTED: Thank you,
12 Attorney Murray. Attorney Blair, do you have any Cross?
13 MR. BLAIR: Hearing Officer Hansted, we
14 have no questions or Cross-Examination of the
15 Intervenors.
16 HEARING OFFICER HANSTED: Thank you.
17 MR. BLAIR: Thank you.
18 HEARING OFFICER HANSTED: Before we
19 proceed with OHCA's questions, I just want to step back a
20 bit, and excuse the ignorance of the Hearing Officer
21 here. This may be very boring for a lot of you in this
22 room.
23 Does the Applicant or the Intervenor have
24 anyone here that can speak clinically about exactly what

1 a sleep lab does in some sort of detail?
2 MR. KYRIACOU: Hearing Officer Hansted,
3 yes. We have our Chief Medical Officer from Gaylord
4 Hospital here.
5 HEARING OFFICER HANSTED: Okay. Would she
6 come up? Would she be willing to do so? Oh, I'm sorry.
7 All right, were you sworn in earlier?
8 MR. STEVE HOLLAND: No, I wasn't.
9 HEARING OFFICER HANSTED: Okay. Would you
10 just be sworn in, please?
11 (Whereupon, Steve Holland was duly sworn
12 in.)
13 MR. HOLLAND: Steve Holland, just like the
14 country.
15 HEARING OFFICER HANSTED: Can you just
16 briefly describe to me, or not so briefly, what exactly a
17 sleep study is, what a sleep lab does, and the difference
18 between a lab-based test and a home-based test?
19 MR. HOLLAND: I'll first just point out my
20 background is internal medicine, emergency medicine and
21 wound care, so I'm not a sleep medicine specialist, but I
22 think I can answer those questions.
23 HEARING OFFICER HANSTED: Okay.
24 MR. HOLLAND: First of all, the sleep

1 medicine and sleep medicine labs have come about, because
2 of a condition known as obstructive sleep apnea. This
3 condition affects people basically while they're
4 sleeping, but has a major effect on both their lungs and
5 especially their heart, and, after a long time of not
6 being treated, can have significant effects, including
7 shortening of a person's life span, so sleep testing came
8 about, because the best way to diagnose the condition was
9 to evaluate the person suspected of having the condition
10 while they were sleeping.
11 To do that, you monitor the person in
12 different fashions, including heart rate, as well as
13 their respiratory rate, breathing, oxygenation, and, to
14 do that, you do that in a lab, where they're sleeping in
15 a bed, typically.
16 Some labs are satellite standalone units,
17 some are actually set up in hotels, but you want the
18 person to be able to sleep like they would at home, and
19 you want to be able to monitor them to see if they
20 actually are showing, you know, the criteria to meet the
21 diagnosis.
22 So, in labs, studies became the standard
23 of care, and, then, more recently, we see a lot of home
24 studies, which, in some situations, is used as a

1 screening test, such that if the proper videoing of the
2 person at home occurs, then they're able to make a
3 determination that they need to have an in-lab test.
4 Sometimes they're able to exclude further testing from
5 that test.
6 Obviously, there's benefits to the patient
7 not having to go to a lab and being able to do it at
8 their home, and it's a cheaper study, less expensive for
9 the insurance company, so there certainly is value there,
10 too.
11 Was there another part to that question?
12 HEARING OFFICER HANSTED: No. I suppose
13 what I'm really trying to get at is does the home-based
14 test negate the need for a clinic-based test? I'm
15 sensing it doesn't.
16 MR. HOLLAND: It negates a number of in-
17 lab sleep tests that will be done in the future. There's
18 no doubt about that. And the trend across the country
19 has been very clear, but I don't think it's going to
20 negate entirely the need.
21 There's going to be more difficult
22 patients, pediatric patients, patients that already have
23 a diagnosis of COPD or heart disease that should have in-
24 lab testing done right from the start.

1 HEARING OFFICER HANSTED: Okay, thank you.
2 MR. MURRAY: Mr. Hansted?
3 HEARING OFFICER HANSTED: Yes?
4 MR. MURRAY: Just before the witness got
5 off, I just wanted to clarify whether or not, besides
6 obstructive sleep apnea, the sleep medicine clinics and
7 the testing looks at other sleep medical issues, such as
8 narcolepsy. I wonder if you can comment on that.
9 HEARING OFFICER HANSTED: Since you don't
10 have Cross, you can ask that question through me.
11 MR. MURRAY: Through you.
12 HEARING OFFICER HANSTED: Thank you.
13 MR. HOLLAND: Yes. Actually, it's not
14 uncommon for a sleep medicine specialist to be
15 specialized in pulmonary care, as well, and, therefore,
16 they take care of patients, who have a combination of
17 disorders, including COPD and obstructive sleep apnea, as
18 well as narcolepsy.
19 HEARING OFFICER HANSTED: Okay.
20 MR. BLAIR: Thank you. I would just say
21 Gretchen Rose basically has treated patients. I don't
22 know if you wanted to hear anything from her, also.
23 HEARING OFFICER HANSTED: I'd like to hear
24 her comment, as well, for fair comment.

1 MS. ROSE: I'm Gretchen Rose. I'm a
2 Registered Polysomnography Technician. Sleep disorders,
3 there's 84 diagnosed sleep disorders. In a sleep lab, we
4 diagnose all of those.
5 A home sleep test is good for obstructive
6 sleep apnea, and that's it. Now while much of the
7 population being seen in a sleep lab is being diagnosed
8 with obstruction sleep apnea, many of those patients also
9 have co-morbidities, which require them to come into the
10 sleep lab.
11 So even the home study is being used as a
12 screening process, the patient actually comes into the
13 sleep lab anyway, so it's almost an additional cost and
14 an extra night for the patient, too.
15 It does have its merit of a home sleep
16 study, but, in most cases, the patients end up coming
17 into the sleep lab.
18 HEARING OFFICER HANSTED: Okay, thank you.
19 MS. ROSE: You're welcome.
20 HEARING OFFICER HANSTED: I'm clear on
21 that now. Thank you, both. Ms. Riggott?
22 MS. RIGGOTT: Yes. I actually have
23 several questions on the application that was submitted.
24 I actually have several questions on the application for

1 the North Haven sleep lab that was submitted.
2 I'm trying to get a better understanding
3 of the purchase of the North Haven site, and I just want
4 to make sure that I understand. Yale is only purchasing
5 the North Haven site, is that correct?
6 MR. KYRIACOU: Yes. Yes. Yale is only
7 acquiring the assets from North Haven, and all the other
8 three sites are being closed.
9 MS. RIGGOTT: Okay and Yale is assuming
10 the lease?
11 MR. KYRIACOU: Acquiring the hardware and
12 assuming the lease.
13 MS. RIGGOTT: Okay and can you explain to
14 me the relationship of the North Haven site to the
15 others, Trumbull, Glastonbury and Guilford?
16 MR. KYRIACOU: Can you clarify what you
17 mean by relationship? It's the largest of our four sites
18 that was established.
19 MS. RIGGOTT: Okay and how was the
20 decision made to close all of the sites versus just the
21 North Haven one that's being sold?
22 MR. KYRIACOU: Sure. This is George
23 Kyriacou. I came on board as CEO in November of 2011,
24 and the organization as a whole was losing money, and,

1 so, we commenced immediately an assessment of all of our
2 programs and which ones were core to our mission, our
3 historical mission, which really has been focused on
4 rehabilitation in medically-complex patients, and really
5 came to the conclusion that, over the past seven years,
6 the sleep program had contributed to overall
7 organizational losses in a significant fashion.
8 And, so, as we looked at where we were
9 going to reallocate our resources and really focus on the
10 future growth maintaining the organizational viability,
11 we identified that the sleep program didn't fit into that
12 focus, and, so, we looked to discontinue the program at
13 that point.
14 Part of that assessment was we were
15 looking at where the technology and the insurance
16 companies practice, because it is really insurance-
17 driven.
18 If you look at our volume over that seven-
19 year period, there is a steady decline in our in-lab
20 volume, and if you look since 2011, when home sleep
21 testing really started to come into its own, there has
22 been a dramatic percent increase in the number of home
23 sleep studies, often mandated by the insurance companies.
24 They simply will not reimburse for an in-

1 lab study, so they really require a home sleep study to
2 be provided, and we said that this is a totally different
3 business than historically, and that was part of the
4 factor that contributed to discontinuing that program.
5 MS. RIGGOTT: Okay, thank you. And, then,
6 as part of this strategic planning process that you talk
7 about, can you explain why the North Haven site was the
8 one that was determined to be sold and not the other
9 sites that you operate?
10 MR. KYRIACOU: We have attempted to find
11 willing buyers for the equipment and to assume the leases
12 at the other locations. So far, no willing buyers of
13 either equipment or anyone to assume the leases has come
14 forward.
15 MS. RIGGOTT: And is the North Haven site
16 does that have the largest volume?
17 MR. KYRIACOU: Yes.
18 MS. RIGGOTT: In terms of losing money
19 with the sleep labs, in looking at some of the other
20 applications that are before us, I did notice it appears
21 that the Glastonbury site is not.
22 MR. KYRIACOU: The Glastonbury site was
23 not, but once the Connecticut Children's Medical Center's
24 new laboratory opened in Farmington, approximately 50

1 percent of our pediatric volume has now transferred from
2 the Glastonbury location to Farmington, and, so, if you
3 look at the current financials, they are also in the red.
4 MS. RIGGOTT: Thank you. Just a couple
5 more questions. With respect to other existing
6 providers, has Gaylord checked with other area providers,
7 other than Yale and CCMC, regarding taking their
8 patients, taking your patients?
9 MR. KYRIACOU: Yes. There's no exclusive
10 with Yale or CCMC, but both organizations identified that
11 they would be willing to work with us to transfer any
12 patients that wanted to come over.
13 We actually had discussions with other
14 providers, as to whether they'd be interested in
15 acquiring both the equipment, the leases, and none of
16 those discussions panned out, except for North Haven.
17 MS. RIGGOTT: Okay. A kind of major
18 question that I have. I'm not sure if you're familiar
19 with our Statewide Health Care Facilities and Services
20 Plan.
21 One of the goals of our planning process
22 is the use of health care facility resources in an
23 efficient, cost-effective manner, while maintaining or
24 improving patients' access to quality health care

1 services.
2 I'd like to get your perspective on how
3 this proposal relates to our plan.
4 MR. KYRIACOU: Well I have to be honest
5 and say that I'm not familiar with it, but, from an
6 access standpoint, what we have seen is there are many,
7 many providers now for sleep medicine services in our
8 market, and I don't think anyone has any problem in being
9 able to get a sleep test being done, based on the
10 numerous locations that exist around the state.
11 So without having seen the plan and really
12 knowing the nuances of it, we believe that this really
13 will have no impact on access or the ability of folks to
14 get services.
15 MS. RIGGOTT: One additional question with
16 several parts. In your pre-file, you mentioned that
17 Yale-New Haven Hospital will assume responsibility for
18 sleep medicine services. Where are the majority of those
19 patients coming from? Is there transportation available,
20 and how will patients get to that site?
21 MR. KYRIACOU: Currently, as we noted in
22 the objection document and I think in the body of the
23 CON, there are really three sources of transportation for
24 patients, who don't have their own transportation.

1 We have historically provided taxi service
2 to patients that were unable to get to our facility
3 through their own vehicles.
4 Second, Logisticare provides no-cost
5 transportation for Medicaid recipients and, also, does
6 some of the transport for day and evening appointments,
7 and, in addition, if you look at the North Haven
8 location, we're on a bus line that includes stops in New
9 Haven and other locations, and it's right off the campus
10 where our facility is located, and I do have the number
11 of cab trips, if you want them as a file.
12 HEARING OFFICER HANSTED: Yeah. I'd like
13 to order that as Late File No. 1.
14 MR. KYRIACOU: Sure.
15 HEARING OFFICER HANSTED: And how many
16 years does that go back, or months?
17 MR. KYRIACOU: I have 43 months of data.
18 HEARING OFFICER HANSTED: Okay. If you
19 could submit those, I'd appreciate it.
20 MR. KYRIACOU: Sure.
21 HEARING OFFICER HANSTED: Do you have
22 those with you here today?
23 MR. KYRIACOU: With scribbled notes on
24 them.

1 HEARING OFFICER HANSTED: You can file a
2 formal late file, Attorney Blair.
3 MR. BLAIR: Okay.
4 HEARING OFFICER HANSTED: Thank you.
5 Attorney Blair, is one week good enough for that? Does
6 that leave enough time?
7 MR. BLAIR: Yeah.
8 HEARING OFFICER HANSTED: Okay.
9 MS. RIGGOTT: And I just have one
10 additional question, and I don't have the exact page in
11 the application, but I know, in the payer mix table, I
12 notice that the projections of the Medicaid population
13 was increasing. Can you speak to that?
14 MR. KYRIACOU: We know that we have
15 updated data through May on our payer mix for the North
16 Haven location, and both the Medicare percent of the
17 patients and the Medicaid percent of the patients has
18 increased from previous time periods. I can't ascribe it
19 to any particular issue or area.
20 HEARING OFFICER HANSTED: And you said you
21 had updated figures for the payer mix?
22 MR. KYRIACOU: Through May.
23 HEARING OFFICER HANSTED: Okay. Would you
24 submit those as Late File No. 2, please? And, again, one

1 week.

2 MS. RIGGOTT: I don't have any further

3 questions.

4 HEARING OFFICER HANSTED: Okay, thank you,

5 Ms. Riggott. I just have a couple of questions. My

6 primary concern here is is access being maintained and

7 hopefully expanded for the folks that require these

8 services?

9 I know Gaylord now provides the

10 transportation, as you've just testified. Is there a

11 plan in place for Yale to provide these same services and

12 opportunities?

13 MR. KYRIACOU: Yes. As part of the

14 arrangement to sell the assets, they've basically

15 committed to providing the same taxi service that we are

16 providing.

17 HEARING OFFICER HANSTED: Okay and I'd

18 like to see a copy of that agreement, and that will be

19 Late File No. 2, and, again, that will be one week. I'm

20 sorry. Late File No. 3.

21 MR. BLAIR: Hearing Officer Hansted, I

22 don't think we're adverse to if there was a stipulation

23 that you wanted to provide with regards to that type of

24 access after you see the plan and the condition, any

1 condition within the order.
2 HEARING OFFICER HANSTED: All right, thank
3 you.
4 MR. MURRAY: Hearing Officer Hansted, can
5 I just have a clarification on that a second? Late File
6 No. 3, is this the purchase sale agreement that you're
7 asking them to provide, or a separate Memorandum of
8 Understanding, or addendum to the purchase sale
9 agreement?
10 HEARING OFFICER HANSTED: He testified
11 that the sale agreement contained a provision for the
12 continued services for transportation, so if it's within
13 that sale agreement, it's the sale agreement that they
14 need to provide.
15 MR. MURRAY: Okay. Thank you very much.
16 HEARING OFFICER HANSTED: Yes. In its
17 entirety.
18 MR. MURRAY: Thank you.
19 MR. BLAIR: I just wanted to clarify what
20 you're looking for, as far as a separate letter, or what?
21 HEARING OFFICER HANSTED: No. It's the
22 actual sale agreement that was referenced.
23 MR. KYRIACOU: The commitment -- maybe I
24 need to clarify. The commitment may be on a separate

1 memorandum they sent us that may not be part of the
2 purchase and sales.
3 HEARING OFFICER HANSTED: Okay. I want to
4 see both the sale agreement and whatever commitment has
5 been made by Yale.
6 MR. KYRIACOU: Okay, so, we'll do both.
7 HEARING OFFICER HANSTED: Yes. That will
8 both be Late File No. 3 together.
9 And, so, I just want to make sure I'm
10 clear on this. What's happening here is we have sleep
11 center services currently being provided in North Haven
12 by Gaylord.
13 Once this transaction takes place, if it
14 does, those services will continue to be provided in
15 North Haven, just as they are currently, is that correct?
16 MR. KYRIACOU: Yes, that is correct.
17 HEARING OFFICER HANSTED: And there won't
18 be any changes?
19 MR. KYRIACOU: There won't be any changes,
20 and the transportation arrangements will continue as they
21 are.
22 HEARING OFFICER HANSTED: Okay, thank you.
23 I'm going to take a 15-minute break at this point. If
24 everyone could just make sure that they're back here

1 within 15 minutes, I'd appreciate it. Thank you.
2 (Off the record)
3 HEARING OFFICER HANSTED: Just before we
4 continue with the hearing, Mayor Harp is here, and she
5 would like to address the community. Mayor Harp?
6 (Applause)
7 MAYOR TONI HARP: Good afternoon, Mr.
8 Hansted.
9 HEARING OFFICER HANSTED: Good afternoon.
10 MAYOR HARP: I'm Toni Harp, and I'm the
11 Mayor of New Haven, and thank you for this opportunity to
12 share a few thoughts about this docket.
13 Let me also thank you and the Commissioner
14 for holding this hearing in New Haven. I appreciate it.
15 There are many things that are not clear about this
16 particular application, but one thing is for certain.
17 The people of New Haven will be significantly affected by
18 the transactions reflected in the Certificate of Need
19 under consideration.
20 I have three primary concerns about the
21 docket. First, it seems clear the application remains
22 incomplete. Intervenors in the matter have argued with
23 merit that Gaylord's facilities in North Haven are not,
24 in fact, closing. Instead, these assets are being sold

1 or transferred to Yale-New Haven Hospital, as letters in
2 the record already reflect.
3 In addition, there's little doubt that
4 closure of Yale University's Sleep Center at 40 Temple
5 Street will ultimately result in patients seeing doctors,
6 who used to practice at the University's facility in
7 Madison and North Haven.
8 Without the details of these transactions
9 on the record and without a much clearer understanding of
10 the significant market changes in sleep medicine
11 services, evidenced by Gaylord Hospital's other closures,
12 it's difficult for me to imagine how OHCA can effectively
13 render judgment in the best interest of the public.
14 Second, we are very concerned about the
15 impact of changes happening in sleep medicine on low
16 income residents in New Haven, in particular, and,
17 particularly, African-Americans and Latinos.
18 As you know, African-American men, in
19 particular, are at a higher risk of sleep apnea than
20 other people, and these proposed changes adversely impact
21 access to services for some patients.
22 Beyond that, severe sleep disorders, such
23 as narcolepsy, often result in medical restrictions or
24 prohibitions on driving to insure the safety of the

1 patient, as well as the public. These restrictions force
2 patients to rely upon public transportation.
3 The State Department of Transportation
4 says a trip from Yale-New Haven Hospital to 6 Devine
5 Street location takes at least an hour, using buses that
6 run only once every half hour in the middle of the day.
7 The fastest route requires significant walks at either
8 end of the ride.
9 Since sleep medicine patients often have
10 significant co-morbidities, including pulmonary
11 conditions, these transportation obstacles pose real
12 barriers to access.
13 And, yes, as the Applicant notes, there
14 are public programs to help low income patients pay for
15 taxis or rides, but these programs are no substitute for
16 the ready access to services on Temple Street at the old
17 University Sleep Center.
18 Navigating public transportation all the
19 way up to Devine Street poses challenges, especially for
20 people with low-wage jobs, who often don't have time off.
21 Approval of this application without
22 taking this into account would result in a hardship for
23 these patients.
24 Third, even for those able to deal with

1 transportation, I'm also very concerned about the
2 possibility that patients and insurers will face much
3 higher costs if this application goes through.
4 As you know, the University Sleep Lab was
5 not a hospital-based facility. Patients, who used to
6 receive care at the Temple Street site, could well face
7 much higher out-of-pocket costs than they did previously,
8 depending on the specifics of their health insurance
9 coverage.
10 This is one more example of a major
11 overall policy concern in the health care field. Even as
12 insurers and employers are asking workers to take on a
13 greater share of health care costs and even as patients
14 are encouraged to seek treatment in more cost-effective
15 settings, hospitals are absorbing these facilities and
16 imposing inflated hospital rates for services provided
17 there.
18 I don't want New Haven residents to have
19 to pay unreasonable fees for service. Furthermore, this
20 application underscores my concern about the impacts of
21 transactions like this, both in sleep medicine, but,
22 also, in other specialties, on the City's bottom line.
23 New Haven is self-insured with regard to
24 health care coverage for its employees, and, still, these

1 costs comprise the City's largest single line item in the
2 budget. We cannot control these costs that hospitals are
3 suddenly allowed to impose higher prices each time they
4 absorb the next doctor's practice.
5 I encourage you not to grant the
6 Certificate of Need, as presented. Instead, I encourage
7 you to require Yale-New Haven Hospital to file a
8 Certificate of Need of its own for this practice and to
9 bring its plans, policies and prices into the open as a
10 result.
11 And however you decide to go forward,
12 please insure real access for low-income patients to
13 whichever facilities wind up offering the services.
14 In my mind, it's unconscionable how the
15 Applicant on this docket claims there will be no
16 measureable impact on access for Medicaid or special
17 population patients with so much evidence to the
18 contrary.
19 Thank you, again, for being here in New
20 Haven to conduct this hearing, and thank you, again, for
21 the opportunity to testify. Thank you.
22 HEARING OFFICER HANSTED: Thank you, Mayor
23 Harp. (Applause)
24 Okay. Before we proceed, just a point of

1 clarification for the record, as to Late File No. 3.
2 Attorney Blair, I just want to make it clear that what
3 I'm looking for is the actual purchase sale agreement
4 with Gaylord Hospital and Yale-New Haven, as well as the
5 agreement to provide the transportation that is currently
6 being provided by Gaylord.
7 MR. BLAIR: Hearing Officer Hansted, I
8 just wanted to make one clarification with regards to
9 Late File No. 3 that you're referencing.
10 I think we stated that it was in the
11 purchase and sale agreement, that there was a memorandum
12 included in that. Upon discussing that with our staff,
13 that does not exist within the purchase and sale
14 agreement, but we will have a written transportation plan
15 that mirrors what exists today provided to you within a
16 week as part of the late files.
17 HEARING OFFICER HANSTED: Okay and, again,
18 I want both whatever you can provide in that respect, as
19 well as the purchase sale agreement.
20 MR. BLAIR: We will provide the full
21 purchase and sale agreement.
22 HEARING OFFICER HANSTED: Thank you. I
23 have one more question before we get to the public
24 comment section.

1 The doctors that are currently providing
2 the services in the North Haven facility under Gaylord's
3 control, will those be the same doctors that continue to
4 provide the services?
5 MR. KYRIACOU: The answer is we don't
6 know. We have not heard that any of the current
7 physicians have been recruited by Yale-New Haven
8 Hospital, so we do not know whether any will be hired by
9 them.
10 HEARING OFFICER HANSTED: So if this were
11 to occur, what would happen is the current patients in
12 North Haven would be instructed or advised that they
13 could go to Yale or Connecticut Children's Medical
14 Center, whichever is appropriate, and utilize one of
15 their doctors, but that wouldn't necessarily mean that
16 they would continue to utilize the doctor they're now
17 using?
18 MR. KYRIACOU: That's correct.
19 HEARING OFFICER HANSTED: Okay, thank you.
20 Attorney Murray, did you want to give a closing
21 statement? We can never tell.
22 MR. MURRAY: I'm obviously electronically-
23 challenged here. Yes, I would, if you'd permit me.
24 HEARING OFFICER HANSTED: Absolutely.

1 MR. MURRAY: Yes. Hearing Officer
2 Hansted, I want to underscore and I think the comments
3 made by Mayor Harp really summarize, I think, the
4 challenges that this Certificate of Need poses for the
5 agency and the fact that there's a lot more information
6 that the agency needs, in order to evaluate this in the
7 context of not only the ending of sleep medicine
8 services, but the acquiring of sleep medicine services.
9 You were absolutely right, as you reminded
10 me, that not until later this year does the agency have
11 actual jurisdiction over the question of acquisition of
12 physician practices by hospitals, however, the agency
13 does have jurisdiction on the whole issue of access, and
14 access is really a key to the inquiry here, and I think
15 what you've heard from our witnesses today, the questions
16 that you've had of the Applicant, the petitioner and the
17 comments made by the Mayor underscore that.
18 Access really is a question for your
19 agency of really two fundamental factors. One is cost,
20 and the other is geography. Let me say a little bit
21 about the cost.
22 I think the agency needs to know a lot
23 more about what the cost is to the patient population for
24 this particular ending of Gaylord Hospital's provision of

1 sleep medicine services in its acquisition by Yale-New
2 Haven Hospital. Specifically, what impact is it going to
3 have on the patient population by paying higher facility
4 fees, as allowed by CMS and private insurers, when those
5 services are provided by outpatient hospital clinics, as
6 opposed to standalone physician services, as they now
7 are, at least they were, at least in terms of the Yale
8 University Sleep Lab that was on Temple Street? So
9 that's clearly one aspect of access, is cost.
10 The other is the patient population is
11 part of geography. It's not that Yale-New Haven Hospital
12 is acquiring or may acquire, based on this last answer,
13 we don't know, in terms of whether or not patients will
14 stay with Yale-New Haven doctors or not, or acquiring
15 Gaylord patients, but that facility in North Haven is
16 also going to be acquiring what were formerly Yale
17 University sleep medicine patients and Yale-New Haven
18 Hospital sleep medicine patients.
19 So a question of that patient mix, in
20 terms of the allocation between and the mix of those
21 patients between Medicaid and Medicare and private
22 insurance, I think is clearly something that the agency
23 needs to look at and I think you're focused on.
24 But the question of transportation is

1 really paramount here. We really haven't heard any
2 information, at least in this public hearing, I know
3 you've requested it, in terms of late filing fee, Late
4 File 3, in terms of what actual arrangements were made in
5 the purchase and sale agreement to assure that patients
6 that were being seen formerly at Yale University Sleep
7 Center now at Yale-New Haven Hospital and will now be
8 seen in North Haven actually have access to care through
9 transportation, whether it's taxi service or others.
10 To underscore what Mayor Harp said, and
11 perhaps there's other people that might say this in the
12 public comments, if you look, for example, at the
13 Connecticut Transit website, you will find that there is
14 an early morning bus on Saturday and a late afternoon bus
15 on Saturday afternoon between Downtown New Haven and the
16 sleep lab, the former Gaylord facility in North Haven.
17 That's hardly the kind of access that
18 people were used to when they could come down here to the
19 corner of Church and Chapel seven days a week, so that's
20 one thing, which I think the agency needs to look at.
21 So, clearly, access is something that your
22 agency has jurisdiction over. Access is both cost, and
23 access is also about patient mix, which is geography, who
24 is going to be in this facility, and how are people going

1 to get the care. Thank you.
2 HEARING OFFICER HANSTED: Thank you.
3 Attorney Blair?
4 MR. BLAIR: I think we've had a
5 significant amount of testimony and information that we
6 filed with regards to what the issues that Gaylord faces
7 here with regards to a request for termination.
8 It was part of an overall plan to focus on
9 their core mission, and I believe the issues that the
10 Intervenor brings to light are real concerns. What I
11 think are concerns, number one, outside the jurisdiction
12 of the agency. Two, are separate from the matter that is
13 before you, with regards to the need to terminate,
14 because of the losses and decreasing volume of services
15 in sleep medicine that have occurred over the years that
16 is in our application that we provided to you.
17 We spent a good amount of time in our
18 objection clarifying some points with regards to access
19 and the three different options that patients will have
20 that we currently provide.
21 It was a very methodical and thoughtful
22 approach to how do we go ahead and close other sleep
23 services, but, at the same time, continue to provide
24 access to patients?

1 So although we understand the concerns of
2 the Intervenor, we believe that there are matters that
3 might be a little larger and will be decided in other
4 forums than this particular application, so we thank you
5 for the time today, and we hope that you look favorably
6 upon our application, and we'll be happy to provide any
7 late file information that helps you arrive at a decision
8 that is favorable to my client.
9 HEARING OFFICER HANSTED: Thank you,
10 Attorney Blair. Before we get to the public comment
11 section, are there any other public officials in the room
12 that would like to give a statement here today? Okay. I
13 don't see any.
14 (Whereupon, the testimony concluded, and
15 the public comment period commenced.)

HEARING RE: GAYLORD HOSPITAL
JUNE 18, 2014

AGENDA

	PAGE
Convening of the Hearing	2
Applicant's Direct Testimony	9
Intervenor's Testimony	14
OHCA's Questions	25, 45
Address of Mayor Toni Harp	40
Closing Remarks	46
Hearing Adjourned	51

.Verbatim [1] 2:1
05 [2] 1:9 2:6
0550 [1] 6:10
1 [3] 10:21 12:18 35:13
106-bed [1] 9:22
11 [1] 11:6
12 [2] 10:16 11:6
13-31884-CON [2] 1:7 2:17
14 [3] 7:17 8:2 52:7
15 [2] 20:7 40:1
15-minute [1] 39:23
18 [5] 1:8 2:6 2:17 19:18 52:2
1988 [1] 10:5
1996 [2] 10:3 10:5
1999 [2] 6:10 20:9
19a-19a-639a [1] 2:22
19a-639 [1] 3:11
2 [3] 36:24 37:19 52:5
20 [2] 1:10 2:5
2000 [2] 6:11 6:22
2006 [1] 10:21
2007 [1] 10:24
2008 [3] 9:23 10:1 10:3
2011 [4] 9:20 9:23 30:23 31:20
2013 [5] 11:13 20:14 20:17 21:5 22:19
2014 [5] 1:8 2:6 2:18 20:20 52:2
25 [1] 52:8
262-4102 [3] 1:13 51:15 52:13
3 [8] 1:9 2:6 37:20 38:6 39:8 45:1 45:9 49:4
3,700 [2] 14:18 16:17
30 [1] 11:13
34 [9] 3:14 4:6 6:12 7:8 7:11 14:17 14:19 16:16 18:10
36 [1] 5:18
4 [1] 10:24
40 [4] 20:19 22:20 41:4 52:9
43 [1] 35:17
45 [1] 52:8
46 [1] 52:10
50 [2] 13:7 32:24
51 [1] 52:11
54 [1] 2:24
6 [1] 42:4
6th [2] 20:20 21:6
784 [1] 23:3
8 [1] 11:5
800 [3] 1:13 51:15 52:13
84 [1] 29:3
9 [1] 52:6
900 [2] 16:18 18:10
99 [1] 6:9
ability [1] 34:13
able [10] 13:3 16:9 17:3 26:18 26:19 27:2 27:4 27:7 34:9 42:24
above [1] 12:19
absolutely [2] 46:24 47:9
absorb [1] 44:4
absorbing [1] 43:15
accepted [1] 22:22
access [42] 1:3 2:3 2:16 7:4 9:17 12:21 13:22 16:9 16:14 17:5 17:9 17:14 17:16 17:17 18:7 18:14 18:18 18:19 18:24 19:12 21:21 33:24 34:6 34:13 37:6 37:24 41:21 42:12 42:16 44:12 44:16 47:13 47:14 47:18 48:9 49:8 49:17 49:21 49:22 49:23 50:18 50:24
accessed [2] 7:2 7:3
accessing [3] 17:10 17:24 19:8
accordance [1] 2:23
account [1] 42:22
acquire [2] 6:15 48:12
acquired [1] 7:5
acquiring [7] 30:7 30:11 33:15 47:8 48:12 48:14 48:16
acquisition [7] 6:23 7:7 7:12 7:19 7:24 47:11 48:1
act [2] 3:4 9:1
actual [5] 17:16 38:22 45:3 47:11 49:4
addendum [1] 38:8
addition [2] 35:7 41:3
additional [4] 12:4 29:13 34:15 36:10
address [5] 5:12 15:12 19:5 40:5 52:9
Adjourned [1] 52:11
administered [1] 19:16
administrative [1] 22:13
administrators [1] 23:9
adopt [4] 9:14 14:12 20:1 22:9
adult [2] 13:3 13:14
adverse [1] 37:22
adversely [1] 41:20
advised [1] 46:12
advocates [1] 15:7
affected [1] 40:17
affects [2] 24:1 26:3
affiliated [1] 13:13
afford [1] 23:23
African-American [1] 41:18
African-Americans [1] 41:17
afternoon [9] 2:12 9:16 14:10 22:6 22:7 40:7 40:9 49:14 49:15
again [6] 16:14 36:24 37:19 44:19 44:20 45:17
against [1] 7:6
agency [17] 6:6 6:11 6:15 6:17 7:13 7:16 8:2 47:5 47:6 47:10 47:12 47:19 47:22 48:22 49:20 49:22 50:12
agency's [1] 8:4
agenda [2] 4:10 52:3
aggressively [2] 17:22 19:11
ago [4] 7:13 7:17 8:2 20:12
agreement [15] 37:18 38:6 38:9 38:11 38:13 38:13 38:22 39:4 45:3 45:5 45:11 45:14 45:19 45:21 49:5
ahead [1] 50:22
allocation [1] 48:20
allowed [2] 44:3 48:4
almost [7] 6:6 6:12 6:18 7:14 7:18 15:16 29:13
amount [2] 50:5 50:17
answer [5] 14:1 15:20 25:22 46:5 48:12
anyway [2] 20:4 29:13
apnea [6] 26:2 28:6 28:17 29:6 29:8 41:19
appearing [1] 3:18
Applause [2] 40:6 44:23
Applicant [10] 4:14 4:15 5:5 9:8 15:23 18:22 24:23 42:13 44:15 47:16
Applicant's [4] 9:11 18:21 18:23 52:6
application [20] 2:18 4:21 5:1 6:8 6:14 7:22 9:3 11:1 12:15 29:23 29:24 36:11 40:16 40:21 42:21 43:3 43:20 50:16 51:4 51:6
applications [1] 32:20
appointments [1] 35:6
appreciate [4] 14:22 35:19 40:1 40:14
approach [1] 50:22
appropriate [1] 46:14
Approval [1] 42:21
approved [1] 11:7
area [2] 33:6 36:19
argue [2] 7:22 17:2
argued [3] 7:21 8:22 40:22
arrangement [1] 37:14
arrangements [2] 39:20 49:4
arrive [1] 51:7
arrived [1] 13:17
ascribe [1] 36:18
aspect [1] 48:9
assessed [1] 11:23
assessment [2] 31:1 31:14
assets [4] 15:14 30:7 37:14 40:24
assigned [1] 3:6
assignment [2] 22:16 22:20
assist [1] 3:6
assistant [1] 22:13
associated [1] 23:13
assume [6] 13:3 13:5 13:20 32:11 32:13 34:17
assuming [2] 30:9 30:12
assure [2] 12:20 49:5
at-risk [4] 7:2 7:10 16:4 17:9
attempt [1] 6:3
attempted [1] 32:10
attention [1] 6:9
Attorney [17] 5:10 5:15 5:19 8:7 8:7 8:13 9:11 14:3 14:6 24:12 24:12 36:2 36:5 45:2 46:20 50:3 51:10
August [1] 10:21
authorization [1] 11:2
availability [1] 13:12
available [1] 34:19
Avenue [2] 21:3 23:3
aware [1] 8:24
awhile [1] 20:22
background [1] 25:20
bar [1] 9:4
barriers [1] 42:12
base [1] 21:15
based [3] 11:21 34:9 48:12
became [2] 22:16 26:22
becoming [1] 9:21
bed [2] 15:17 26:15
beds [2] 10:16 11:6
behalf [3] 5:4 8:22 14:18
below [1] 12:14
benefits [1] 27:6
best [3] 10:9 26:8 41:13
better [1] 30:2
between [4] 25:18 48:20 48:21 49:15
Beyond [1] 41:22
bills [1] 23:23
bit [4] 4:12 5:10 24:20 47:20
Blair [24] 4:7 4:7 5:10 8:7 8:9 9:11 14:3 14:4 24:12 24:13 24:17 28:20 36:2 36:3 36:5 36:7 37:21 38:19 45:2 45:7 45:20 50:3 50:4 51:10
Blair's [1] 5:19
board [1] 30:23
body [1] 34:22
boring [1] 24:21
bottom [3] 4:2 4:3 43:22
break [1] 39:23
breathing [1] 26:13
brief [2] 4:21 5:23
briefly [2] 25:16 25:16
bring [1] 44:9
brings [1] 50:10
budget [1] 44:2
building [2] 21:3 21:7
bus [5] 17:14 21:22 35:8 49:14 49:14
buses [1] 42:5
business [1] 32:3
buyers [2] 32:11

32:12
cab [1] 35:11
campus [1] 35:9
Canham-Clyne [3] 14:10 14:12 14:15
cannot [2] 23:23 44:2
capacity [4] 9:19 11:6 15:17 19:14
care [40] 1:3 2:3 2:16 7:1 8:19 9:17 9:19 10:3 11:23 11:23 12:2 12:20 12:21 13:3 13:5 13:22 16:9 16:14 17:4 17:11 17:17 17:24 18:7 18:14 19:9 19:9 23:10 25:21 26:23 28:15 28:16 33:19 33:22 33:24 43:6 43:11 43:13 43:24 49:8 50:1
carefully [1] 13:17
case [5] 2:23 5:12 5:18 6:20 8:5
cases [1] 29:16
caused [1] 23:22
CCMC [4] 13:6 13:14 33:7 33:10
center [17] 2:19 9:24 10:5 10:13 13:1 13:4 13:6 13:20 16:20 16:21 16:24 23:18 39:11 41:4 42:17 46:14 49:7
Center's [1] 32:23
CEO [4] 9:18 9:21 9:22 30:23
certain [1] 40:16
certainly [3] 15:17 17:10 27:9
Certificate [10] 6:8 10:20 11:7 11:11 18:21 19:3 40:18 44:6 44:8 47:4
Certification [2] 11:1 17:20
challenged [1] 46:23
challenges [3] 16:4 42:19 47:4
challenging [1] 17:17
change [3] 15:8 19:16 19:19
changes [8] 12:10 15:1 23:24 39:18 39:19 41:10 41:15 41:20
changing [3] 11:23 12:6 17:22
Chapel [1] 49:19
Chapter [1] 2:24
charged [1] 16:10
charts [1] 23:19
cheaper [1] 27:8
checked [1] 33:6
Chief [2] 9:24 25:3
Children's [5] 12:24 13:4 13:20 32:23 46:13
choices [1] 18:3
choose [1] 4:16
choosing [1] 18:6
Christmas [2] 21:5 22:19
chunk [1] 16:23
Church [3] 1:10 2:5 49:19
circumstances [5] 6:6 6:12 7:14 15:19 18:15
citizenry [1] 14:24
city [2] 7:2 14:23
City's [2] 43:22 44:1
claims [1] 44:15
clarification [3] 38:5 45:1 45:8
clarify [4] 28:5 30:16 38:19 38:24
clarifying [1] 50:18
clear [11] 13:16 16:22 17:18 17:19 22:16 27:19 29:20 39:10 40:15 40:21 45:2
clearer [1] 41:9
clearly [3] 48:9 48:22 49:21
client [1] 51:8
clinic [2] 23:2 23:5
clinic-based [1] 27:14
clinical [4] 12:11 13:2 16:18 18:11
clinically [1] 24:24
clinics [3] 23:7 28:6 48:5
close [3] 18:17 30:20 50:22
closed [6] 16:21 19:18 20:13 20:15 21:6 30:8
closing [5] 13:16 20:19 40:24 46:20 52:10
closure [4] 11:14 17:11 21:9 41:4
closures [2] 19:1 41:11
CMS [1] 48:4
co-morbidities [4] 17:16 21:19 29:9 42:10
collaborating [1] 13:18
collaboratively [1] 13:1
College [1] 2:5
combination [1] 28:16
combined [1] 20:15
coming [3] 19:10 29:16 34:19
commenced [2] 31:1 51:15
comment [8] 4:21 6:5 28:8 28:24 28:24 45:24 51:10 51:15
comments [6] 4:24 5:23 7:16 47:2 47:17 49:12
Commission [1] 7:6
Commissioner [2] 3:3 40:13
commitment [3] 38:23 38:24 39:4
committed [1] 37:15
community [4] 2:5 9:22 18:19 40:5
companies [2] 31:16 31:23
company [1] 27:9
compelling [1] 8:14
completed [1] 4:18
complex [1] 12:2
comprise [1] 44:1
CON [3] 15:14 18:23 34:23
concentrate [1] 12:1
concern [3] 37:6 43:11 43:20
concerned [2] 41:14 43:1
concerning [1] 3:10
concerns [4] 40:20 50:10 50:11 51:1
concluded [1] 51:14
conclusion [1] 31:5
condition [6] 26:2 26:3 26:8 26:9 37:24 38:1
conditions [1] 42:11
conduct [1] 44:20
conducted [2] 2:23 20:17
conducting [1] 21:4
confusing [2] 21:10 21:12
Connecticut [17] 1:1 1:11 2:2 2:6 2:20 2:22 2:24 3:12 10:1 10:3 12:24 13:4 13:19 15:21 32:23 46:13 49:13
consider [3] 2:18 3:9 18:24
consideration [3] 21:15 22:2 40:19
consists [1] 10:16
consolidated [1] 16:2
consolidation [2] 16:3 17:6
contained [1] 38:11
contested [1] 2:23
context [4] 7:23 11:16 17:8 47:7
continue [7] 8:4 39:14 39:20 40:4 46:3 46:16 50:23
continued [6] 11:8 12:21 13:22 23:4 23:11 38:12
continuity [1] 12:20
contrary [1] 44:18
contributed [2] 31:6 32:4
control [3] 16:23 44:2 46:3
convenient [1] 23:24
Convening [1] 52:5
COPD [2] 27:23 28:17
copy [1] 37:18
core [3] 12:1 31:2 50:9
corner [1] 49:19
correct [4] 30:5 39:15 39:16 46:18
cost [9] 16:12 16:12 18:18 29:13 47:19 47:21 47:23 48:9 49:22
cost-effective [2] 33:23 43:14
costs [9] 16:10 18:2 18:8 19:8 43:3 43:7 43:13 44:1 44:2
counsel [4] 3:24 4:5 4:7 4:11
country [2] 25:14 27:18
couple [2] 33:4 37:5
course [2] 12:16 15:8
court [1] 5:6
coverage [2] 43:9 43:24
CPAP [1] 10:14
criteria [1] 26:20
critical [1] 19:5
Cross [2] 24:12 28:10
Cross-Examination [1] 24:14
Cross-Examine [1] 4:16
CT [3] 1:13 51:15 52:13
current [6] 15:1 15:23 18:21 33:3 46:6 46:11
data [2] 35:17 36:15
date [1] 21:24
Dawkins-Doumbia [4] 22:5 22:8 22:9 22:12
days [2] 10:16 49:19
deal [1] 42:24
December [1] 11:13
decide [1] 44:11
decided [1] 51:3
decision [10] 3:9 10:8 11:17 11:19 11:24 12:4 12:20 13:17 30:20 51:7
decline [1] 31:19
declined [1] 12:18
declining [1] 12:16
decreasing [1] 50:14
delivery [1] 12:6
denied [1] 20:23
deny [3] 7:8 9:7 18:20
department [6] 1:2 2:2 3:3 10:12 22:13 42:3
depending [1] 43:8
Deputy [1] 14:15
describe [1] 25:16
designated [4] 3:3 3:13 3:15 5:11
detail [1] 25:1
details [1] 41:8
determination [2] 10:21 27:3
determined [1] 32:8
determining [1] 19:2
Development [1] 10:2
deviate [2] 4:11 7:16
Devine [3] 11:5 42:4 42:19
diagnose [2] 26:8 29:4
diagnosed [2] 29:3 29:7
diagnosis [2] 26:21 27:23
diagnostic [1] 10:17
difference [1] 25:17
different [7] 6:21 12:13 23:15 23:15 26:12 32:2 50:19
differently [1] 7:21
difficult [5] 17:15 18:3 21:24 27:21 41:12
difficulties [1] 18:12
diminished [1] 12:5
direct [3] 4:22 12:17 52:6
directly [1] 4:14
Director [1] 14:16

disciplines [2] 18:6 18:14
discontinue [7] 10:8 11:2 11:11 11:17 11:19 12:5 31:12
discontinuing [1] 32:4
discussing [1] 45:12
discussions [2] 33:13 33:16
disease [1] 27:23
disorders [4] 28:17 29:2 29:3 41:22
diversified [1] 21:16
docket [7] 1:7 2:17 6:9 15:11 40:12 40:21 44:15
doctor [2] 23:14 46:16
doctor's [1] 44:4
doctors [7] 21:9 23:8 41:5 46:1 46:3 46:15 48:14
document [1] 34:22
documents [1] 3:18
doesn't [1] 27:15
done [3] 27:17 27:24 34:9
doubt [2] 27:18 41:3
down [2] 20:10 49:18
Downtown [1] 49:15
dramatic [3] 16:11 18:7 31:22
Drive [1] 11:4
driven [1] 31:17
driving [1] 41:24
drop [1] 13:7
duly [2] 5:7 25:11
duplication [1] 12:7
during [5] 6:22 11:23 15:8 20:16 21:9
early [1] 49:14
effect [1] 26:4
effective [1] 20:19
effectively [1] 41:12
effects [1] 26:6
efficient [1] 33:23
eight [1] 11:9
either [3] 15:18 32:13 42:7
electronically [1] 46:22
elsewhere [1] 18:1
emergency [1] 25:20
employed [1] 16:18
employees [1] 43:24
employers [1] 43:12
employment [1] 8:17
encourage [2] 44:5 44:6
encouraged [1] 43:14
end [2] 29:16 42:8
ending [2] 47:7 47:24
enhanced [1] 12:10
enter [1] 3:21
entire [1] 14:20
entirely [1] 27:20
entirety [1] 38:17
environment [1] 11:23
equipment [3] 32:11 32:13 33:15
equipped [1] 10:13
especially [2] 26:5 42:19
essentially [1] 19:9
establish [2] 10:23 11:4
established [1] 30:18
evaluate [2] 26:9 47:6
evening [1] 35:6
evidence [1] 44:17
evidenced [1] 41:11
exact [2] 7:14 36:10
exactly [2] 24:24 25:16
example [2] 43:10 49:12
except [1] 33:16
exclude [1] 27:4
exclusive [1] 33:9
excuse [1] 24:20
exhibits [2] 3:21 4:1
exist [2] 34:10 45:13
existing [1] 33:5
exists [1] 45:15
expanded [1] 37:7
expanding [1] 22:3
expect [1] 14:23
expensive [1] 27:8
experienced [1] 13:7
explain [2] 30:13 32:7
extra [1] 29:14
face [3] 18:13 43:2 43:6
Faced [1] 12:19
faces [1] 50:6
facilities [7] 19:1 19:10 19:18 33:19 40:23 43:15 44:13
facility [19] 6:16 6:24 8:19 15:15 19:6 20:9 20:14 23:13 23:15 33:22 35:2 35:10 41:6 43:5 46:2 48:3 48:15 49:16 49:24
fact [5] 6:5 15:22 19:15 40:24 47:5
factor [1] 32:4
factors [3] 11:21 12:4 47:19
faculty [1] 21:17
fair [1] 28:24
familiar [2] 33:18 34:5
far [2] 32:12 38:20
Farmington [4] 13:7 13:9 32:24 33:2
Farms [1] 11:3
fashion [1] 31:7
fashions [1] 26:12
fastest [1] 42:7
favor [1] 7:7
favorable [1] 51:8
favorably [1] 51:5
fee [4] 16:11 17:23 17:23 49:3
fees [4] 19:6 23:13 43:19 48:4
few [3] 20:10 22:23 40:12
field [1] 43:11
figures [1] 36:21
file [17] 5:21 15:13 18:22 35:11 35:13 36:1 36:2 36:24 37:19 37:20 38:5 39:8 44:7 45:1 45:9 49:4 51:7
filed [5] 5:11 8:10 10:20 11:10 50:6
files [1] 45:16
filing [1] 49:3
finally [4] 16:6 18:17 19:13 20:17
financials [1] 33:3
findings [1] 3:10
fine [1] 20:5
first [11] 6:4 6:5 7:12 8:17 14:22 15:13 16:16 17:5 25:19 25:24 40:21
fit [1] 31:11
five [1] 19:18
focus [3] 31:9 31:12 50:8
focused [2] 31:3 48:23
folks [4] 4:24 16:18 34:13 37:7
follow-up [1] 8:8
followed [1] 4:14
following [2] 6:13 15:12
force [1] 42:1
foremost [2] 8:17 15:13
forestall [1] 6:3
formal [2] 19:4 36:2
former [1] 49:16
formerly [2] 48:16 49:6
forth [1] 3:11
forums [1] 51:4
forward [3] 15:9 32:14 44:11
four [1] 30:17
Fourteen [1] 7:13
front [2] 6:22 15:12
full [1] 45:20
fundamental [1] 47:19
furthermore [2] 8:20 43:19
future [6] 15:10 15:20 21:24 22:2 27:17 31:10
Gateway [1] 2:5
Gaylord [34] 1:4 1:5 2:4 2:18 2:19 3:13 4:8 9:18 9:22 10:7 10:11 10:12 10:20 11:1 11:3 11:10 11:22 12:9 12:19 12:23 13:11 13:17 25:3 33:6 37:9 39:12 41:11 45:4 45:6 47:24 48:15 49:16 50:6 52:1
Gaylord's [5] 11:16 15:14 19:1 40:23 46:2
general [4] 2:22 3:1 3:12 11:18
geographic [1] 19:12
geography [3] 47:20 48:11 49:23
George [4] 9:13 9:13 9:18 30:22
given [2] 14:21 19:15
glad [1] 14:1
Glastonbury [5] 13:8 30:15 32:21 32:22 33:2
global [1] 7:23
goals [1] 33:21
goes [1] 43:3
good [10] 2:11 9:16 14:10 22:5 22:7 29:5 36:5 40:7 40:9 50:17
Gorman [1] 6:23
Governor [1] 9:1
grant [1] 44:5
granted [5] 6:7 6:11 6:17 7:17 8:3
greater [2] 16:17 43:13
Gretchen [4] 19:24 20:1 28:21 29:1
Group [1] 23:8
growth [2] 19:17 31:10
guidelines [1] 3:11
Guilford [4] 20:8 20:13 20:14 30:15
half [2] 20:12 42:6
HAMDEN [3] 1:13 51:15 52:13
hand [1] 5:6
handed [1] 4:10
happening [4] 7:24 17:8 39:10 41:15
happy [1] 51:6
hardly [1] 49:17
hardship [1] 42:22
hardware [1] 30:11
Harp [9] 40:4 40:5 40:7 40:10 40:10 44:23 47:3 49:10 52:9
Hartford [2] 10:2 10:3
Haven's [1] 19:11
health [22] 1:2 1:3 2:3 2:3 2:16 3:4 8:19 9:17 9:19 10:2 11:22 11:23 12:2 16:14 18:7 33:19 33:22 33:24 43:8 43:11 43:13 43:24
hear [6] 16:4 16:15 20:4 24:6 28:22 28:23
heard [5] 5:2 24:4 46:6 47:15 49:1
heart [3] 26:5 26:12 27:23
held [3] 2:5 2:17 2:21
Hello [1] 9:13
help [1] 42:14
helps [1] 51:7
Henry [2] 4:3 4:5
hereby [4] 9:14 14:12 20:1 22:9
Hi [1] 19:24
high-quality [1] 12:21
higher [6] 23:23 41:19 43:3 43:7 44:3 48:3
highest [1] 13:22
hired [1] 46:8
historical [1] 31:3
historically [2] 32:3 35:1
holding [2] 14:22 40:14
Holland [8] 25:8 25:11 25:13 25:13 25:19 25:24 27:16 28:13
home [12] 12:12 19:17 26:18 26:23 27:2 27:8 29:5

29:11 29:15 31:20 31:22 32:1
home-based [2] 25:18 27:13
honest [1] 34:4
hope [1] 51:5
hopefully [1] 37:7
hospital [51] 1:4 3:13 4:8 6:15 6:24 7:5 8:1 9:22 10:12 10:20 11:1 11:10 12:24 13:3 13:14 13:17 13:19 15:13 15:18 15:19 15:24 16:11 16:23 17:21 18:22 19:9 19:10 20:22 22:17 23:5 23:8 23:11 23:14 23:17 23:20 24:3 24:7 25:4 34:17 41:1 42:4 43:16 44:7 45:4 46:8 48:2 48:5 48:11 48:18 49:7 52:1
Hospital's [4] 2:18 10:7 41:11 47:24
hospital-based [3] 17:23 19:7 43:5
hospitals [4] 15:4 43:15 44:2 47:12
hotels [1] 26:17
hour [2] 42:5 42:6
hours [1] 5:18
housekeeping [1] 5:10
Howard [2] 21:3 23:3
identical [5] 6:6 6:12 6:19 7:14 7:18
identified [3] 2:16 31:11 33:10
ignorance [1] 24:20
imagine [1] 41:12
immediately [1] 31:1
impact [13] 14:24 16:14 16:24 17:2 17:5 17:22 18:24 19:6 34:13 41:15 41:20 44:16 48:2
impacts [1] 43:20
importantly [3] 7:10 16:6 17:5
impose [1] 44:3
imposing [1] 43:16
improving [1] 33:24
in-lab [3] 12:12 27:3 31:19
include [1] 10:17
included [5] 12:5 12:14 16:17 16:20 45:12
includes [2] 15:17 35:8
including [5] 19:6 26:6 26:12 28:17 42:10
income [2] 41:16 42:14
incomplete [1] 40:22
inconvenience [1] 23:22
increase [6] 11:6 15:17 16:11 18:2 18:7 31:22
increased [1] 36:18
increasing [2] 18:12 36:13
individual [1] 19:7
individuals [1] 5:4
industry [1] 16:8
infinite [1] 8:3
inflated [1] 43:16
information [4] 47:5 49:2 50:5 51:7
inpatient [2] 12:1 12:6
inquiry [1] 47:14
Instead [2] 40:24 44:6
Institute [2] 6:16 7:3
institutional [1] 16:13
instructed [2] 23:16 46:12
insurance [6] 27:9 31:15 31:16 31:23 43:8 48:22
insure [4] 13:1 19:12 41:24 44:12
insurers [3] 43:2 43:12 48:4
interest [4] 7:8 7:9 10:9 41:13
interested [1] 33:14
internal [3] 22:13 22:22 25:20
International [1] 14:16
intervene [1] 6:4
Intervenor [16] 3:15 4:15 4:16 5:5 5:11 5:12 6:7 6:11 6:18 7:18 8:3 8:22 9:5 24:23 50:10 51:2
Intervenor's [1] 52:7
Intervenors [2] 24:15 40:22
investigate [2] 17:21 19:11
issue [2] 36:19 47:13
issues [8] 8:17 15:10 15:12 18:18 21:19 28:7 50:6 50:9
item [1] 44:1
items [1] 8:14
itself [1] 15:19
January [6] 6:11 10:24 20:8 20:14 20:19 21:6
jeopardy [1] 7:1
Jewel [1] 3:3
jobs [2] 7:9 42:20
John [5] 4:7 4:7 14:9 14:10 14:12
judgment [1] 41:13
June [4] 1:8 2:6 2:17 52:2
jurisdiction [10] 8:16 8:18 8:20 8:23 9:2 15:5 47:11 47:13 49:22 50:11
Kaila [3] 3:7 3:20 3:20
Kevin [2] 2:11 3:2
key [2] 15:12 47:14
kind [2] 33:17 49:17
knowing [1] 34:12
known [1] 26:2
Kyriacou [29] 9:13 9:14 9:16 9:18 25:2 30:6 30:11 30:16 30:22 30:23 32:10 32:17 32:22 33:9 34:4 34:21 35:14 35:17 35:20 35:23 36:14 36:22 37:13 38:23 39:6 39:16 39:19 46:5 46:18
lab [30] 11:6 12:6 20:9 20:10 20:13 20:14 20:15 20:19 20:21 21:6 22:20 22:21 22:24 23:1 25:1 25:17 26:14 27:7 27:17 27:24 29:3 29:7 29:10 29:13 29:17 30:1 32:1 43:4 48:8 49:16
lab-based [1] 25:18
laboratories [1] 11:3
laboratory [3] 11:5 17:12 32:24
labs [5] 19:2 26:1 26:16 26:22 32:19
laid [3] 20:7 22:24 23:2
large [3] 16:1 16:23 24:7
larger [2] 17:8 51:3
largest [3] 30:17 32:16 44:1
last [5] 12:16 15:8 19:18 21:4 48:12
late [14] 35:13 36:2 36:24 37:19 37:20 38:5 39:8 45:1 45:9 45:16 49:3 49:3 49:14 51:7
Latinos [1] 41:17
layoffs [1] 20:16
lease [2] 30:10 30:12
leases [3] 32:11 32:13 33:15
least [6] 6:21 7:19 42:5 48:7 48:7 49:2
leave [1] 36:6
left [1] 22:21
legislative [1] 15:8
legislature [1] 8:24
length [1] 8:13
less [1] 27:8
letter [2] 10:21 38:20
letters [1] 41:1
level [1] 13:22
licensed [1] 15:17
life [1] 26:7
light [1] 50:10
likely [1] 14:24
limit [1] 4:23
limited [2] 3:15 12:1
line [3] 35:8 43:22 44:1
listed [1] 3:22
literally [1] 18:11
lives [1] 17:1
local [12] 3:14 4:6 6:7 6:12 6:18 6:20 7:8 7:11 14:17 14:19 16:16 18:10
located [3] 10:13 11:3 35:10
location [8] 10:16 11:15 13:9 13:10 33:2 35:8 36:16 42:5
locations [5] 11:12 11:20 32:12 34:10 35:9
Logisticare [1] 35:4
longer [2] 21:1 21:3
look [9] 19:14 31:18 31:20 33:3 35:7 48:23 49:12 49:20 51:5
looked [2] 31:8 31:12
looking [5] 15:9 31:15 32:19 38:20 45:3
looks [1] 28:7
losing [3] 7:9 30:24 32:18
losses [2] 31:7 50:14
low [2] 41:15 42:14
low-income [2] 21:18 44:12
low-wage [1] 42:20
lungs [1] 26:4
Madison [3] 16:2 23:6 41:7
maintained [1] 37:6
maintaining [2] 31:10 33:23
major [3] 26:4 33:17 43:10
majority [1] 34:18
management [6] 11:16 11:22 12:19 20:17 20:23 23:16
manager [1] 20:23
mandated [1] 31:23
mandatory [1] 20:18
manner [1] 33:23
market [4] 15:1 16:24 34:8 41:10
marketplace [1] 19:20
markets [1] 12:8
matter [3] 2:3 40:22 50:12
matters [1] 51:2
may [11] 4:21 6:1 7:4 9:11 14:6 24:21 36:15 36:22 38:24 39:1 48:12
Mayor [10] 40:4 40:5 40:7 40:10 40:11 44:22 47:3 47:17 49:10 52:9
mean [2] 30:17 46:15
meantime [1] 22:23
measureable [1] 44:16
Medicaid [5] 35:5 36:12 36:17 44:16 48:21
medical [13] 9:24 10:5 12:24 13:4 13:20 21:19 23:8 23:19 25:3 28:7 32:23 41:23 46:13
medically-complex [2] 12:3 31:4
Medicare [2] 36:16 48:21
Medicare/Medicaid [1] 23:23
medicine [49] 1:5 2:4 10:8 10:11 10:22 10:23 11:8 11:11 11:17 11:19 12:5 12:7 12:11 12:21 12:23 13:11 13:12 13:18 15:1 15:20 16:19 18:16 19:12 19:16 20:7 22:14 22:16 22:20 22:22 23:1 25:20 25:20 25:21 26:1 26:1 28:6 28:14 34:7 34:18 41:10 41:15 42:9 43:21 47:7 47:8 48:1

48:17 48:18 50:15
meet [1] 26:20
meeting [1] 20:18
Melissa [2] 22:5 22:8
member [1] 3:6
members [5] 4:20 7:9 14:18 14:18 18:10
members' [2] 7:8 17:1
memorandum [3] 38:7 39:1 45:11
men [1] 41:18
mentioned [1] 34:16
Meriden [1] 10:1
merit [2] 29:15 40:23
methodical [1] 50:21
microphone [1] 4:1
middle [1] 42:6
MidState [2] 9:24 10:5
might [2] 49:11 51:3
mind [1] 44:14
minutes [2] 4:24 40:1
mirrors [1] 45:15
mission [3] 31:2 31:3 50:9
mix [6] 36:11 36:15 36:21 48:19 48:20 49:23
models [1] 12:6
moment [1] 17:9
money [2] 30:24 32:18
monitor [2] 26:11 26:19
months [3] 19:19 35:16 35:17
morning [1] 49:14
most [4] 14:24 16:6 17:4 29:16
move [1] 16:22
moved [4] 13:9 20:10 20:13 23:3
moving [2] 17:13 21:1
Ms [25] 3:20 3:23 14:11 19:24 20:3 20:6 22:5 22:8 22:12 29:1 29:19 29:21 29:22 30:9 30:13 30:19 32:5 32:15 32:18 33:4 33:17 34:15 36:9 37:2 37:5
Mullen [1] 3:3
Murray [22] 4:3 4:5 4:5 5:15 5:17 6:2 8:7 8:13 9:9 14:6 14:7 24:9 24:12 28:2 28:4 28:11 38:4 38:15 38:18 46:20 46:22 47:1
must [3] 15:12 15:13 15:19
name [4] 3:2 14:12 19:24 22:8
narcolepsy [3] 28:8 28:18 41:23
Navigating [1] 42:18
necessarily [1] 46:15
need [18] 6:8 10:21 11:1 11:7 11:11 17:20 18:21 19:3 27:3 27:14 27:20 38:14 38:24 40:18 44:6 44:8 47:4 50:13
needs [4] 47:6 47:22 48:23 49:20
negate [2] 27:14 27:20
negates [1] 27:16
Network [1] 10:2
never [1] 46:21
new [31] 1:11 2:6 10:22 11:4 12:24 13:6 13:9 14:23 16:17 18:19 19:3 19:13 20:11 20:15 21:16 21:18 22:21 22:22 23:3 23:5 24:3 32:24 35:8 40:11 40:14 40:17 41:16 43:18 43:23 44:19 49:15
next [1] 44:4
night [3] 10:18 21:5 29:14
nights [1] 10:17
no-cost [1] 35:4
none [1] 33:15
Nonetheless [1] 9:4
North [41] 1:6 2:5 2:19 10:11 10:13 10:15 10:23 11:5 11:8 11:12 11:14 11:20 12:15 12:23 13:11 15:14 16:2 17:13 18:23 21:23 23:5 30:1 30:3 30:5 30:7 30:14 30:21 32:7 32:15 33:16 35:7 36:15 39:11 39:15 40:23 41:7 46:2 46:12 48:15 49:8 49:16
Norwich [2] 20:9 20:13
noted [1] 34:21
notes [2] 35:23 42:13
nothing [2] 14:4 24:9
notice [2] 32:20 36:12
notify [1] 13:12
November [2] 9:20 30:23
now [11] 16:10 21:11 29:6 29:21 33:1 34:7 37:9 46:16 48:6 49:7 49:7
nuances [1] 34:12
number [5] 6:10 27:16 31:22 35:10 50:11
numbers [1] 21:14
numerous [1] 34:10
object [1] 6:2
objection [6] 5:11 5:19 8:13 9:8 34:22 50:18
objections [3] 3:24 4:6 4:8
obstacles [1] 42:11
obstruction [1] 29:8
obstructive [4] 26:2 28:6 28:17 29:5
obviously [4] 6:2 17:1 27:6 46:22
occasions [1] 6:22
occur [1] 46:11
occurred [1] 50:15
occurs [1] 27:2
October [1] 20:17
off [7] 20:8 22:24 23:2 28:5 35:9 40:2 42:20
offering [1] 44:13
office [8] 1:3 2:3 2:16 9:17 15:4 15:10 16:9 17:21
officials [1] 51:11
often [5] 17:15 31:23 41:23 42:9 42:20
OHCA [9] 3:9 3:20 3:21 4:17 5:20 6:20 10:24 14:11 41:12
OHCA's [10] 3:19 3:22 8:16 8:18 8:19 8:23 9:2 15:5 24:19 52:8
old [1] 42:16
once [4] 7:4 32:23 39:13 42:6
one [18] 11:4 30:21 32:8 33:21 34:15 36:5 36:9 36:24 37:19 40:16 43:10 45:8 45:23 46:14 47:19 48:9 49:20 50:11
ones [1] 31:2
open [2] 23:1 44:9
opened [5] 13:6 20:9 20:11 23:5 32:24
opening [1] 23:17
operate [1] 32:9
operating [2] 9:24 10:16
Operations [1] 10:4
opportunities [1] 37:12
opportunity [8] 5:16 5:19 5:21 6:3 10:6 13:23 40:11 44:21
opposed [1] 48:6
option [1] 23:24
options [1] 50:19
order [3] 35:13 38:1 47:6
ordered [1] 9:6
organization [2] 10:10 30:24
organizational [2] 31:7 31:10
organizations [1] 33:10
originally [1] 9:6
ought [1] 18:15
out-of [1] 19:7
out-of-pocket [5] 16:10 16:12 18:2 18:8 43:7
outcome [1] 19:4
outpatient [3] 10:12 12:2 48:5
outside [2] 4:10 50:11
overall [4] 19:14 31:6 43:11 50:8
overnight [3] 10:14 21:4 21:11
overrule [1] 9:7
own [5] 7:8 31:21 34:24 35:3 44:8
oxygenation [1] 26:13
p.m [2] 1:9 2:7
page [2] 36:10 52:4
panned [1] 33:16
paramount [1] 49:1
parent [1] 14:17
part [14] 9:8 16:7 16:22 17:20 23:2 27:11 31:14 32:3 32:6 37:13 39:1 45:16 48:11 50:8
participating [1] 9:5
participation [1] 3:16
particular [9] 7:12 7:22 8:5 36:19 40:16 41:16 41:19 47:24 51:4
particularly [2] 17:15 41:17
parties [1] 5:7
parts [1] 34:16
party [1] 3:14
passed [1] 9:1
past [3] 11:9 16:8 31:5
patient [12] 12:17 21:15 24:6 27:6 29:12 29:14 42:1 47:23 48:3 48:10 48:19 49:23
patients [66] 10:9 12:3 12:22 13:2 13:4 13:12 13:14 13:15 13:21 16:8 17:4 17:15 17:24 18:4 18:5 18:12 18:15 19:8 20:24 21:5 21:8 21:13 21:20 22:1 23:4 23:9 23:17 23:22 24:6 27:22 27:22 27:22 28:16 28:21 29:8 29:16 31:4 33:8 33:8 33:12 34:19 34:20 34:24 35:2 36:17 36:17 41:5 41:21 42:2 42:9 42:14 42:23 43:2 43:5 43:13 44:12 44:17 46:11 48:13 48:15 48:17 48:18 48:21 49:5 50:19 50:24
patients' [1] 33:24
pay [2] 42:14 43:19
payer [3] 36:11 36:15 36:21
payers [1] 16:13
paying [1] 48:3
pediatric [5] 13:5 13:8 13:15 27:22 33:1
Pennsylvania [1] 9:23
people [8] 7:2 26:3 40:17 41:20 42:20 49:11 49:18 49:24
percent [5] 13:7 31:22 33:1 36:16 36:17
perhaps [2] 16:6 49:11
period [2] 31:19 51:15
periods [1] 36:18
permit [4] 4:15 5:21 5:24 46:23
permitted [1] 7:11
person [4] 26:9 26:11 26:18 27:2
person's [1] 26:7
perspective [3] 15:23 15:24 34:2
petitioner [3] 7:20 7:23 47:16
petitioner's [1] 6:3
Phone [1] 21:14
physical [1] 17:17
physician [6] 8:21 12:17 15:4 19:9 47:12 48:6
physician's [2] 16:9

21:2
physician-based [1] 17:22
physicians [1] 46:7
place [3] 17:7 37:11 39:13
plan [8] 19:11 33:20 34:3 34:11 37:11 37:24 45:14 50:8
planning [3] 11:24 32:6 33:21
plans [2] 15:20 44:9
plus [1] 19:1
pocket [1] 19:8
point [8] 5:24 7:19 15:2 16:16 25:19 31:13 39:23 44:24
points [2] 14:21 50:18
policies [1] 44:9
policy [1] 43:11
polysomnography [4] 10:18 10:18 10:19 29:2
pool [1] 17:3
population [11] 7:2 7:10 13:5 13:8 19:13 29:7 36:12 44:17 47:23 48:3 48:10
populations [2] 16:4 17:10
portion [1] 4:19
pose [2] 17:9 42:11
poses [2] 42:19 47:4
position [2] 4:22 22:22
possibility [1] 43:2
Post [4] 1:12 3:7 51:15 52:12
potential [1] 7:1
practice [10] 7:17 8:21 12:11 22:18 23:3 23:18 31:16 41:6 44:4 44:8
practices [4] 15:4 16:19 18:11 47:12
pre-file [1] 34:16
pre-filed [4] 9:14 14:13 20:1 22:9
prepared [1] 8:15
present [2] 4:21 16:3
presentation [2] 4:14 9:12
presented [1] 44:6
President [4] 9:18 9:21 10:2 10:4
previous [2] 5:20 36:18
previously [3] 10:4 17:24 43:7
prices [2] 44:3 44:9
primary [2] 37:6 40:20
principles [1] 3:10
private [2] 48:4 48:21
problem [1] 34:8
proceed [4] 9:11 14:6 24:19 44:24
proceeding [2] 3:14 19:5
proceedings [2] 2:1 6:4
process [4] 11:24 29:12 32:6 33:21
professors [1] 21:17
program [7] 10:15 13:13 13:15 31:6 31:11 31:12 32:4
programs [3] 31:2 42:14 42:15
prohibitions [1] 41:24
projections [1] 36:12
proper [1] 27:1
proposal [1] 34:3
proposed [2] 17:7 41:20
provide [11] 37:11 37:23 38:7 38:14 45:5 45:18 45:20 46:4 50:20 50:23 51:6
provided [12] 11:8 12:8 13:13 32:2 35:1 39:11 39:14 43:16 45:6 45:15 48:5 50:16
provider-based [1] 10:12
providers [5] 12:8 33:6 33:6 33:14 34:7
provides [2] 35:4 37:9
providing [5] 11:17 13:18 37:15 37:16 46:1
provision [2] 38:11 47:24
provisions [1] 2:24
psychiatric [3] 6:16 7:1 7:3
public [20] 1:2 2:2 2:15 2:21 3:4 4:19 4:20 9:1 21:21 41:13 42:1 42:2 42:14 42:18 45:23 49:2 49:12 51:10 51:11 51:15
pulmonary [2] 28:15 42:10
purchase [12] 15:3 15:14 30:3 38:6 38:8 39:2 45:3 45:11 45:13 45:19 45:21 49:5
purchased [1] 20:22
purchasing [1] 30:4
purported [1] 8:18
purposes [1] 9:2
pursuant [1] 2:21
put [3] 6:24 7:15 9:1
putting [1] 6:23
quality [1] 33:24
questions [14] 4:17 7:11 13:24 19:6 24:14 24:19 25:22 29:23 29:24 33:5 37:3 37:5 47:15 52:8
quite [1] 7:21
raise [2] 5:5 7:11
rate [2] 26:12 26:13
rates [1] 43:16
rather [1] 19:9
Ray [1] 6:22
RE [1] 52:1
reach [1] 17:15
read [3] 3:17 14:20 20:3
ready [1] 42:16
real [3] 42:11 44:12 50:10
reallocate [1] 31:9
really [16] 27:13 31:3 31:4 31:9 31:16 31:21 32:1 34:11 34:12 34:23 47:3 47:14 47:18 47:19 49:1 49:1
reason [1] 18:9
reasonable [1] 16:10
reasons [1] 6:19
receive [1] 43:6
received [1] 10:24
recently [2] 16:20 26:23
recipients [1] 35:5
recognize [1] 15:2
record [8] 3:18 3:19 3:21 3:22 40:2 41:2 41:9 45:1
recorded [1] 3:7
records [1] 23:19
recruited [1] 46:7
red [1] 33:3
reduced [1] 17:14
reference [1] 12:18
referenced [1] 38:22
referencing [1] 45:9
referrals [2] 12:17 12:18
reflect [1] 41:2
reflected [1] 40:18
regard [1] 43:23
regarding [2] 4:22 33:7
Regardless [1] 19:4
regards [6] 37:23 45:8 50:6 50:7 50:13 50:18
regional [1] 17:6
Registered [1] 29:2
regularly [1] 18:5
regulation [1] 15:3
rehab [1] 12:2
rehabilitation [1] 31:4
reimburse [1] 31:24
reimbursement [2] 12:13 19:7
relate [1] 18:19
relates [1] 34:3
relationship [2] 30:14 30:17
relevant [1] 14:21
rely [1] 42:2
remains [1] 40:21
Remarks [1] 52:10
reminded [1] 47:9
render [1] 41:13
reporter [1] 5:6
Reporting [4] 1:12 3:8 51:15 52:12
represents [1] 16:16
request [5] 7:15 8:4 18:20 18:21 50:7
requested [1] 49:3
require [5] 18:22 29:9 32:1 37:7 44:7
requires [1] 42:7
Research [1] 14:16
resident [1] 24:5
residents [3] 21:18 41:16 43:18
resources [3] 12:1 31:9 33:22
respect [4] 8:20 9:7 33:5 45:18
respiratory [1] 26:13
response [2] 5:15 5:22
responsibility [2] 13:20 34:17
rest [1] 23:1
restrictions [2] 41:23 42:1
result [6] 13:21 19:2 41:5 41:23 42:22 44:10
resulted [1] 12:11
resummarize [1] 18:17
returned [1] 22:24
review [2] 5:16 5:19
reviewed [1] 8:13
ride [1] 42:8
rides [1] 42:15
Riggott [19] 3:7 3:20 3:20 3:24 14:11 29:21 29:22 30:9 30:13 30:19 32:5 32:15 32:18 33:4 33:17 34:15 36:9 37:2 37:5
right [9] 4:2 5:6 21:5 21:11 25:7 27:24 35:9 38:2 47:9
rights [1] 3:15
risk [1] 41:19
Road [1] 11:3
room [3] 15:7 24:22 51:11
Rose [8] 19:24 20:1 20:3 20:6 28:21 29:1 29:1 29:19
route [1] 42:7
ruled [2] 7:6 7:6
ruling [3] 5:14 5:20 8:4
run [1] 42:6
safety [1] 41:24
sale [14] 8:21 38:6 38:8 38:11 38:13 38:13 38:22 39:4 45:3 45:11 45:13 45:19 45:21 49:5
sales [1] 39:2
satellite [1] 26:16
Saturday [2] 49:14 49:15
says [1] 42:4
School [1] 16:19
screening [2] 27:1 29:12
scribbled [1] 35:23
seamless [1] 13:1
seat [1] 2:13
second [4] 15:2 35:4 38:5 41:14
Secondly [4] 15:16 15:22 17:13 17:18
section [4] 2:22 3:11 45:24 51:11
see [11] 8:20 21:4 21:10 23:4 23:14 26:19 26:23 37:18 37:24 39:4 51:13
seeing [1] 41:5
seek [1] 43:14
seeking [1] 11:2
self-insured [1] 43:23
sell [1] 37:14
sense [1] 6:13
sensing [1] 27:15
sent [1] 39:1
separate [4] 38:7 38:20 38:24 50:12
served [2] 9:19 9:23

serves [1] 12:9
service [10] 1:12 10:15 13:2 21:14 35:1 37:15 43:19 49:9 51:15 52:12
services [45] 1:5 2:4 2:19 3:8 10:8 10:17 10:22 10:23 11:8 11:12 11:17 11:20 12:2 12:5 12:7 13:13 13:18 13:21 15:16 16:1 16:14 33:19 34:1 34:7 34:14 34:18 37:8 37:11 38:12 39:11 39:14 41:11 41:21 42:16 43:16 44:13 46:2 46:4 47:8 47:8 48:1 48:5 48:6 50:14 50:23
serving [1] 10:1
session [1] 15:9
set [2] 3:11 26:17
settings [1] 43:15
seven [4] 10:16 31:5 31:18 49:19
several [4] 8:14 29:23 29:24 34:16
severe [1] 41:22
share [3] 10:7 40:12 43:13
shift [1] 12:12
shipped [1] 21:23
shortening [1] 26:7
shortly [1] 2:13
showing [1] 26:20
shows [1] 12:15
signed [1] 4:20
significant [13] 16:13 16:24 17:16 18:3 19:15 19:19 21:19 26:6 31:7 41:10 42:7 42:10 50:5
significantly [2] 17:14 40:17
similar [1] 7:4
simply [2] 7:15 31:24
single [1] 44:1
site [9] 30:3 30:5 30:14 32:7 32:15 32:21 32:22 34:20 43:6
sites [4] 30:8 30:17 30:20 32:9
situation [1] 7:18
situations [1] 26:24
sleeping [3] 26:4 26:10 26:14
sold [3] 30:21 32:8 40:24
Sometimes [1] 27:4
sorry [3] 9:7 25:6 37:20
sort [1] 25:1
sources [1] 34:23
span [1] 26:7
speak [4] 5:1 8:15 24:24 36:13
speakers [1] 14:8
special [1] 44:16
specialist [2] 25:21 28:14
specialized [1] 28:15
specialties [1] 43:22
Specialty [2] 9:19 11:22
Specifically [1] 48:2
specifics [1] 43:8
spent [1] 50:17
split [1] 10:18
spring [1] 6:22
staff [12] 3:6 3:17 3:21 9:17 14:12 17:3 20:18 22:23 23:2 23:9 23:15 45:12
stand [2] 5:5 9:6
standalone [2] 26:16 48:6
standard [1] 26:22
standpoint [1] 34:6
start [1] 27:24
started [3] 2:12 20:8 31:21
state [5] 1:1 2:2 15:21 34:10 42:3
statement [2] 46:21 51:12
Statewide [1] 33:19
status [6] 6:7 6:12 6:18 7:18 8:3 9:5
Statutes [3] 2:22 3:1 3:12
stay [1] 48:14
stayed [1] 23:1
steady [1] 31:19
step [1] 24:19
Steve [3] 25:8 25:11 25:13
still [5] 19:17 21:8 21:11 21:13 43:24
stipulation [1] 37:22
stop [1] 13:17
stops [1] 35:8
strategic [2] 11:24 32:6
Street [15] 1:10 2:6 11:5 17:12 20:11 20:19 21:2 21:6 22:21 41:5 42:5 42:16 42:19 43:6 48:8
structure [1] 12:13
structured [1] 16:7
structures [3] 16:11 17:23 17:23
students [1] 21:17
studies [6] 12:12 12:12 21:4 26:22 26:24 31:23
study [9] 12:15 21:11 21:21 25:17 27:8 29:11 29:16 32:1 32:1
subject [1] 11:15
submit [2] 35:19 36:24
submitted [2] 29:23 30:1
subsequent [2] 5:22 7:16
subsequently [3] 6:21 7:7 11:10
substitute [1] 42:15
such [3] 27:1 28:7 41:22
suddenly [1] 44:3
summarize [2] 14:21 47:3
suppose [1] 27:12
suspected [1] 26:9
switched [1] 23:19
sworn [5] 5:6 5:7 25:7 25:10 25:11
system [1] 19:14
table [7] 3:19 3:22 4:10 12:14 12:18 24:3 36:11
takes [2] 39:13 42:5
taking [6] 17:7 22:17 23:18 33:7 33:8 42:22
taxi [4] 21:20 35:1 37:15 49:9
taxis [1] 42:15
taxpayer [1] 24:1
Technician [1] 29:2
technology [2] 12:10 31:15
Temple [10] 17:12 20:11 20:19 21:1 21:6 22:21 41:4 42:16 43:6 48:8
temporary [2] 22:15 22:20
terminate [2] 10:21 50:13
termination [5] 1:5 2:4 2:19 15:16 50:7
terms [7] 7:9 32:18 48:7 48:13 48:20 49:3 49:4
test [9] 25:18 25:18 27:1 27:3 27:5 27:14 27:14 29:5 34:9
testified [3] 6:21 37:10 38:10
testify [2] 5:4 44:21
testimony [11] 8:10 8:11 9:14 14:13 14:20 20:1 22:10 50:5 51:14 52:6 52:7
testing [7] 10:14 19:17 26:7 27:4 27:24 28:7 31:21
tests [1] 27:17
thank [52] 2:13 3:23 4:4 4:9 5:9 8:6 8:12 9:9 9:15 10:6 13:23 14:2 14:5 14:9 14:14 19:23 20:2 22:3 22:4 22:11 24:7 24:8 24:10 24:11 24:16 24:17 28:1 28:12 28:20 29:18 29:21 32:5 33:4 36:4 37:4 38:2 38:15 38:18 39:22 40:1 40:11 40:13 44:19 44:20 44:21 44:22 45:22 46:19 50:1 50:2 51:4 51:9
therapeutic [1] 10:19
therapy [1] 10:14
therefore [1] 28:15
they've [1] 37:14
Third [2] 16:3 42:24
thoughtful [1] 50:21
thoughts [1] 40:12
threat [1] 17:9
three [10] 4:24 6:21 11:12 11:20 12:17 20:12 30:8 34:23 40:20 50:19
three-sided [1] 15:24
through [10] 3:22 7:21 10:3 28:10 28:11 35:3 36:15 36:22 43:3 49:8
Throughout [1] 22:15
today [12] 2:15 3:5 3:7 5:2 10:7 13:24 18:10 35:22 45:15 47:15 51:5 51:12
together [1] 39:8
Toni [3] 40:7 40:10 52:9
tonight [1] 8:15
tonight's [1] 4:19
too [2] 27:10 29:14
totally [1] 32:2
transaction [3] 16:1 16:7 39:13
transactions [4] 17:8 40:18 41:8 43:21
transfer [4] 8:19 15:15 18:23 33:11
transferred [2] 33:1 41:1
Transit [1] 49:13
transition [1] 13:2
transitioned [1] 23:10
transport [1] 35:6
transportation [17] 23:24 34:19 34:23 34:24 35:5 37:10 38:12 39:20 42:2 42:3 42:11 42:18 43:1 45:5 45:14 48:24 49:9
treated [2] 26:6 28:21
treatment [1] 43:14
trend [2] 16:7 27:18
trip [1] 42:4
trips [1] 35:11
Trumbull [1] 30:15
trying [3] 18:13 27:13 30:2
turn [2] 4:1 19:21
two [5] 11:2 15:6 20:12 47:19 50:12
type [1] 37:23
typically [1] 26:15
ultimately [3] 16:3 18:9 41:5
unable [1] 35:2
uncommon [1] 28:14
unconscionable [1] 44:14
under [14] 6:6 6:12 7:14 7:18 8:16 8:18 8:19 8:23 9:2 15:5 15:18 16:11 40:19 46:2
underscore [3] 47:2 47:17 49:10
underscores [1] 43:20
understand [3] 7:20 30:4 51:1
Union [4] 6:7 6:18 14:16 14:17
Unite [4] 3:14 14:16 14:17 14:18
units [1] 26:16
University [11] 6:17 7:4 16:19 19:2 20:6 22:14 42:17 43:4 48:8 48:17 49:6
University's [3] 6:24 41:4 41:6
unnecessary [1] 12:7
unreasonable [1] 43:19
up [9] 4:20 14:8 20:7 23:17 25:6 26:17 29:16 42:19 44:13
updated [2] 36:15 36:21

used [5] 26:24 29:11 41:6 43:5 49:18
using [2] 42:5 46:17
utilize [2] 46:14 46:16
value [1] 27:9
variety [1] 11:21
various [1] 17:8
vehicles [1] 35:3
versus [1] 30:20
viability [1] 31:10
Vice [2] 10:2 10:4
videoing [1] 27:1
view [1] 7:19
viewed [2] 7:23 11:16
views [1] 7:20
vital [1] 18:19
vocal [1] 15:7
volume [8] 12:6 12:15 16:1 31:18 31:20 32:16 33:1 50:14
walks [1] 42:7
Wallingford [2] 10:22 11:3
website [1] 49:13
week [5] 36:5 37:1 37:19 45:16 49:19
welcome [2] 9:10 29:19
well-insured [1] 18:13
well-qualified [1] 17:3
Wharf [1] 11:4
wheelchairs [1] 21:20
whichever [2] 44:13 46:14
whole [2] 30:24 47:13
willing [4] 25:6 32:11 32:12 33:11
wind [1] 44:13
wisdom [1] 8:3
within [5] 38:1 38:12 40:1 45:13 45:15
without [4] 34:11 41:8 41:9 42:21
witness [1] 28:4
witnesses [6] 7:22 14:8 16:5 16:15 19:22 47:15
women [1] 15:6
wonder [1] 28:8
worked [2] 20:6 20:8
workers [3] 16:17 24:1 43:12
wound [1] 25:21
written [7] 3:10 5:14 5:19 5:22 7:16 8:11 45:14
Yale [26] 6:15 6:16 7:3 12:23 16:19 19:1 20:6 20:9 21:2 22:14 22:16 23:4 23:8 24:2 30:4 30:6 30:9 33:7 33:10 37:11 39:5 41:4 46:13 48:7 48:16 49:6
Yale-New [32] 6:15 6:23 7:5 7:24 13:3 13:14 13:19 15:13 15:18 15:24 16:22 17:4 17:20 18:22 19:10 19:11 20:22 22:2 22:17 23:8 23:17 34:17 41:1 42:4 44:7 45:4 46:7 48:1 48:11 48:14 48:17 49:7
Yale-University [1] 17:11
year [2] 31:19 47:10
years [11] 7:13 7:17 8:2 11:9 12:17 20:7 20:10 20:12 31:5 35:16 50:15
yet [2] 5:15 8:22

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 25th day of June, 2014.

Paul Landman
President

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Gaylord Hospital**

DOCKET NUMBER: **13-31884-CON**

PUBLIC HEARING: **June 18, 2014 at 3:00 p.m.**

PLACE: **Gateway Community College**
20 Church St. Community Room (N100)
New Haven, CT 06510

EXHIBIT	DESCRIPTION
A	Letter from Gaylord Hospital ("Applicant") dated December 30, 2013, enclosing the CON application for the termination of services at sleep medicine in North Haven under Docket Number 13-31884, received by OHCA on December 30, 2013. (79 pages)
B	OHCA's letter to the Applicant dated January 29, 2014, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31884. (3 pages)
C	Applicant's responses to OHCA's letter of January 29, 2014, dated February 6, 2014, in the matter of the CON application under Docket Number 13-31884, received by OHCA on February 19, 2014. (18 pages)
D	Letter from UNITE HERE International Union, Local 34 dated April 8, 2014 noticing their concerns, requesting a hearing and requesting status as a party or in the alternative an intervenor in the matter of the CON application under Docket Number 13-31884, received by OHCA on April 8, 2014. (7 pages)
E	Letter from UNITE HERE International Union, Local 34 dated April 15, 2014 enclosing supporting material related to their letter requesting a public hearing in the matter of the CON application under Docket Number 13-31884, received by OHCA on April 16, 2014. (31 pages)
F	OHCA's letter to the Applicant dated April 22, 2014, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31884. (2 pages)

G	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for June 18, 2014, in the matter of the CON application under Docket Number 13-31884, dated May 21, 2014. (4 pages)
H	Designation letter dated May 22, 2014 of Hearing Officer in the matter of the CON application under Docket Number 13-31884. (1 page)
I	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the **revised** location for the public hearing scheduled for June 18, 2014, in the matter of the CON application under Docket Number 13-31884, dated May 27, 2014. (4 pages)
J	Applicant's responses to OHCA's letter of April 22, 2014, dated May 27, 2014, in the matter of the CON application under Docket Number 13-31884, received by OHCA on May 27, 2014.
K	Email from the Applicant to OHCA dated May 29, 2014 noticing the appearance of Attorney John Blair in the matter of the CON application under Docket Number 13-31884, received by OHCA on May 29, 2014. (2 pages)
L	OHCA's Ruling on the Petition of UNITE HERE International Union, Local 34 to be granted intervenor status with limited rights in the matter of the CON application under Docket Number 13-31884, dated May 29, 2014. (1 page)
M	OHCA's letter to the Applicant dated June 10, 2014, requesting prefile testimony in the matter of the CON application under Docket Number 13-31884. (1 page)
N	Letter from the Intervenor enclosing Prefile Testimony dated June 11, 2014 in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 11, 2014. (9 pages)
O	Letter from the Applicant enclosing Prefile Testimony dated June 13, 2014 in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 31, 2014. (4 pages)
P	Intervenor's letter to OHCA dated June 16, 2014 enclosing a notice of appearance for Livingston, Adler, Pulda, Meiklejohn and Kelly P.C. in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 16, 2014. (1 page)
Q	Letter from the Applicant to OHCA datedJune 17, 2014 objecting to UNITE HERE Local 34 being designated as an Intervenor in the matter of the CON application under Docket Number 13-31884, received by OHCA on June 17, 2014. (10 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31884-CON

Gaylord Hospital

Termination of Services at Gaylord Sleep Medicine in North Haven

June 18, 2014 at 3:00 p.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

III. OHCA's Questions-Applicant

IV. Intervenor's Testimony (15 minutes)

V. Applicant's Questions- Intervenor

VI. OHCA's Questions-Intervenor

VII. Public Comment

VIII. Closing Remarks

VI. Public Hearing Adjourned

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

JUNE 18, 2014
PUBLIC COMMENT

GAYLORD HOSPITAL

TERMINATION OF SERVICES AT GAYLORD'S SLEEP MEDICINE IN NORTH HAVEN

INFORMATIONAL SHEET FOR PERSONS
SIGNING UP TO SPEAK FROM THE GENERAL PUBLIC

Any and all persons are welcome to make a comment on the record at the public hearing for Docket Number: 13-31884-CON. All those who wish to speak must sign up prior to speaking.

- Please make sure you have signed up on OHCA's Sign-Up Sheet for the General Public.
- Please only sign up for yourself.
- Individuals who have signed up to speak will be called in the order they appear on the sign-up sheet.
- Your comments should be your own personal opinion.
- Your comments should be limited to **three (3) minutes** or less.
- If you do not wish to speak on the record and would instead like to submit a written comment by mail please do so at your earliest convenience. Such written comments are part of OHCA's administrative record in this matter and have the same weight as all verbal comments made at the hearing. Please address your comments to:

Kimberly R. Martone
Director of Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capitol Avenue, MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

- **Agenda for this Proceeding is located on the back**

Testimony of Melissa Dawkins-Doumbia
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for hearing June 18, 2014

Good afternoon Mr Hansted. My name is Melissa Dawkins-Doumbia. I live at 24 Daisy St., New Haven CT. I am an administrative assistant in the Internal Medicine Department at Yale University. Throughout my time working at Yale Sleep Medicine, it became clear that Yale-New Haven Hospital was taking over the practice.

Before Christmas in 2013, I was temping at the Sleep Medicine lab at 40 Temple Street in New Haven. I then left the sleep lab when I got my new position in Internal Medicine. In the meantime, a few staff from the sleep lab had been laid off.

I returned to help the Sleep Medicine lab because it stayed open after the rest of the staff was laid off. However, the clinic moved over to 784 Howard Avenue in New Haven where they continued to see patients until Yale-New Haven Hospital opens its clinics in North Haven and Madison. We were told that the clinics will have Yale Medical Group doctors but Yale-New Haven Hospital administrators and staff.

The patients were told that they would be transitioned and that their care would be continued by the hospital. They were not told about any facility fees associated with being seen at the hospital, just that they could see the same doctor but at a different facility with different staff. I was instructed by management to tell patients:

> "Yale-New Haven Hospital will be opening up a sleep center. They will be taking over our practice. All of your charts and medical records will be switched over to the hospital."

Melissa Dawkins-Doumbia 06/18/2014

Testimony of Gretchen Rose
Before the Office of Health Care Access
RE: Docket No. 12-31884 CON
Pre-filed for

My name is Gretchen Rose and I live at 1353 N. Stone St., W. Suffield, CT. I worked at the Yale University Sleep Lab at 40 Temple Street in New Haven until I was laid off last December.

I have worked for Yale University Sleep Medicine for 15 years, since 1998. When I started, I worked in the Guilford lab. In 1999, Yale opened a lab in Norwich which I was moved to, and a few years later, the lab in New Haven on Temple Street.

About 2 ½ to 3 years ago, the Norwich lab closed. One employee was laid off and the rest were consolidated into the Guilford and New Haven labs. In January 2013, the Guilford lab closed and we were all combined into the New Haven lab.

In October 2013, management conducted a mandatory meeting. They told us they were closing the sleep lab at 40 Temple Street effective January 6, 2014. We asked if the clinic was being purchased by Yale-New Haven Hospital. For a while, management denied that it was. Our manager told us that we could tell patients that we were moving and that they could be seen at the Yale Physicians Building on Howard Avenue. She said that we would no longer be conducting overnight studies. We saw our last patient right before Christmas.

The University denied that Yale-New Haven Hospital was taking control of the practice. They told us that it was not happening, that they didn't know where we were hearing that from. It is not an option. Yale-New Haven had talked to the University earlier but nothing came of it. It was denials everywhere.

Gretchen Rose 6-18-2014

Testimony of John Canham-Clyne
Deputy Director of Research, UNITE HERE International Union,
On behalf of UNITE HERE Local 34,
Before the Office of Health Care Access
Kevin Hansted, Hearing Officer
Docket No. 13-31884 CON
Pre-filed for Hearing June 18, 2014

Good afternoon, Mr. Hansted. On behalf of the 3,700 members of UNITE HERE Local 34, thank you for holding this hearing, and, in particular, for ensuring that the citizens of New Haven, who will be most affected by this case, have an opportunity to be heard. This pre-filed testimony incorporates by reference the affidavits attached to our letter of April 8, 2014 requesting a hearing and status.

Local 34 sought status in this case for two reasons. First, we represent roughly 900 clerical and technical employees in the clinical practices of the Yale University School of Medicine. Among those are 11 employees of the Yale Medical Group's sleep laboratory who have been laid off as a result of the transactions in front of the Office.

Second, UNITE HERE Locals in Connecticut represent thousands of patients who are struggling to cope with the increasing costs and the access challenges of a rapidly transforming health care system. Those costs manifest themselves both as increased individual out of pocket costs at the point of service, and in increasingly contentious collective bargaining negotiations.

We believe that this hearing and the docket before you must address the following issues:

1. Yale-New Haven Hospital must file a Certificate of Need for the purchase of Gaylord's assets in North Haven.
2. The case must be reviewed in its entirety. This is a complex, three-sided transaction in which Yale-New Haven Hospital is taking over the practice of sleep medicine from Yale Medical School, purchasing Gaylord's North Haven assets and consolidating services in suburban locations as Gaylord closes its other facilities.
3. This consolidation presents challenges for at-risk populations. Former and potential patients from New Haven's low-income communities of color may struggle with the proposed geographic changes.
4. The transaction in its entirety may raise costs at the point of service, both to individual patients and institutional payers, with a demonstrated effect on access.
5. The effect of the transactions has been to force highly experienced workers to choose between maintaining their salaries, job security, retirement and health care benefits, and continuing to work in the field of sleep medicine. This diminishes the pool of trained employees in the field.

Yale-New Haven Hospital Must File a Certificate of Need

The transaction as described to OHCA in the original Certificate of Need is fictitious. Gaylord is not "terminating" its sleep medicine operations in North Haven. It is closing its other sleep medicine facilities, but transferring its North Haven sleep medicine assets to Yale-New Haven Hospital, which will continue providing service at the North Haven location. There is voluminous evidence on the record for this fact.

The original CoN omitted any mention of an asset transfer. However, upon request for further information from OHCA, the Applicant submitted a letter that mentioned in passing a "...sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital...."[1] Similarly, the draft notice to patients attached to the completed CoN states "As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations." [2]

The transfer of ownership of a health care facility requires a Certificate of Need. Additionally, by adding Applicant's North Haven assets, Yale-New Haven Hospital will create an "an increase of the licensed bed capacity of a health care facility," which also triggers a Certificate of Need.

The Transaction Must be Reviewed in its Entirety

The transfer of Gaylord Hospital's North Haven assets to Yale-New Haven Hospital is one part of a complex three-sided transaction. Yale-New Haven Hospital is assuming control of Yale University's sleep medicine practice, purchasing the assets of Gaylord's North Haven operations and consolidating services in suburban locations.

Prior to the filing of Gaylord's CoN, Yale University serially closed its sleep medicine laboratories in Norwich, Guilford and New Haven, beginning three years ago with the Norwich facility. By October 2013, Clerical and Technical employees at each site had been given layoff notices. In December, the Yale Medical Group mailed notices to patients informing them that YMG physicians would continue to see them at the Yale-New Haven Hospital Shoreline Medical Center in Guilford and the Yale Physicians' Building in New Haven for consultations and follow-up appointments.[3]

After YMG laid off its clerical and technical staff in New Haven, it brought in temps and clerical staff from other parts of the university to help out. These temporary workers were instructed to tell patients that their doctors would be moving to Yale-New Haven Hospital Sleep Center locations in North Haven and Madison. Melissa Dawkins, an Administrative Assistant in the Internal Medicine Department, was one of the workers helping out in the Sleep Center after the layoffs. She said she was told to say: "Yale-New Haven Hospital will be opening up a sleep center. They'll be taking over our practice. All of your charts

---

[1] Letter dated Feb. 10, 2014 from George Kyriacou to Richard D Aquila enclosed in Connecticut Department of Public Health's Office of Health Care Access, Docket No. 13-31885-CON.

[2] "NOTICE TO OUR SLEEP MEDICINE PATIENTS" enclosed in Docket No. 13-31885-CON. Note: the original letter in the file does not specify a date.

[3] Letter from Dr. Christine Won of Yale Sleep Medicine to a patient, December 2013.

and medical records will be switched over to the hospital."[4] This directive from YMG management clearly suggests that YNHH is taking over YMG's practice.

The closure of the University's sleep labs, the "termination" of Gaylord's sleep services, and the opening of Yale-New Haven sleep facilities in North Haven and Madison are not unrelated, coincidentally timed transactions. For OHCA to proceed as if that were the case would be a disservice to the public. The transaction must be evaluated in its entirety to properly determine its full impact on the health care system.

Indeed, to fully understand what is happening in the market for sleep medicine, the closure of Gaylord Hospital's Trumbull, Glastonbury and Guilford operations must be evaluated in the context of the closure of Yale Medical Group's three facilities as well. Obviously, the development of home sleep testing is shrinking the need for site-based sleep labs. However, six closures in the space of 36 months, five of them within the last 18 months, constitutes dramatic change in the market.

For OHCA to discharge its responsibility to the public, the Office cannot view sweeping marketplace changes in a vacuum. Even viewing the closing of Gaylord's multiple sites likely would not give the Office sufficient scope to understand and review the impact of market changes on sleep medicine patients. Only by bringing the dominant market actor that is driving these changes, Yale-New Haven Hospital, under scrutiny for its impact on cost and access can the entire picture of the consolidation of sleep medicine services in Connecticut be explained to the public.

Regional Consolidation as Proposed Poses Threats to Access for At-Risk Populations

The consolidation of regional sleep medicine services in suburban locations poses a potential threat to at-risk populations. In the CoN deemed complete, the Applicant claims:

> "There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients."[5]

Further, when asked to"[i]dentify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes," the Applicant responded "Not applicable." When the three-way transaction is understood in its entirety, the resulting array of available regional outpatient sleep center services compared to what was available likely will have an adverse impact on access for the Medicaid population and certain special populations.

Yale-New Haven Hospital's decision to take over the Yale Medical Group sleep medicine practice and provide those services in North Haven and Madison may provide excellent service to suburban patients. However, YNHH has not provided sufficient assurance of continued access to affordable sleep medical care to the entire community previously served by the Yale University physicians soon to be working in YNHH's North Haven facility. The new locations are potentially inconvenient to low-income patients – whether insured by Medicaid, private insurance or uninsured – dependent on public transportation. Certain demographics with a

---

[4] Affidavit by Melissa Dawkins, March 17, 2014.

[5] CT DPH OHCA Docket No. 13-31885-CON, pg. 50.

strong need for services may disproportionately see a marked decrease in access to sleep medicine. For instance, African-American men are more likely to suffer from sleep apnea.[6] YMG's closure of its urban sleep center and Yale-New Haven Hospital's purchase of a suburban clinic may thus have a disparate negative impact on African-American men, particularly low-income African-American men.

The Transaction in its Entirety May Raise Costs to Individual Patients and Institutional Payers

The Centers for Medicare and Medicaid Services (CMS) issued regulations in 2002 permitting hospitals to designate physician practices that they control as parts of an outpatient department, even when such facilities are miles from the hospital's core campus. Such a designation allows the hospital to bill for what were once physician office visits as if they were visits to the hospital itself. "Hospital-based," or "Provider-based" billing allows hospitals to charge much higher prices for services that are often indistinguishable from those provided at lower cost in a physician office setting – most commonly by the addition of "facility fees" on top of physicians' professional fees.

The Congressional Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare spends an additional $2 billion a year on provider-based services that cannot reasonably be distinguished from those provided in doctors' offices. MedPAC contends that treatment in an office converted to a satellite hospital outpatient department can cost patients and insurers an average of 80% more than equivalent treatment at a doctor's office that is not owned by a hospital.[7]

The trend toward provider-based billing for services that can be provided safely in doctor's offices has raised serious concerns among federal and state policymakers. MedPAC has been advising Congress to equalize billing for equivalent services for two years.[8] Connecticut Attorney General George Jepsen issued a report in April 2014, which concluded

> The "facility fee," also referred to as an "outpatient hospital charge" therefore, is a separate overhead charge assessed by a hospital that is increasingly being billed for services rendered in an office setting. When billed by previously independent physicians' practices, these charges – which can be hundreds of dollars or higher – are often surprising, confusing and financially burdensome to patients. This is particularly the case for patients who received regular care from a provider over long periods of time at roughly consistent cost, and who had no notice that the provider at some point in time had become hospital-based.[9]

Dramatic increases in billing for physician services – and especially the shift to hospital-based charges – have arrived in Connecticut at the worst possible moment. Patients are increasingly enrolled in plans with large copays and high deductibles. As the Attorney General notes:

> A decade ago, most Americans had comprehensive health insurance with low deductibles, coinsurance and co-pays. Their inpatient care was provided in the traditional

---

[6] Pranathiageswaran, Sukanya, M. Safwan Badr, Richard Severson, and James A. Rowley. "The Influence of Race on the Severity of Sleep Disordered Breathing." Journal of Clinical Sleep Medicine, 9(4): 303-309.

[7] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.

[8] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Pg. 72.

[9] Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees, April, 2014, Pg. 2

> hospital setting and specialty care and routine services were provided by primary care physicians and specialists unaffiliated with large hospital systems. *Those days are over.* In 2012 the annual family premium was 30% higher than in 2007 and 97% higher than in 2002.5Likewise, in 2006 10% of employer health plans had a deductible of at least $1,000; by 2009 that number rose to 22% and in 2011 it rose again to 31% of employer health plans.6 It is clear, therefore, that payers are reacting to the increased costs of health care by shifting more responsibility for these costs to consumers.

Thus, just as consumers are becoming responsible for more costs, and government and private payers are trying to shift care from higher cost settings to more appropriate venues, large numbers of physician practices are now "provider-based." A patient who might have paid a $40 specialist copay for an office visit may still pay that fee, but later receive a bill for a several hundred dollar copay for the facility, or worse, a $1,000+ deductible payment for outpatient hospital services. The consequences can be devastating for individuals.

OHCA should examine carefully the payment history for Sleep Medicine services, not only at Applicant's facilities, which are reportedly provider-based, but at the Yale Medical Group as well. The portion of the patients at Yale-New Haven's successor facility to the Applicant's that are transitioning from the Yale Medical Group sleep center may face facility fees and other increased costs for the first time.

Our members experience this phenomenon on a regular basis. Gloria Timpko, a Senior Administrative Assistant at Yale University's Department of Cardiology, testified on this issue in front the Public Health Committee. She said:

> "Heart transplant patients need to be seen on a weekly basis for the first couple of months following transplant and they already have high costs for the medications they need to prevent rejection of the transplant. Suddenly getting a second bill for a weekly clinic visit is proving to be a severe burden."[10]

The experience of workers in clinics that have undergone the transformation to nominal hospital control highlights the need for OHCA to carefully review the full transaction. Many of our members have seen patients struggle with paying increased fees and fear that some may choose to reduce the frequency of doctors' visits or cease treatment all together.

Consolidation Diminishes the Pool of Skilled Workers

11 technicians were laid off by Yale Medical Group's sleep center when it closed its three locations. The workers were told that they could take advantage of Local 34's layoff protections and seek employment in another occupation within the University.

To remain in their chosen field, the technicians were told that they could apply to work with Yale-New Haven Hospital as their employer, but with loss of seniority, lower wages, and poorer benefits.

In order to capture the financial rewards of "provider-based billing," Yale University and Yale-New Haven Hospital now share clinics. Ms. Timpko's transplant clinic, as noted above, is nominally managed by Yale-New Haven Hospital. But the clinic retains both University physicians and University workers.

---

[10] Gloria Timpko, testimony in favor of S.B. 35 (An Act Concerning Acquisitions, Joint Ventures and Affiliation of Group Medical Practices), CT General Assembly Public Health Committee, March 5, 2014.

When Yale-New Haven Hospital took over the University practice, it chose to push seasoned professionals out of the field, or require them to take pay and benefits cuts.

Conclusion

Applicant is not terminating services in North Haven, it is transferring assets to Yale-New Haven Hospital.

OHCA should:

- Deny Applicant's request for a Certificate of Need
- Require Yale-New Haven Hospital and Applicant to file a Certificate of Need for the transfer of Applicant's North Haven assets or;
- Consider the impact of the closures of all Gaylord facilities plus the Yale University sleep labs in determining the result of the new Certificate of need.

Whether OHCA formally chooses to bring these major changes in the sleep center market together in a single case or not, the following questions must be addressed:

- What impact will the takeover of YMG's clinic by Yale-New Haven Hospital have on individual out of pocket costs and institutional payer costs?
- What is Yale-New Haven Hospital's plan to ensure access to sleep medicine services for at-risk urban populations?
- Will there be adequate overall system capacity following the transactions.

June 16, 2014

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Gaylord Hospital

DN: 13-31884-CON

Hearing Date: June 18, 2013

Time: 3:00 p.m.

Proposal: Termination of Gaylord Sleep Medicine

OHCA Exhibit #	Description
1	late file 1
2	43 mos of data on cab trips 1 wk 1 week
3	late file 2 1 wk payer mix
4	1 week
5	late file 3 agreement for Yall to provide taxi service 1 wk

~~late file 4~~ + purchase agreements

~~late file~~

Exhibit R - bus schedule

PUBLIC HEARING

INTERVENOR

SIGN UP SHEET

June 18, 2014
3:00 p.m.

Applicant: Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine

Name	Phone	Fax	Representing Organization/Self
Henry F. Murray Esq.	860.570.4635	860 232 7818	Local 34 UNITE HERE
John Canham-Clyne	203-664-2064		Local 34 UNITE HERE
Gretchen E. Rose	860.558.6555		Local 34 unite here
Melissa Doumbia-Dawkins	203-8875613		Local 34, unite here

PUBLIC HEARING

APPLICANT

SIGN UP SHEET

June 18, 2014
3:00 p.m.

Applicant: Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine

Name	Phone	Fax	Representing Organization/Self
George Kyriacou	203-284-2741		Gaylord
Sonya LaBarbera	(203)741-3380	(203)949-2148	Gaylord
Jon Mace	(203)741-3324		GAYLORD
Steve Holland	(203)741-3302		GAYLORD
ART TEDESCO	203 741 3307		GAYLORD

Public Hearing
Gaylord Hospital

Name	Phone	Fax	Representing Organization/Self
Dana Goldberg	203-284-2800		Gaylord
John Blair	860 280 4059		Gaylord
Janine Epright	860-284-2841		Gaylord

Jennifer Dupont
Ebm Ruth

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET
June 18, 2014
3:00 p.m.

Applicant: Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine

PRINT Name	Representing Organization/Self
Art Creiser	self
Pam O'Donnell	[redacted] self
Lynette Thomas	self
Elizabeth Lowe	self
Lorraine Skibitsky	self

Public Hearing
Gaylord Hospital

PRINT Name	Representing Organization/Self
Louise Benson	self
Lisa Masciantonio	self
Gerri Hadden	self
Amelia Prostano	self
Kristen Reid	self
Gloria Timpko	self
Sierra Murphy	self
Kim Chapman-Mathis	Self

Public Hearing
Gaylord Hospital

General ~~General~~ Public
Speaker Sign-Up

PRINT Name	Representing Organization/Self
Lynette Murphy	General self
ARTHUR GREISER	PAUL ABRINGER

Public Hearing
Gaylord Hospital

General Public
Speaker Sign-In

PRINT Name	Representing Organization/Self
Jackie Hicks	Self

Public Hearing
Gaylord Hospital

General Public
Speaker Sign-Up

PRINT Name	Representing Organization/Self
Yolanda Giordano	Self

Public Hearing
Gaylord Hospital

General Public
Speaker Sign In

PRINT Name	Representing Organization/Self
Jean Carlan	Self

PUBLIC HEARING

PUBLIC OFFICIAL

SIGN UP SHEET

June 18, 2014
3:00 p.m.

Applicant: Docket Number: 13-31884-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine

Name	Phone	Fax	Representing Organization/Self
Joni Harp	(203)946-8200		Mayor /

IN THE MATTER OF:

A Certificate of Need Application by
Gaylord Hospital, Inc.

Docket Number: 13-31884-CON

ORDER

On June 18, 2014, the Office of Health Care Access held a Public Hearing in this matter. At the Public Hearing, the applicant, Gaylord Hospital, Inc., was ordered to file a complete copy of the Asset Purchase Agreement between Yale-New Haven Hospital, Inc. and Gaylord Hospital, Inc. On June 25, 2015 the Office of Health Care Access received an incomplete copy of the Asset Purchase Agreement between Yale-New Haven Hospital, Inc. and Gaylord Hospital, Inc. Specifically, the Asset Purchase Agreement excluded Article 3.

The applicant, Gaylord Hospital, Inc., is hereby ordered to submit a complete copy of the Asset Purchase Agreement between Yale-New Haven Hospital, Inc. and Gaylord Hospital, Inc., including Article 3, on or before July 9, 2014 to the Office of Health Care Access.

7/2/14
Date

Kevin T. Hansted
Hearing Officer

* * * COMMUNICATION RESULT REPORT (JUL. 2. 2014 3:06PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUL. 2. 2014 3:05PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
435	MEMORY TX		918602327818	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: HENRY F. MURRAY, ESQ.

FAX: 18602327818

AGENCY: LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY PC

FROM: PAOLO FIDUCIA

DATE: 07/02/2014 **Time:** 3:00 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-
CON Order

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUL. 2. 2014 3:26PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUL. 2. 2014 3:04PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
434	MEMORY TX		918607606493	E-2)2)2)2)2)	0/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOHN D. BLAIR, ESQ.

FAX: 18607606493

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 07/02/2014 **Time:** 3:00 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-
CON Order

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUL. 2. 2014 3:30PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUL. 2. 2014 3:08PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
436	MEMORY TX		918607606493	E-2)2)2)2)2)	0/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOHN D. BLAIR, ESQ.

FAX: 18607606493

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 07/02/2014 **Time:** 3:00 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
13-31884-
CON Order

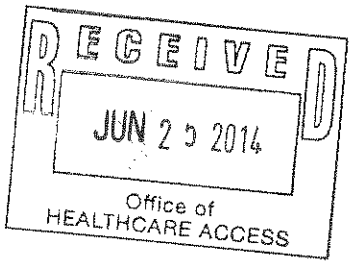
PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Olejarz, Barbara

From: Hansted, Kevin
Sent: Thursday, July 17, 2014 11:06 AM
To: Olejarz, Barbara
Subject: FW: Letter of Commitment -Transportation for Sleep Medicine Services
Attachments: Letter of Commitment -Transportation for Sleep Medicine Services - YNHH.PDF; ATT00001.txt



Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

CONFIDENTIALITY NOTICE: This email and any attachments are for the exclusive and confidential use of the intended recipient. If you are not the intended recipient, please do not read, distribute or take action in reliance on this message. If I have sent you this message in error, please notify me immediately by return email and promptly delete this message and any attachments from your computer system. We do not waive attorney-client or work product privilege by the transmission of this message.

-----Original Message-----
From: John D. Blair [mailto:john@blairlawllc.com]
Sent: Wednesday, June 25, 2014 2:24 PM
To: Hansted, Kevin
Cc: Riggott, Kaila; Lazarus, Steven; Martone, Kim
Subject: Letter of Commitment -Transportation for Sleep Medicine Services

Attorney Hansted,

Please find enclosed the final late file requested for the Gaylord Hospital hearing, Transportation Agreement.

RECEIVED
JUN 25 2014
Office of
HEALTHCARE ACCESS

Letter of Commitment

Transportation for Sleep Medicine Services

This document serves as a formal binding commitment by Yale-New Haven Hospital (YNHH), whereby YNHH will assure continued accessibility to sleep medicine services by providing transportation at the same level of service as provided today by the Gaylord Hospital Sleep Medicine Program.

Similar to Gaylord Hospital's current Sleep Medicine transportation program, YNHH's Sleep Medicine transportation program guidelines relative to the Devine Street, North Haven site are outlined below:

> YNHH's sleep medicine transportation program is designed to address community need, as well as to comply with prevailing federal law governing the provision of free transportation to federal health care program beneficiaries.
>
> The overarching principle of YNHH's sleep medicine transportation program is to ensure continued access to sleep medicine services by providing transportation services where necessary due to a lack of other means of affordable public transportation or other alternatives, all consistent with YNHH's mission.
>
> YNHH's transportation services will operate to and from the Devine Street, North Haven location.
>
> For patients residing in the Greater New Haven region, if that patient has a scheduled appointment for sleep medicine services at the North Haven site, has made a reasonable effort to arrange transportation and is unable to obtain personal transportation, cannot access public transportation, and does not have insurance-covered transportation, YNHH will arrange for transportation services at no expense to the patient.
>
> Transportation provided under this YNHH program will be modest (e.g., shuttle or other taxi service), and YNHH will not shift the cost of its transportation program to any federal health care program. The program will not be marketed or advertised, but will be made available to patients based on an individual showing of need.

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Richard D'Aquila
President & Chief Operating Officer
Date: June 25, 2014

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHOEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2006

RECEIVED
JUL 10 2014
Office of HEALTHCARE ACCESS

DATE: 7/10/14 TIME:

TO: Kevin Hansted FAX NO: 860-418-7053

FROM: Henry Murray

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET) 4

SPECIAL INSTRUCTIONS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL Virginia.

THIS MESSAGE IS ONLY FOR THE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. Any dissemination, distribution or copying of this communication other than by the intended recipient is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect), and destroy all copies of this communication. Thank you.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG

DANIEL E. LIVINGSTON
OREGO D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

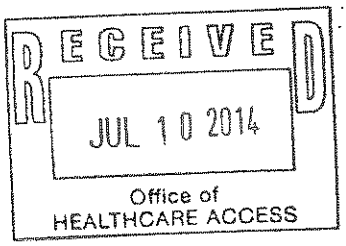
*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
hfmurray@lapm.org

July 9, 2014

Via Facsimile 860.418.7053



Kevin T. Hansted
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket No.: 13-31884-CON
Certificate of Need Application by Gaylord Hospital

Dear Hearing Officer Hansted:

Attached hereto please find a copy of an affidavit submitted by Melissa Dawkins-Doumbia providing further information for the Commission that the Intervenor, Unite Here Local 34, believes is relevant to the above-referenced matter now being considered by the Commission. We request that Ms. Dawkins-Doumbia's affidavit be accepted as a late filed exhibit. When I get Ms. Dawkins-Doumbia's original, signed affidavit, I will forward it to OHCA to substitute for the photocopy. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds
Enclosure
cc: John D. Blair, Esq.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

In the Matter of,	:	
A Certificate of Need Application by Gaylord Hospital	:	**Docket No,: 13-31884-CON**
	:	**July 9, 2014**

AFFIDAVIT

STATE OF CONNECTICUT)
) ss. NEW HAVEN
COUNTY OF NEW HAVEN)

MELISSA DAWKINS-DOUMBIA, being duly sworn, deposes and states that:

1. I am over the age of eighteen and understand the meaning and obligation of the oath.

2. I am a member of Local 34, UNITEHERE and provided testimony at the public hearing conducted by OHCA on June 18, 2014 in New Haven, Connecticut.

3. I am an administrative assistant in the Department of Internal Medicine at Yale University and was assigned on a temporary basis to the University's Sleep Medicine Lab at 40 Temple Street in New Haven, Connecticut in December, 2013.

4. During the time I was there, as I testified at the public hearing, we were instructed to tell our patients that the lab was closing and that they would be seen, from now on, at the Yale New Haven Hospital facility on Howard Avenue in New Haven until YNHH opened its sleep clinics in Madison and North Haven.

5. During the hearing on June 18, 2014 representatives of Gaylord Hospital stated that Gaylord Hospital and Yale-New Haven Hospital had an agreement to continue Gaylord's transportation procedures for any patients who might have trouble getting to North Haven.

6. When I was at the Sleep Medicine lab on Temple St. I was trained to handle patient calls after Yale University's sleep laboratory closed. During that training I was not given any instructions to inform our patients about the availability of transportation to North Haven, nor at any time thereafter was I given any such instruction.

7. I was given no training or instructions to ask any patients who might need sleep studies about their transportation needs. In addition I was given no training, instructions or guidance on how to answer any questions that patients might ask about transportation to the North Haven facility.

I affirm that the foregoing is true and accurate to the best of my knowledge and belief under the penalty of perjury.

Melissa Dawkins-Doumbia

Melissa Dawkins-Doumbia

Subscribed and sworn before me this 9th day of July, 2014.

Commissioner of the Superior Court
Notary Public

DP CONLON
NOTARY PUBLIC
My Commission Expires May 31 2019

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1933-2008

RECEIVED
JUL 11 2014
Office of HEALTHCARE ACCESS

DATE: 7/11/14 TIME:

TO: Kevin Hansted FAX NO: 860-418-7053

FROM: Henry Murray

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET) 3

SPECIAL INSTRUCTIONS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL Virginia.

THIS MESSAGE IS ONLY FOR THE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. Any dissemination, distribution or copying of this communication other than by the intended recipient is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect), and destroy all copies of this communication. Thank you.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
hfmurray@lapm.org

July 11, 2014

Via Facsimile 860.418.7053

Kevin T. Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket No.: 13-31884-CON
Certificate of Need Application by Gaylord Hospital

Dear Hearing Officer Hansted:

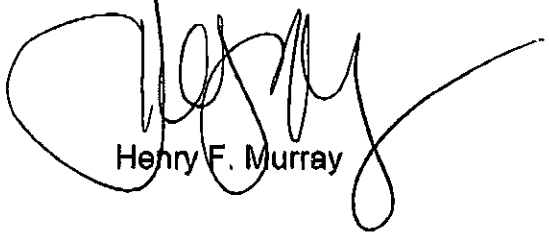
On behalf of the intervenor, Unite Here Local 34, I want to raise with you our concern that the applicant has failed to provide the Commission with documents it promised as part of its late filed submissions. As you will recall, representatives of Gaylord Hospital told the Commission that it would provide a copy of a memorandum of agreement between itself and the purchaser of its North Haven facility, Yale-New Haven Hospital. It claimed that this alleged memorandum set forth an agreement between those two parties for a continuation of free or low cost transportation for patients as a term and condition of the purchase/sale agreement. So far no such memorandum of agreement has been forthcoming from the applicant. Moreover, in our review of the Purchase/Sale Agreement, including the recently provided Article 3, we can find no evidence that such an agreement exists.

The failure to provide this alleged memorandum leads to the conclusion that no such agreement exists, and that transportation for inner city and low income patients was not part of, nor contemplated by, the parties in the transaction for Yale-New Haven Hospital to acquire the Gaylord North Haven facility. Members of the general public and the mayor of New Haven were clear in their statements at the public hearing that the lack of reliable and affordable transportation to the North Haven facility is a real

access barrier to continuing care for sleep medicine patients.

We request that you require the applicant to produce this alleged transportation agreement between itself and Yale-New Haven Hospital. If the applicant cannot produce such a document, we further request that you require the applicant to provide a full explanation to the Commission as to why it made such a representation at the public hearing when apparently it knew no such document existed.

Very truly yours,



Henry F. Murray

HFM:vds
cc: John D. Blair, Esq.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
hfmurray@lapm.org

RECEIVED
JUL 14 2014
Office of
HEALTHCARE ACCESS

July 11, 2014

Kevin T. Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket No.: 13-31884-CON
Certificate of Need Application by Gaylord Hospital

Dear Hearing Officer Hansted:

Enclosed herewith is the signed affidavit of Melissa Dawkins-Doumbia. Please substitute this original affidavit for the facsimile copy we sent to your office on July 9, 2014. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds
Enclosure
cc: John D. Blair, Esq. (w/enc)

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

In the Matter of,	:	
	:	**Docket No,: 13-31884-CON**
A Certificate of Need Application by Gaylord Hospital	:	
	:	**July 9, 2014**

AFFIDAVIT

STATE OF CONNECTICUT)
) ss. NEW HAVEN
COUNTY OF NEW HAVEN)

MELISSA DAWKINS-DOUMBIA, being duly sworn, deposes and states that:

1. I am over the age of eighteen and understand the meaning and obligation of the oath.

2. I am a member of Local 34, UNITEHERE and provided testimony at the public hearing conducted by OHCA on June 18, 2014 in New Haven, Connecticut.

3. I am an administrative assistant in the Department of Internal Medicine at Yale University and was assigned on a temporary basis to the University's Sleep Medicine Lab at 40 Temple Street in New Haven, Connecticut in December, 2013.

4. During the time I was there, as I testified at the public hearing, we were instructed to tell our patients that the lab was closing and that they would be seen, from now on, at the Yale New Haven Hospital facility on Howard Avenue in New Haven until YNHH opened its sleep clinics in Madison and North Haven.

5. During the hearing on June 18, 2014 representatives of Gaylord Hospital stated that Gaylord Hospital and Yale-New Haven Hospital had an agreement to continue Gaylord's transportation procedures for any patients who might have trouble getting to North Haven.

6. When I was at the Sleep Medicine lab on Temple St. I was trained to handle patient calls after Yale University's sleep laboratory closed. During that training I was not given any instructions to inform our patients about the availability of transportation to North Haven, nor at any time thereafter was I given any such instruction.

7. I was given no training or instructions to ask any patients who might need sleep studies about their transportation needs. In addition I was given no training, instructions or guidance on how to answer any questions that patients might ask about transportation to the North Haven facility.

I affirm that the foregoing is true and accurate to the best of my knowledge and belief under the penalty of perjury.

Melissa Dawkins-Doumbia

Melissa Dawkins-Doumbia

Subscribed and sworn before me this 9th day of July, 2014.

DP Conlon

Commissioner of the Superior Court
Notary Public

DP CONLON
NOTARY PUBLIC
My Commission Expires May 31 2019

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY E. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER OOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2005

RECEIVED
JUL 17 2014
Office of HEALTHCARE ACCESS

DATE: 7/16/14 TIME:

TO: Kevin Hansted FAX NO: 860-418-7053

FROM: Henry Murray

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET) 3

SPECIAL INSTRUCTIONS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL Virginia.

THIS MESSAGE IS ONLY FOR THE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. Any dissemination, distribution or copying of this communication other than by the intended recipient is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect), and destroy all copies of this communication. Thank you.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

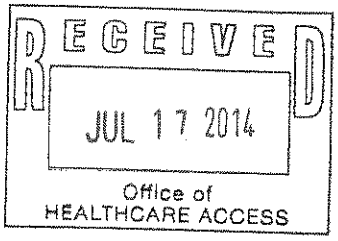
OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
hfmurray@lapm.org

July 16, 2014



Via Facsimile 860.418.7053

Kevin T. Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket No.: 13-31884-CON
Certificate of Need Application by Gaylord Hospital

Dear Hearing Officer Hansted:

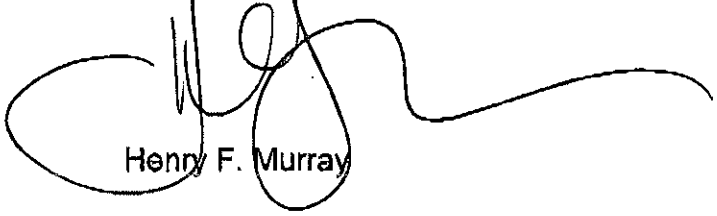
On July 11, 2014, I wrote expressing concern on the part of the intervenor, Unite Here Local 34, that the applicant, Gaylord Hospital, had failed to provide the Commission with a memorandum of agreement between itself and the purchaser of its North Haven asset, Yale-New Haven Hospital (YNHH), to continue free or low cost transportation for New Haven residents to the North Haven facility. Within minutes of sending that letter, we received a copy of the Letter of Commitment on the part of Yale-New Haven Hospital addressing this issue.

This Letter of Agreement, however, ought to raise more questions for the Commission than it answers. As you will recall, at the Hearing on June 18, 2014, George Kyriacou, the applicant's President and CEO, testified that an agreement on transportation existed between Gaylord and YNHH. He told the Commission that it was either in the actual purchase/sale agreement or in a separate memorandum. The Letter of Commitment signed by YNHH's President and Chief Operating Officer, Richard D'Aquila, is dated June 25, 2014. This is one week *after* the OHCA hearing in New Haven, and *after* the applicant told the Commission that such an agreement existed. It is at least clear from the face of the document that no such commitment existed for YNHH, with respect to its agreement to purchase the Gaylord North Haven facility, at

the time the representations were made at the hearing.

These discrepancies again point up why it is essential that both Gaylord *and* YNHH be required to file a joint CON with the Commission for the transaction to acquire Gaylord's sleep medicine business and assets. Only in that way can the Commission be assured that promises made with respect to access for low and moderate income urban residents are real and intended to be enforced as part of any sale.

Very truly yours,



Henry F. Murray

HFM:vds
cc: John D. Blair, Esq.

OFFICE OF THE MAYOR

TONI N. HARP

50th Mayor of New Haven Connecticut

New Haven
All-America City
2008

July 18, 2014

Kevin Hansted
Hearing Officer
State of Connecticut Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Ref: Docket No. 13-31884 CON

Dear Hearing Officer Hansted:

At the June 18, 2014 hearing on the above-referenced docket, Gaylord Hospital asserted that it had come to an agreement with Yale-New Haven Hospital (YNHH) with regard to continued transportation services for patients who have difficulty accessing care.

Gaylord's original late file documents contain no such agreement. The only reference to transportation is a spreadsheet showing the amount of money Gaylord spent on taxi service for Medicaid patients over the past several years.

This does not in any way satisfy the serious concerns raised by me and dozens of other New Haven residents at that hearing. The Medicaid taxi program, while an important source of transportation for many patients, covers only a portion of those for whom access to facilities in North Haven may be a problem. Uninsured patients ineligible for Medicaid and other low income patients with disabilities who cannot drive face similar problems. As noted at the hearing, even well-insured sleep medicine patients may face problems - sleep disorders sometimes lead to physician orders to limit or cease driving.

Moreover, The Medicaid taxi program has been the subject of recent media reports in which patients have complained of long waits in cold weather or no service whatsoever when promised, causing them to miss vital appointments.

An explanatory letter from YNHH, dated June 25, 2014, arrived a full week after the hearing. Yet, at the hearing, Gaylord asserted that the Asset Purchase Agreement and/or

165 Church Street, New Haven, CT 06510
phone 203.946.8200 *fax* 203.946.7683

a separate Memorandum of Agreement contained assurances that Yale-New Haven would continue Gaylord's transportation policies.

YNHH says it "will assure continued accessibility to sleep medicine services by providing transportation at the same level of service as provided today by the Gaylord Hospital Sleep Medicine Program," according to the letter. The letter then describes a shockingly low level of service for anyone not currently eligible for insurance funded transportation:

> *For patients residing in the Greater New Haven region, if that patient has a scheduled appointment for sleep medicine services at the North Haven site, has made a reasonable effort to arrange transportation and is unable to obtain personal transportation, cannot access public transportation, and does not have insurance - covered transportation, I'NHH will arrange for transportation services at no expense to the patient.*
>
> *Transportation provided under this YNHH program will be modest (e.g., shuttle or other taxi service), and YNHH will not shift the cost of its transportation program to any federal health care program. The program will not be marketed or advertised, but will be made available to patients based on an individual showing of need.*

YNHH must understand that this proposed project is not merely taking over Gaylord's North Haven assets but that it has precipitated other market changes that will adversely impact patients who can least afford them. The truth is, the North Haven facilities will not only consolidate much of Gaylord's current services from other suburban locations, but replace the far more convenient former University facilities on Temple Street in New Haven.

The Temple St. location has a bus stop in front of it, and lies a block and a half from the New Haven Green, where nearly every bus line in Greater New Haven originates, ends, or stops en route. The North Haven site has only two bus lines nearby, each of which runs less frequently than many downtown lines, and each requires a significant walk to reach the facilities.

Given the nature of sleep disorders, the fact that minority patients are more likely to suffer from them, and the concentration of these patients in New Haven, YNHH's letter of commitment is wholly inadequate to patients' needs. YNHH must be required to implement a more comprehensive transportation plan than simple reliance on the Medicaid taxi program and an unadvertised, ill-defined "commitment" to provide rides to patients who can satisfy staff – based on standards that have not been articulated – that they really do need a ride to critical health care services.

I renew my request that you require Yale-New Haven Hospital to file a separate Certificate of Need for this transaction.

Sincerely,

Toni N. Harp
Mayor – City of New Haven

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 232-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

RECEIVED
JUL 25 2014
Office of
HEALTHCARE ACCESS

DANIEL E. LIVINGSTON
GREGO D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

DATE: 7/25/14 TIME:

TO: Kevin Hansted FAX NO: 860-418-7053

FROM: Henry Murray

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET) 3

SPECIAL INSTRUCTIONS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL Virginia.

THIS MESSAGE IS ONLY FOR THE USE OF THE ADDRESSEE AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. Any dissemination, distribution or copying of this communication other than by the intended recipient is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect), and destroy all copies of this communication. Thank you.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG

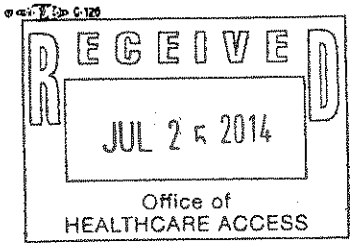
DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4835
hfmurray@lapm.org



July 25, 2014

Via Facsimile 860.418.7053

Kevin T. Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Docket No.: 13-31884-CON
Certificate of Need Application by Gaylord Hospital

Dear Hearing Officer Hansted:

This is a response to an undated letter addressed to you from Attorney John Blair on behalf of Gaylord Hospital, in which he accuses me of making false representations to the Commission. This is simply not true. I just received a copy of Attorney Blair's letter today from your office.

Here are the facts.

On June 25, 2014, we received copies of three (3) documents filed by Gaylord Hospital with the Commission. The memorandum of understanding between Gaylord Hospital and Yale-New Haven Hospital, dated June 25, 2014, was not one of those documents. Because we had no evidence that any such document had been provided, I wrote my July 11, 2014, letter to you, and it was faxed at 9:40 a.m. At 1:08 p.m, that same day, I received an email from a Commission staff member, Paolo Fiducia, attaching the June 25, 2014, memorandum between Gaylord and YNHH on transportation. It was only as a result of that email that Local 34 UNITE HERE had any inkling that such a document existed. If Gaylord filed it on June 25, 2014, along with the other documents, then I stand corrected. However, whether due to oversight by Attorney Blair or the staff of the Commission, we never received it until the afternoon of

July 11, 2014.

Notwithstanding the apparent mistake in providing us with the document, I believe my comments in the July 16, 2014. letter to you are still valid and germane to this matter. My comments clearly and accurately reflect Mr. Kyriacou's comments and corrections at the June 18, 2014, hearing. The issue I raised in the July 16, 2014, letter, however, went not to Mr. Kyriacou's representations, which I have no reason to dispute, but to why such a memorandum, presumably negotiated by Gaylord and YNHH as some earlier point in time, had a date of June 25, 2014 – one week after the hearing in New Haven. This is still a valid and legitimate discontinuity which the Commission should consider during its evaluation of the CON. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds
cc: John D. Blair, Esq.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 25, 2014

Via Fax Only

John D. Blair, Esq.
Blair Law LLC
P.O. Box 141
Rocky Hill, CT 06067

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Sleep Medicine Services in North Haven
Closure of Public Hearing

Dear Attorney Blair:

Please be advised, by way of this letter, the public hearing held on June 18, 2014, in the above referenced matter is hereby closed as of July 25, 2014. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Laurie Greci at (860) 418-7032.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH:lkg

C: Henry F. Murray, Esq.

* * * COMMUNICATION RESULT REPORT (JUL. 30. 2014 8:29AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUL. 30. 2014 8:28AM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
521	MEMORY TX		98602327818	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Henry F. Murray, Esq.

FAX: 860 232-7818

AGENCY: Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.

FROM: Laurie Greci

DATE: 7/30/2014

NUMBER OF PAGES: 2
(including transmittal sheet

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Sleep Medicine Services in North Haven
Closure of Public Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUL. 30. 2014 8:51AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUL. 30. 2014 8:29AM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
522 MEMORY TX		98607606493	E-2) 2) 2) 2) 2)	0/ 2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: John D. Blair, Esq.

FAX: 860 760-6493

AGENCY: Blair Law LLC

FROM: Laurie Greci

DATE: 7/30/2014

NUMBER OF PAGES: 2
(including transmittal sheet

RE: Certificate of Need Application, Docket Number 13-31884-CON
Gaylord Hospital
Termination of Sleep Medicine Services in North Haven
Closure of Public Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Fiducia, Paolo

From: Fiducia, Paolo
Sent: Wednesday, July 30, 2014 12:28 PM
To: 'John D. Blair'
Subject: RE: Follow Up
Attachments: 31884 Closure of Hearing.pdf

Hi John,

Attached is the info.

Thanxs,

Paolo

From: John D. Blair [mailto:john@blairlawllc.com]
Sent: Wednesday, July 30, 2014 11:53 AM
To: Fiducia, Paolo
Subject: Follow Up

Thanks for the call today. Could you please scan the document and email, my fax no longer is working.

-John

John D. Blair
Blair Law
PO Box 141
Rocky Hill, CT 06067
(860) 280-4059
john@blairlawllc.com