

BEFORE THE STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS



Request by Yale-New Haven Hospital : Docket No.
: :
For a Declaratory Ruling : April 24, 2015

REQUEST BY YALE-NEW HAVEN HOSPITAL FOR A DECLARATORY RULING

In accordance with Section 4-176 of the Connecticut General Statutes and Regulations of Connecticut State Agencies Section 19a-9-12, Yale-New Haven Hospital (“YNHH”) submits to the Office of Health Care Access (“OHCA”) this Request for Declaratory Ruling (“Request”). YNHH intends to relocate its inpatient rehabilitation unit services (“IRU”) from its St. Raphael’s campus to leased space at Milford Hospital. The IRU services would be provided by the same YNHH-affiliated physicians and staff to substantially the same patient population with the same projected payor mix under the same provider license.

Nevertheless, OHCA has determined that this proposed relocation constitutes a “termination” of services requiring a Certificate of Need (“CON”). YNHH disagrees that a CON is necessary under these circumstances. Accordingly, YNHH files this Request for Declaratory Ruling seeking a determination regarding the applicability to the specified circumstances here of the provisions of Connecticut General Statutes §§ 19a-638(a)(5) and 19a-639c.

STATEMENT OF QUESTIONS PRESENTED

1. Where YNHH will provide the same services through the same physicians to substantially the same patient population in a different location, does this constitute a “termination” of inpatient services under Connecticut General Statutes § 19a-638(a)(5), which would require a CON?

2. Does YNHH's planned relocation of IRU services to Milford constitute a relocation of a "health care facility" under Connecticut General Statutes § 19a-638c such that a CON is required, even where the relocation will not substantially change the patient population served or the payor mix?
3. Where YNHH's relocation of the IRU services does not constitute a termination of services pursuant to Connecticut General Statutes § 19a-638(a)(5), nor a relocation requiring a CON under Connecticut General Statutes § 19a-638c, is YNHH permitted to move forward with the relocation irrespective of whether CON approval is obtained?

FACTUAL BACKGROUND

Yale-New Haven Hospital (YNHH) currently provides inpatient rehabilitation medicine and therapy services in a Centers for Medicare and Medicaid Services (CMS) certified 24-bed acute rehabilitation unit currently located on its St. Raphael's campus at 1450 Chapel Street in New Haven.¹ This unit (the "IRU") provides acute inpatient rehabilitation services and serves as a discharge placement for those patients in need of inpatient rehabilitative care after an acute care hospitalization. As such, the YNHH IRU predominantly serves as a discharge placement for patients treated at YNHH, though it is available to patients discharged from other area hospitals.

YNHH plans to relocate the IRU to leased space in Milford Hospital's main hospital building, located at 300 Seaside Avenue. The impetus for this relocation is to free-up needed space on the Chapel Street campus to permit the coordination of musculoskeletal services in one location. YNHH will continue to operate, staff and bill for IRU services provided in the Milford location. The IRU in Milford will operate as a YNHH satellite location, using existing YNHH

¹ Unless otherwise noted, all facts provided herein are drawn from YNHH's CON application, attached as Ex. A hereto.

licensed beds. The IRU in the Milford location will provide the same services to substantially the same patient population by the same staff, just at a different physical location. For those patients being discharged from YNHH, intra-facility transportation will be provided by YNHH, just as it is now.

The same geographic areas served by YNHH's IRU will continue to be served in the Milford location. The communities representing the top 80% of the IRU's existing volume are: New Haven, Hamden, East Haven, West Haven, North Haven, Orange, Milford, Wallingford, North Branford, Branford, and Guilford. These communities are expected to continue representing the top 80% of IRU volume after relocation.² Likewise, the payor mix is expected to remain unchanged after relocation.

It has been YNHH's position that where YNHH is continuing to provide the same services to the same patients, the relocation of YNHH's IRU does not effectuate a "termination" of services such that a CON is required. *See* 10/10/2014, 10/30/2014 and 11/14/2014 Letters from YNHH to OHCA, attached as Exs. B, C, D. However, on February 24, 2015, OHCA concluded that the relocation does constitute a "termination" requiring CON approval because it is a cessation of services at a particular physical location. 2/24/2014 Letter from OHCA to YNHH, attached as Ex. E. In light of that determination, YNHH has filed a CON application requesting a CON to relocate the IRU. However, YNHH continues to believe that OHCA lacks authority to require a CON under these circumstances. In order to ensure that this argument is preserved, and because the CON process itself does not contain a clear mechanism for addressing this issue, YNHH is filing this Request for Declaratory Ruling.³

² The number of patients from the Milford area may increase due to the relocation.

³ If the CON application is granted, this Request may become moot.

STATEMENT OF PERSONAL INTEREST IN REQUEST

As discussed above, YNHH has a concrete and personal interest in obtaining a determination of how Connecticut General Statutes §§ 19a-638(a)(5) and 19a-639c apply to the relocation of the YNHH IRU and whether a CON is required before YNHH can proceed with relocation of the IRU. Further, YNHH has an interest in obtaining a declaratory ruling for purposes of determining whether future service relocations may require CON approval.

DISCUSSION

I. Relocation of the IRU Services Does Not Constitute a Termination.

Section 19a-638(a) of the Connecticut General Statutes enumerates specific circumstances under which a CON is required. The only provision claimed to be relevant by OHCA is subsection (a)(5), which requires that a CON be obtained for a “termination of inpatient or outpatient services offered by a hospital.” Though the word “termination” is not defined by OHCA statutes, its meaning is plain: to cease or end. Here, YNHH is not ceasing to provide the IRU services; it is merely relocating them. No CON is needed under these circumstances.

As the legislature has directed, in the absence of ambiguity, the interpretation of a statute should be based on the text alone. *See* Conn. Gen. Stat. §1-2z (interpretation of a statute must be based only on the text of statute and its relationship with other statutes where language is unambiguous); *Saunders v. Firtel*, 293 Conn. 515, 525 (2009) (“Only if we determine that the statute is not plain and unambiguous or yields absurd or unworkable results may we consider extratextual evidence of its meaning”)

“[W]ords and phrases shall be construed according to the commonly approved usage of language.” Conn. Gen. Stat. §1-1(a). Courts rely on dictionary definitions to determine the

common and ordinary meaning of an undefined statutory term. *E.g., State v. Sandoval*, 263 Conn 524, 552 (2003) (“To ascertain that [common] usage, we look to the dictionary definition of the term.”); *Connecticut Nat’l Bank v. Giacomi*, 242 Conn. 17, 33 (1997). According to the Oxford English Dictionary, “termination” means “the action of bringing something or coming to an end.” Black’s Law Dictionary (Sixth Ed.) similarly defines terminate as to “put an end to; to make to cease; to end.” Indeed, the Connecticut Supreme Court has embraced a similar dictionary definition of “termination.” *See Perruchio v. Allen*, 156 Conn. 282, 286 (1968) (approving use of Webster’s definition of “termination” as the “end in time or existence: close, cessation, conclusion ... the act of terminating... or bringing to an end or concluding.”).

The IRU services being provided by YNHH are not ending or ceasing. They are merely moving to a different physical location. As discussed above, YNHH will be providing the same services through the same staff and physicians to substantially the same patient population at the new site. All YNHH inpatients being discharged to IRU services will be discharged to the IRU in Milford, in the same way that they are currently discharged to the IRU on the St. Raphael’s campus. There is no sense in which the services being provided are coming to an end.

Even assuming, *arguendo*, that there is some doubt as to the meaning of the word “termination” in isolation, that doubt is eliminated by reviewing the statute as a whole, as we must. As the Connecticut Supreme Court has emphasized, “[t]he test to determine ambiguity is whether the statute, when read in context, is susceptible to more than one reasonable interpretation.” *Saunders*, 293 Conn. at 525. Each part or section of a statute should be construed in connection with every other part or section to produce a harmonious whole. *Connecticut Light & Power Co. v. Texas-Ohio Power, Inc.*, 243 Conn. 635 (1998).

Here, Section 19a-638 uses the words “termination” *and* “relocation,” and uses them in distinct ways. Subsection (a) lists various circumstances where a “termination” of services requires a CON. By contrast, the legislature addresses relocation in subsection (c), providing that “any health care facility that proposes to relocate pursuant to section 19a-639c shall send a letter to the office that describes the project and requests that the office make a determination as to whether a certificate of need is require.” Conn. Gen. Stat. § 19a-638(c). Under Section 19a-639c, a CON is required only for the “relocation of a facility,” and only if the applicant is unable to demonstrate that the “population served by the health care facility and the payer mix will not substantially change as a result of the facility’s proposed relocation.”

The legislature clearly knew the difference between the concepts of “termination” and “relocation” and where it wanted to capture the concept of “relocation” in the CON scheme, it did so clearly and unambiguously. Specifically, the legislature chose to require a CON for a relocation only where the relocation (1) is of a facility; and (2) will have a substantial effect on patient population or payor mix.

Where the legislature uses two terms in close proximity with different meanings, the terms “must then be assumed to have been used with discrimination and with full awareness of the difference in their ordinary meanings.” *Lostritto v. Comm’y Action Agency of New Haven, Inc.*, 269 Conn. 10, 20 (2004); *Plourde v. Liburdi*, 207 Conn. 412, 416 (1988) (“the use of different words [or the absence of repeatedly used words in the context of] the same [subject matter] must indicate a difference in legislative intention”). In drafting Section 19a-638, the legislature clearly distinguished between terminations and relocations and this distinction makes sense. Moving a service has far less impact on patients than eliminating the service altogether.

Hence, requiring a CON only for service terminations is wholly consistent with the purpose and structure of the CON law.

YNHH's interpretation is also supported by the fact that construing "termination" of a service to include "relocation" of a service would lead to bizarre results. Under that view, an entire hospital facility could relocate without CON approval under Section 19a-639c, so long as OHCA was satisfied that there would not be a substantial impact on patient population or payor mix. Yet the far more modest relocation of a service would require a CON as a "termination" in every instance. "The law favors rational and sensible statutory construction; we interpret statutes to avoid bizarre or nonsensical results." *State v. Sandoval*, 263 Conn. 524, 553 (2003) (internal citations and quotation marks omitted). Interpreting "termination" to include "relocation" would yield just such nonsensical results and must be rejected. *Butler v. Hartford Technical Institute, Inc.*, 243 Conn. 454 (1997) (holding that when two constructions are possible, courts will adopt construction that makes the statute effective and workable, and not the construction which leads to difficult and possibly bizarre results).

OHCA is not free to "engraft additional requirements onto clear statutory language," even if it believes it would be good policy. *Farmers Texas County Mut. v. Hertz Corp.*, 282 Conn. 535 (2007); *see also Evanuska v. City of Danbury*, 99 Conn. App. 42, rev'd on other ground 285 Conn. 348 (2007) (explaining that a court may not, by construction, supply omissions in a statute or add exceptions or qualifications, merely because the court opines that good reason exists for so doing; in such a situation, the remedy lies not with the court but with the General Assembly). Moreover, a court will review OHCA's determination on this question of law de novo, with no special deference. *Connecticut Light & Power Co. v. Texas-Ohio Power, Inc.*, 243 Conn. 635, 642 (1998). Relocations of services that do not have a substantial impact on

patient population or payor mix simply do not require a CON under the plain and unambiguous terms of the statute. YNHH respectfully requests that OHCA issues a declaratory ruling accordingly.

II. The Relocation of the IRU Also Does Not Require a CON Under Section 19a-639c.

While OHCA's determination that a CON was required to relocate the IRU to Milford was based exclusively on its conclusion that the relocation constituted a "termination" of services and was not based on Section 19a-639c, *see* Ex. E, YNHH seeks a determination of the applicability of that Section here as well in order to ensure that it has full clarity on whether a CON is required for this service relocation and for potential service relocations in the future. YNHH believes that Section 19a-639c does not require a CON here for two reasons. First, Section 19a-639c only applies to the relocation of a "facility" and the IRU is a service. The CON statutory scheme distinguishes between a "health care facility" and a "service." *Compare, e.g.,* Conn. Gen. Stat. 19a-638(a)(1) (using term "facility") *with* 19a-638(a)(5) (using term "service"). As discussed above, where the legislature uses two different terms in the same statute, it is deemed to have used them to convey distinct meanings.

Even assuming, however, that the relocation of the IRU constituted a relocation of a facility, no CON would be required. Pursuant to Section 19a-639c, a CON is required for the relocation of a facility only where the relocation will have a "substantial" effect on the patient population served or the payor mix. Here, the evidence submitted by YNHH, *see* Exs. A-D, makes clear that the relocation will have little or no impact on either. The IRU is relatively unique in that it receives predominantly patients being discharged from YNHH. YNHH will continue to discharge patients to this IRU on the same basis going forward. Thus, there is abundant evidence to expect that the patient and payor mix will be virtually unchanged by the

move. OHCA did not conclude otherwise in determining that a CON was required, relying exclusively on the termination rationale.

CONCLUSION AND REQUEST FOR RELIEF

YNHH respectfully requests that OHCA issue a ruling declaring that YNHH is entitled to move forward with the relocation of its IRU services from YNHH's St. Raphael's campus to leased space in Milford, regardless of whether it receives CON approval because neither Section 19a-638(a)(5) nor Section 19a-638c apply and/or require a CON under these facts.

REQUEST FOR HEARING

YNHH requests that a hearing be held on this Request for Declaratory Ruling. YNHH asks that this Request and the exhibits attached hereto be made a part of the hearing record.

YNHH further requests that it be made a party to the proceeding.

Respectfully submitted,



Kim Rinehart, Esq.

Wiggin and Dana LLP

P.O. Box 1832

New Haven, CT 06508-1832

Tel: 203-498-4400

Fax: 203-782-2889

Email: krinehart@wiggin.com

On behalf of:

Yale-New Haven Hospital, Inc.

20 York Street

New Haven, CT 06510



March 23, 2015

Ms. Kimberly Martone
Director of Operations
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Yale-New Haven Hospital CON Submission
Relocation of the Inpatient Rehabilitation Unit to Milford, Connecticut

Dear Ms. Martone:

Please find enclosed one (1) original and four (4) copies of a Certificate of Need application for the relocation of Yale-New Haven Hospital's (YNHH) inpatient rehabilitation unit (IRU). In addition, a CD is provided that includes a scanned copy of the CON in its entirety as well as MS Word and MS Excel files.

As you are aware, YNHH does not believe that a CON is required here because the relocation of its IRU does not constitute a termination of a service, nor does it constitute a relocation that would require CON approval. YNHH reserves all rights to challenge OHCA's authority to require a CON in this matter.

Please feel free to contact me at (203) 863-3908 with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Rosenthal".

Nancy Rosenthal
Senior Vice President, Health Systems Development

Enclosures

20 York Street
New Haven, CT 06504



Yale-New Haven Hospital

Certificate of Need Application Relocation of the Inpatient Rehabilitation Unit to Milford, Connecticut

March 23, 2015

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Exhibit I – Checklist & General Information

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 a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.
 - (*New*). A completed supplemental application specific to the proposal type, available on OHCA's website under "OHCA Forms." A list of supplemental forms can be found on page 2.
 - 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.
 - 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 completed Financial Attachment
 - Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.
 - 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 applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: _____ Check No.: _____
 OHCA Verified by: _____ Date: _____

General Information

Main Site*	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME	
	N/A as per OHCA	004041836	Acute Care Hospital	Yale-New Haven Hospital	
	STREET & NUMBER				
	20 York Street				
	TOWN			ZIP CODE	
New Haven			06510		

*For additional sites

Project Site	PROJECT SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME	
	N/A as per OHCA	004041836	Acute Care Hospital	Yale-New Haven Hospital	
	STREET & NUMBER				
	1450 Chapel Street				
	TOWN			ZIP CODE	
New Haven			06510		

Operator	OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)		
	1851568828 (NPI)	Acute Care Hospital	Yale-New Haven Hospital		
	STREET & NUMBER				
	20 York Street				
	TOWN			ZIP CODE	
New Haven			06510		

Chief Executive	NAME		TITLE		
	Marna Borgstrom		Chief Executive Officer		
	STREET & NUMBER				
	20 York Street				
	TOWN		STATE	ZIP CODE	
	New Haven		CT	06510	
	TELEPHONE	FAX	E-MAIL ADDRESS		
(203) 688-	(203)	Marna.borgstrom@ynhh.org			

Title of Attachment:

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES	<input checked="" type="checkbox"/>	Attachment I
	NO	<input type="checkbox"/>	

Does the Applicant have non-profit status? If yes, attach documentation.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Attachment II
Identify the Applicant's ownership type.	PC <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input checked="" type="checkbox"/>	Other: _____
Applicant's Fiscal Year (mm/dd)	Start <u>10/1</u>	End <u>9/30</u>

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information	NAME		TITLE
	Nancy Rosenthal		Senior Vice President, Health Systems Development
	STREET & NUMBER		
	5 Perryridge Road		
	TOWN	STATE	ZIP CODE
	Greenwich	CT	06830
	TELEPHONE	FAX	E-MAIL ADDRESS
	(203) 688-3908	(203) 863-4736	nancy.rosenthal@ynhh.org
RELATIONSHIP TO APPLICANT	Employee		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by	NAME		TITLE
	Karen Banoff, KMB Consulting, LLC		Principal
	STREET & NUMBER		
	91 Old Hollow Road		
	TOWN	STATE	ZIP CODE
	Trumbull	CT	06611
	TELEPHONE	FAX	E-MAIL ADDRESS
	(203) 459-1601	(203) 459-1601	kbanoff@kmbconsult.com
RELATIONSHIP TO APPLICANT	Consultant		

Exhibit II – Filing Fee Check

Notice to Purchaser - In the event that this check is lost, misplaced or stolen, a sworn statement and 90-day waiting period will be required prior to replacement. This check should be negotiated within 90 days.

Cashier's Check - Customer Copy

No. 1340003012

Void After 90 Days 30-1/1140

Date 03/20/15 02:11:32 PM 9

YALE NEW HAVEN HOSPITAL
0004 0021178 0144

NTX

Pay

 **BANK OF AMERICA** **500.00**
FIVE ZERO ZERO DOLLARS

***\$500.00

To The Order Of **TREASURER, STATE OF CONNECTICUT**
YNHHRU

Not-Negotiable
Customer Copy
Retain for your Records

Remitter (Purchased By): **MATTHEW MCKENNAN**

Bank of America, N.A.
SAN ANTONIO, TX

001641005594

Bank of America 

Cashier's Check

No. 1340003012

Notice to Purchaser - In the event that this check is lost, misplaced or stolen, a sworn statement and 90-day waiting period will be required prior to replacement. This check should be negotiated within 90 days.

Void After 90 Days 30-1/1140

Date 03/20/15 02:11:32 PM

YALE NEW HAVEN HOSPITAL
0004 0021178 0144

NTX

Pay

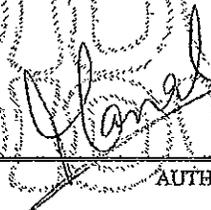
 **BANK OF AMERICA** **500.00**
FIVE ZERO ZERO DOLLARS

***\$500.00

To The Order Of **TREASURER, STATE OF CONNECTICUT**
YNHHRU

Remitter (Purchased By): **MATTHEW MCKENNAN**

Bank of America, N.A.
SAN ANTONIO, TX


AUTHORIZED SIGNATURE

⑈ 1340003012⑈ ⑆ 14000019⑆ 001641005594⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENTS.

Exhibit III – Evidence of Public Notice

CLASSIFIED NEW HAVEN REGISTER REAL ESTATE

February 28, 2015 MORE AT FACEBOOK.COM/NEWHAVENREGISTER AND TWITTER.COM/NHREGISTER www.nhregister.com

Debra M. Cozzo \$45,000
James Scarpato L.C. \$450,000
 to Sean Cahill
 Haven Inc to RAL \$,000

Habitat For Humanity \$1,000
 157 Clay St. Paul Davis and Reverso
 Mig Solution Int to Reverse Mig Solution
 Inc. \$89,000
 122 Cottage St. Akilah Bulde and US
 Bank NA Tr to US Bank NA Tr. \$1
 535 Howard Ave. Arthur Mabry and
 Wells Fargo Bank NA to Wells Fargo Bank
 NA \$1

525 Washington Ave. Anideo J. and
 Rosanna Cappella to 511 Washington
 Avenue LLC \$250,000
 647 Middletown Ave. CMB Capital
 Appraisal to RAL North Haven LLC.
 \$2,025,000
 18 Lincoln St. George T. Welles to Dawn
 M. Styles \$167,000
 141 Half Milk Rd. Benhaven Inc to RAL
 \$640,000
 2 Gross St. Prudent Funding Assoc to
 Teach and Kim Salyers \$272,000

WALLINGFORD
 78 Fuller Dr. to 70: Sandra Clowson to
 Anthony and Beverly Desmaris \$82,750
 20 Orchard Ln. Robert Haddon and
 Bank Of America NA to Bank Of America
 NA \$1

Austin to Eric Elkanbrack and
 Wellman \$405,000
 28 Forest Glen Dr. Margaret
 Federico to Jason and Carline
 \$320,000
 191 Rimmon Rd. Robert E. (
 Travis S. Baker to Elizabeth A
 \$274,000
 88 Rimmon Rd. Joan Coppo
 Anthony Fischetti and Jill Harri
 \$289,000

FINISHED
 garage,
 kitchen,
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 \$1700/mo

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HELP WANTED FULL-TIME

HVAC TECHNICIAN
 HVAC technician needed
 with supervisory
 experience that will
 provide facilities support
 for several office
 buildings in and around
 New Haven, including 100
 College Street.
 The position reports
 directly to the Director of
 Facilities Mgmt and will
 also work directly with
 tenants, must be
 extremely customer
 oriented. This position
 is 40 hours/week and
 requires some off hours
 work/over time. Please
 send resume to
 Dale Baldwin at
 dbaldwin@vivent.com

HELP WANTED PART-TIME

PART-TIME CUSTODIAN for
 downtown New Haven church.
 Must be available Sundays.
 Call 203-624-2523 for more
 info and application.

HEALTHCARE

DIRECTOR
 OUTPATIENT SERVICES
 SCADD DUAL DIAGNOSIS
 LIC AND SUBSTANCE
 ABUSE EXP REQ.
 EMAIL RESUME TO
 SCADD@SCADD.ORG

RESTAURANT FOOD SERVICE

DISHWASHER/WAITSTAFF.
 Diner Exp. needed. Apply at:
 Country Corner Diner, 756
 Amity Rd. (Rt. 63), Bethany.
 203-393-1489

RESTAURANT FOOD SERVICE

SHORT ORDER COOK.
 Diner Exp. needed, Breakfast/
 lunch/Dinner. FT. \$15/hour.
 Apply to: Country Corner
 Diner, 756 Amity Rd. (Rt. 63),
 Bethany. 203-393-1489

SITUATIONS WANTED

SEEKING EMPLOYMENT
 Gentleman with Autism and
 tics seeking assembly
 work in and around New
 Haven Shoreline area.
 requires adjustment time to
 settle in. Will be best
 employee you ever had.
 Call 203-264-3051

LEGAL NOTICES

LIQUOR PERMIT
 Notice of Application
 This is to give notice
 that I
LEONARD REIZFELD
 461 AMITY RD
 WOODBRIDGE CT 06525
 Have filed a request
 placarded 02/28/2015
 with the Department of
 Consumer Protection to
 distribute alcoholic liquor
 as a WHOLESALE LIQUOR
 permit with a business
 located at:
 55 MARSH HILL RD
 ORANGE, CT 06477-3612
 The business will be
 owned by:
LEONARD C. REIZFELD
 Objections must be filed
 by: 04/11/2015
LEONARD REIZFELD

PUBLIC NOTICE

Pursuant to a determina-
 tion issued by the Office
 of Health Care Access,
 and in accordance with
 Connecticut General Statu-
 tes Section 19a-638(a)(4),
 Yale-New Haven Hospital
 plans to submit a Certifi-
 cate of Need Application

LEGAL NOTICES

NOTICE OF PUBLIC HEARING WEST HAVEN WATER POLLUTION CONTROL COMMISSION

To whom it may concern:
 The West Haven Water
 Pollution Control Com-
 mission will hold a public
 hearing on Wednesday,
 March 11, 2015 at 6:30
 p.m. in the Water Pol-
 lution Control Facilities
 Administration Building's
 Conference Room located
 at 2 Beach Street on the
 following agenda:

Submission of the Water
 Pollution Control Commis-
 sion proposed operating
 budget for the fiscal year
 2015-2016 in the amount
 of \$11,522,745.00 and a
 proposed sewer use fee
 rate of \$468.00 per unit.

Peter O'Neill, Chairman
 Water Pollution Control
 Commission

PROBATE NOTICES

NOTICE TO CREDITORS
 ESTATE OF James Joseph
 Mahe

The Hon. Beverly K. Stre-
 itz-Kefalas, Judge of the
 Court of Probate, District
 of Milford - Orange Pro-
 bate District, by decree
 dated December 24, 2014,
 ordered that all claims
 must be presented to the
 fiduciary at the address
 below. Failure to promptly
 present any such claim
 may result in the loss of

Notice of Tentative Determination to Agricultural Structures, Dredging & Fill and Tidal Wetlands And Intent to Waive Public Hearing

Applicant: Joseph Karpinski
 Application No. 201406293-SB
 Municipality: Town of Westbrook

The Department of Energy and Environmental Pro-
 tection ("DEEP") hereby gives notice that a tentative det-
 ermination has been reached to approve the following app-
 lication submitted under Sections 22a-361 and 22a-32 of t-
 he Connecticut General Statutes ("CGS") for a permit to i-
 nstall, construct, alter, expand, or maintain any structure,
 work, waterway of the coastal jurisdiction line,
 coastal or navigable waters of the state and in til-
 lands for private recreational boating access.

The Commissioner also gives notice of intent to wa-
 ve the requirement for public hearing pursuant to CGS
 22a-32 and that the Commissioner shall hold a hea-
 ring receipt of a petition signed by twenty-five or more
 persons pursuant to CGS Sections 22a-32 and 22a-361(b). If
 the Commissioner also gives notice that a hearing may be
 held on this application if a written request is received by
 the applicant, or if the Commissioner determines that t-
 he public interest will best be served thereby.

Applicant's Name and Address: Joseph Karpinski
 Haviland Road, Ridgefield, CT 06877
 Contact: David L. P. P.O. Box 421, Mystic, CT 06340
 Email: dlo@docj.com; 860-672-8939
 Site Location: Westbrook Tax Assessor's Referent
 169, Block 025

PROPOSED ACTIVITY
 The proposed activity includes installation of a pie-
 and float and will affect coastal resources and tid-
 lands.

INFORMATION REQUESTS/PUBLIC COMMENT

Interested persons may obtain a copy of the appli-
 cation from the above contacts or by sending a request
 electronic copy to DEEP at sue.bailey@ct.gov. The a-
 pplication is available for inspection at the DEEP Office (I-
 95 Island Sound Programs, 79 Elm Street, Hartford, CT
 - 430 Monday through Friday. Additional surveys, p-
 hoto, or other materials may be available with the original a-
 pplication file at DEEP. All interested parties are invited
 to express their views on the tentative determination con-
 cerning this application. Written comments on the appli-
 cation should be directed to Susan Bailey, DEEP Office o-
 f Island Sound Programs, 79 Elm Street, Hartford, CT
 06127, no later than April 9, 2015. Comments regard-
 ing this application may be submitted via electronic mail to
bailey@ct.gov.

PETITIONS FOR HEARING
 Petitions for a hearing should include the application
 number and show how the tentative determination

SUNDAY, MARCH 7, 2016

LEGAL NOTICES

Connecticut Legal Notice

Funding Opportunity in Support of Nonprofit, Faith-based, and Government Agencies Providing Emergency Food, Shelter, and Utility Assistance Services

The United Way of Greater New Haven Announces FY 15 Emergency Food and Shelter Program (EFSP) Investment Process

United Way of Greater New Haven will administer \$489,718 in federal funds under the Emergency Food and Shelter National Need Program (EFSP) for fiscal year 2015 through a competitive application process for New Haven County nonprofits, faith-based, and government agencies for emergency services program funding. Other organizations such as smaller emerging nonprofits are encouraged to apply in partnership with an eligible 501(c)(3) organization that agrees to serve as the fiscal agent for the grant.

Programs who have provided direct services including emergency food, emergency shelter, emergency utility, emergency rent/mortgage assistance and transitional housing services for at least 12 ongoing months to individuals and families in crisis or prevention services that help people avoid crisis in the towns of Ansonia, Beacon Falls, Bushy, Branford, Cheshire, Derby, East Haven, Guilford, Hamden, Madison, Meriden, Middletown, Milford, Naugatuck, New Haven, North Branford, North Haven, Orange, Oxford, Prospect, Seymour, Southbury, Wallingford, Waterbury, West Haven, Wolcott, and Woodbridge are welcome to apply for funding. Applications, detailed instructions, funding criteria and guidelines for the 2015 EFSP grant process is available at uwgnh.org. Applications due 4p.m. Friday, March 13, 2015.

Housing Authority of the City of New Haven

Invitation for Bid HVAC Meter Upgrades at Consulate Baker Bakery - Phase 2

LEGAL NOTICES

LEGAL NOTICE PUBLIC HEARING

The State Board of Education will conduct a public hearing on the application for the renewal of a charter for Common Ground High School in the City of New Haven. The public hearing will be held on March 10, 2015, beginning at 6 p.m. and concluding on or before 8 p.m. at Wilbur Cross High School auditorium located at 181 Marshall Dr. in New Haven, CT. Anyone interested in commenting on the application for the renewal of a charter for Common Ground is welcome. All organizations and individuals offering comments are encouraged to provide a written copy of their remarks.

LIQUOR PERMIT

Notice of Application This is to give notice that I, LEONARD REIZFELD, 481 AMITY RD WOODBRIDGE CT 06525 Have filed a request placarded 02/28/2015 with the Department of Consumer Protection to distribute alcoholic liquor as a WHOLESALE LIQUOR permit with a business located at 55 MARSH HILL RD ORANGE, CT 06477-3612 The business will be owned by: LEONARD C. REIZFELD. Objections must be filed by: 04/11/2015 LEONARD REIZFELD

NOTICE OF PERMIT APPLICATION

Town(s): New Haven

Notice is hereby given that Magellan Terminals Holdings, L.P. (the applicant) of One Williams Center, MD 27, Tulsa, Oklahoma 74172 will submit to the Department of Energy and Environmental Protection an application for a permit for a Title V source under Connecticut General Statutes, and section 22a-174-33 of the Regulations of Connecticut State Agencies which are regulated under the Federal Clean Air Act (CAA).

Specifically, the applicant proposes to apply for a permit renewal for a Title V source. The proposed permit will take place at

LEGAL NOTICES

NOTICE OF PUBLIC HEARING WEST HAVEN WATER POLLUTION CONTROL COMMISSION

To whom it may concern: The West Haven Water Pollution Control Commission will hold a public hearing on Wednesday, March 11, 2015 at 6:30 p.m. in the Water Pollution Control Facilities Administration Building's Conference Room located at 2 Peach Street on the following agenda:

Submission of the Water Pollution Control Commission proposed operating budget for the fiscal year 2015-2016 in the amount of \$1,522,745.00 and a proposed sewer use fee rate of \$48.00 per unit.

Foster O'Hara, Chairman Water Pollution Control Commission

PUBLIC NOTICE

Pursuant to a determination issued by the Office of Health Care Access and in accordance with Connecticut General Statute Section 19a-639(a)(4), Yale-New Haven Hospital plans to submit a Certificate of Need Application to the Connecticut Department of Public Health's Office of Health Care Access for the relocation of Yale New Haven Hospital's Inpatient Rehabilitation Unit from 1450 Chapel Street, New Haven, Connecticut to leased space at 900 Seaside Avenue, Milford, Connecticut. The estimated total capital expenditure for the project will be \$5,500,000.

FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.: AAN-CV-13-6014890-5 Case Name: Nationstar Mortgage LLC, D/B/A Champion Mortgage Co. v. Michael John D. Et Al

FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No. NNH-CV-13-604747-5 Case Name: Federal National Mortgage Association vs. Marc Suraci, Et Al Property Address: 120 Wooster St, Unit O New Haven, CT Property Type: Residential Condominium

Date of Sale: Saturday, March 7, 2015 at 12:00 Noon

Committee Name: Attorney Gerard M. Saff Commission Phone Number: (203) 865-1309

See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No. AAN-CV-10-6004986-5 Case Name: Deutsche Bank National Trust Company, as Trustee vs. Allendorf, Eric, Et Al

Property Address: 91 West Walk West Haven, CT Property Type: Residential

Date of Sale: Sat., March 14, 2015

Committee Name: Vincent R. Falcone Committee Phone Number: (203) 931-1762 ext. 118

See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE FORECLOSURE

CLASSIFIED

NEW HAVEN REGISTER monster

WWW.NHREGISTER.COM

Monday, March 2, 2015 MORE UPDATES AT FACEBOOK.COM/NEWHAVENREGISTER AND TWITTER.COM/NHREGISTER

▶▶ HOW TO PLACE A CLASSIFIED AD ▶▶

CALL ▶ 1.800.922.7066 (Toll Free)

Classified is open Monday through Friday from 8am to 5pm.

The ad deadline is 5pm for publication; the following day (Friday) @ 5pm for publication; Sunday or Monday.

Please check your ad on the last day it is published to make sure it is correct. If you find an error, please e-mail ADVERTISE@NHREGISTER.COM. Call 1.800.922.7066. The New Haven Register will be responsible for only ONE incorrect insertion.

EMAIL ▶ classifiedads@nhregister.com
WEBSITE ▶ www.nhregister.com
FAX ▶ 1-888-243-0060

APARTMENTS FOR RENT UNFURNISHED

LOOK!
ANSOMIA
2 BR townhouse units available at Beaver Brook Apts. Located in wooded setting yet 10 minutes to New Haven and Bridgeport withing traffic lights. Prices from \$850-\$1050. incl. heat & hot water. Full special 1/2 off first mo's rent. Call for your appointment today. 203-734-5117

DRURY - 1BR - \$695, plus utility & parking. Ready to move in. Some new appliances. Interviews. No pets. 937-6939/458-9183

Do you have a Section 8 voucher? Sections 3 BR apartment in New Haven. Handicap Accessible. Washer, Dryer, Dishwasher, Central Air, In-unit laundry. Apply. \$1100 plus utilities. ETC. 203-772-4545

Handicap spacious 2 bdrm. off st parking, newly renovated. Call 203-795-3748

NEW HAVEN - 1 BR, 3rd floor, off street parking, 10 yrs. STAB/NO. Call (203) 874-2754

NEED WANTED FULL TIME

DRIVER, Class A or B tanker. Hazardous WIC card, current medical. Apply at Tardis Chris, 60 Britta in St. Meriden, CT.

HEALTH CARE
HIRING HOME HEALTH AIDES
Home Health Care Assistants
Personal Care Assistants
CNAs: 81-lingual/ Spanish a plus. (203) 789-0777 or fax resume (203) 789-0766
br/6 203-380-8983

RESTAURANT FOOD SERVICE
Do you have a Section 8 voucher? Sections 3 BR apartment in New Haven. Handicap Accessible. Washer, Dryer, Dishwasher, Central Air, In-unit laundry. Apply. \$1100 plus utilities. ETC. 203-772-4545

RESTAURANT HIRING - EXPERIENCED:
COOKS, KITCHEN STAFF & WAITSTAFF/SERVERS
FULL-TIME & PART-TIME
Days, nights, holidays available. Will train. Apply @ Jimmie's 5 Rock St. West Haven.

Entertainment will consist of more information.

SITUATIONS WANTED

SEEKING EMPLOYMENT
Gentleman with Avian and touristics seeking assembly work in and around New Haven Shoreline area. requires adjustment time to be able to work. Will be best employee you ever had. Call 203-264-3051

LEGAL NOTICES
Notice of Application
This is to give notice that I, JOSE LOPEZ, residing at 588 PERRY STREET #13 NEW HAVEN, CT 06513-2522

Have filed an application for a RESTAURANT LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 446 FORDS AVE. NEW HAVEN, CT 06512-1932
The business will be owned by RICH ENTERPRISE LLC

Employees covered by the certification may qualify for benefits such as health, job search and relocation allowances, and income support.
Eligible workers may contact the nearest Department of Labor, Connecticut Job Center for information and assistance or visit the Department of Labor Internet site at www.dol.state.ct.us

LEGAL NOTICES

ATTENTION !!!
Employees of Covidien LP located in North Haven, CT who provided production of medical devices and general surgical products.
You were certified on January 20, 2015 as eligible to apply for Trade Adjustment Assistance (TAA) under the federal Trade Act if you are totally or partially separated from employment on or after December 31, 2013 and on or before January 20, 2017.

Employees covered by the certification may qualify for benefits such as health, job search and relocation allowances, and income support.
Eligible workers may contact the nearest Department of Labor, Connecticut Job Center for information and assistance or visit the Department of Labor Internet site at www.dol.state.ct.us

NEW HAVEN CITY PLAN COMMISSION
Public Hearing
Wed. March 18, 2015
7:00 PM
145 Church St.
New Haven, CT

ORDER OF THE BOARD OF ALDERS
Amendment to Section 53 of the Code of Ordinances, the New Haven Zoning Ordinance, regarding the Appointment of Members of the Board of Zoning Appeals.
At this time testimony will be accepted relative to this which part is set forth at City Plan Department, City Hall, 100 State Street, and at the office of the City Clerk, for discussion and accomodation, 203-565-5553 (voice) or 203-565-5553 (TTY).

LEGAL NOTICES

NEW HAVEN CITY PLAN COMMISSION
Public Hearing
Wed. March 18, 2015
7:00 PM
145 Church St.
New Haven, CT

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PUBLIC NOTICE
pursuant to a determination issued by the Office of Health Care Access, and in accordance with the Connecticut General Statutes, Section 36a-683a (a) Yale-New Haven Hospital plans to submit a Certificate of Need Application to the Connecticut Department of Public Health's Office of Health Care Access for the relocation of Yale New Haven Hospital's Inpatient Rehabilitation Unit from 450 Chapel Street, New Haven, Connecticut to leased space at 300 Seaside Avenue, Milford, Connecticut. The estimated total capital expenditure for the project will be \$5,500,000.

YOU'LL NEVER KNOW how effective a classified ad is until you see one yourself! Reach the entire area without leaving the comfort of your home. Call and place your classified. Today to sell those unwanted items.

Exhibit IV – Affidavit

Affidavit

Applicant: Yale-New Haven Hospital

Project Title: Relocation of Inpatient Rehabilitation Services from New Haven to Milford, Connecticut

I, James Staten,

Senior Vice President & Chief Financial Officer

(Name)

(Position – CEO or CFO)

of Yale-New Haven Hospital being duly sworn, depose and state that the (Yale-New Haven Hospital) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature



Date

3/20/15

Subscribed and sworn to before me on

3/20/15



Notary Public/Commissioner of Superior Court

My commission expires:

ROSE ARMINIO
NOTARY PUBLIC
~~State of Connecticut~~
My Commission Expires
February 28, 2018



Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Yale-New Haven Hospital (YNHH) provides both inpatient and outpatient rehabilitation medicine and therapy services. YNHH's inpatient rehabilitation services are provided in an inpatient unit certified by the Centers for Medicare and Medicaid Services (CMS). There are a total of 24 certified beds with 18 currently operational on the Chapel Street campus. This unit provides acute inpatient rehabilitation (IRU) services consistent with federal regulations Subpart B of 42 CFR Part 412. The IRU serves as a discharge placement for inpatients in need of intensive inpatient rehabilitative care after an acute care hospitalization. YNHH plans to relocate the IRU to leased space in Milford Hospital's (MH) main hospital building, located at 300 Seaside Avenue. YNHH will continue to operate, staff and bill for IRU services provided in the Milford location. The IRU in Milford will operate as a YNHH satellite location, using existing YNHH licensed beds.

The impetus for this relocation is to create needed post-operative space for YNHH's Musculoskeletal Center (MSC) being established on the Chapel Street campus. Planning for the MSC began with the acquisition of the Saint Raphael Healthcare System in 2012. This center brings together orthopedics, neurology, rheumatology, physiatry, pain management and podiatry. Physician office space for all of these specialty physicians will be located in one area on the Chapel Street campus. Rehabilitation therapies such as physical, occupational and speech therapy will also be located in the same area. Two existing operating rooms were recently renovated and equipped to offer state-of-the art equipment for musculoskeletal surgeries. Musculoskeletal services, including physician offices and outpatient therapy will also be provided in existing outpatient locations including Guilford, Milford and two locations in New Haven. Inpatient volume projections require an additional nursing care unit and there are no other cost effective options.

YNHH and MH began discussing ways the two organizations can collaborate. MH has available space to accommodate the IRU and has experienced financial challenges over the past several years. Relocation of the IRU to MH was determined to be the least expensive option for YNHH to create needed inpatient capacity on the Chapel Street campus for the MSC. No additional beds will need to be added to YNHH's license. MH will significantly benefit from rental income and purchased ancillary services to be paid by YNHH. Finally, the IRU serves as a discharge placement and can serve patients from multiple acute care settings. Milford offers a more central regional location for Yale New Haven Health System member hospitals and affiliated physicians.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "S" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

Response

YNHH is a non-profit, 1,541-bed tertiary medical center that includes Smilow Cancer Hospital at Yale-New Haven, Yale-New Haven Children's Hospital and Yale-New Haven Psychiatric Hospital. YNHH regularly ranks among the best hospitals in the U.S. and is accredited by The Joint Commission. In conjunction with the Yale School of Medicine (YSM) and Yale Cancer Center, YNHH is nationally recognized for its commitment to teaching and clinical research.

Relying on the skill and expertise of more than 4,500 university and community physicians and advanced practitioners, including more than 600 resident physicians, YNHH provides comprehensive, multidisciplinary, family-focused care in more than 100 medical specialty areas. In addition to providing quality medical care to patients and families, YNHH is the second largest employer in the New Haven area with more than 12,000 employees. YNHH is also the flagship member of Yale New Haven Health System (YNHHS).

IRU at YNHH

YNHH provides both inpatient and outpatient rehabilitation medicine and therapy services. YNHH's inpatient rehabilitation services are provided in an inpatient unit certified by the Centers for Medicare and Medicaid Services (CMS). There are a total of 24 certified beds with 18 currently operational on the Chapel Street campus (see Attachment III for CMS letter). This unit provides acute inpatient rehabilitation (IRU) services consistent with federal regulations Subpart B of 42 CFR Part 412. A copy of Medicare's coverage criteria for Inpatient Rehabilitation Facilities is provided in Attachment IV. The IRU serves as a discharge placement for inpatients in need of inpatient rehabilitative care after an acute care hospitalization. The most common diagnoses or conditions for patients utilizing the IRU are lower extremity joint replacement, stroke, pain, spinal cord injury, lower extremity fracture, and movement disorders. The majority of patients are over the age of 65 and Medicare fee for service represents the largest payor.

Musculoskeletal Center at YNHH & IRU Relocation to Milford Hospital

YNHH plans to relocate the IRU to leased space in MH's main hospital building, located at 300 Seaside Avenue. YNHH will continue to operate, staff and bill for IRU services provided in the Milford location. The IRU in Milford will operate as an YNHH satellite location, using existing YNHH licensed beds. It is important to stress that the

IRU in the Milford location will provide the same services to the same patients by the same staff, just at a different physical location.

The impetus for this relocation is to address physical space constraints on YNHH's New Haven campus and create needed post-operative space for YNHH's Musculoskeletal Center (MSC) being established on the Chapel Street campus. The MSC brings together orthopedics, neurology, rheumatology, physiatry, pain management and podiatry. Physician office space for all of these specialty physicians will be located in one area on the Chapel Street campus. Rehabilitation therapies such as physical, occupational and speech therapy will also be located in the same area. Two existing operating rooms have been renovated and equipped to offer state-of-the art equipment for musculoskeletal surgeries. Musculoskeletal services will also be provided in outpatient locations including Guilford, Milford and two locations in New Haven. Inpatient volume projections for the MSC require an additional inpatient nursing unit and there are no cost effective options on the New Haven campus. Services to be provided by the MSC are considered acute care services and therefore should be located with other related acute care services. The current IRU location is ideal for the MSC unit required. The proposal does not require any additional beds to be added to YNHH's license.

The IRU will be relocated to the second floor at MH's main hospital building. The unit is being renovated to house 24 beds, YNHH's current CMS certified beds. There will be some significant improvements to the unit's configuration and ambiance as compared with the current IRU in New Haven. A total of 18 private rooms will be available as compared to two (2) on the current unit. The unit will have new and pleasant furnishings. All needed support spaces, offices, a conference room, storage, etc. will be located on the same floor close to the unit. A rehabilitation gym will be located in close proximity to the unit.

Collaboration with MH

YNHH and MH have held discussions regarding how the two organizations can collaborate. MH has experienced financial challenges over the past several years. The relocation of the IRU to available space at MH represents an initial opportunity for the two organizations to collaborate and bring needed benefits to one another. The IRU relocation will produce rental income and income for purchased ancillary services which will benefit MH financially. The income to MH will help to improve the organization's financial health, thus helping to support access to its services utilized by the local community. Benefits to YNHH include the ability to use an existing inpatient area at MH and avoid the construction of new space on the New Haven campus for the MSC, which would be more expensive.

Milford represents a more central location for Fairfield and New Haven county residents who utilize YNHHS member hospitals and physician practices and required IRU services. As previously stated, the IRU is a post-acute care hospitalization level of care. There are a limited number of IRUs in the State of Connecticut and therefore they serve patients being discharged from multiple hospitals. The length of stay in an IRU is approximately 15 days. Families will find access to MH much easier than New Haven. There is ample free parking, less traffic, and the campus is much simpler to navigate. The Milford location offers major benefits to patients and families during a longer rehabilitation stay.

Geographic Area Served

The same geographic areas served by YNHH's IRU will continue to be served in the Milford location. The communities representing the top 80% of the IRU's volume include: New Haven, Hamden, East Haven, West Haven, North Haven, Orange, Milford, Wallingford, North Branford, Branford, and Guilford. In addition, the Milford location is expected to facilitate access to the IRU for area residents served by Milford Hospital and affiliated YNHHS Hospitals and physician practices.

Timeframe

Construction began in late 2014 at MH and is due to be complete in early June 2015. YNHH plans to open the IRU at MH on or about June 15, 2015. In order to ensure a seamless transition, admissions to the IRU in New Haven will be stopped approximately 2-3 weeks prior to the planned move (the average length of stay for IRU patients). All patients will be discharged from the New Haven location by the end of a week (Friday) and the Milford unit will open for new patient admissions the following Monday. If necessary, any patients who cannot be discharged will be transported from New Haven to Milford.

In summary, this proposal is needed to create inpatient capacity on the YNHH Chapel Street campus to support the MSC's inpatient needs. It also provides a significant benefit to MH which has available space and is in need of new revenue streams to improve its financial condition. Finally, it offers a regional and central location for access to the IRU for YNHHS member hospitals and affiliated practices, without compromising access to, or the quality of, IRU services for existing patients.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

Response

YNHH began discussions with MH in May of 2014. These discussions focused on establishing YNHH's IRU as a satellite inpatient rehabilitation unit in Milford thus serving as a regional resource to accommodate the needs of patients from New Haven, Milford and other communities served by the YNHHS affiliates.

On July 11, 2014, YNHH's Executive Committee of the Board of Trustees approved the relocation of the IRU to leased space in MH. YNHH and MH executed a Definitive Agreement for this transaction on September 2, 2014. The terms of the agreement are outlined below:

- YNHH will relocate its IRU to leased space at MH but the unit will continue to be operated as an YNHH service.
- YNHH will employ or engage all technical, nursing and other staff as required.
- YNHH will appoint a medical director to oversee clinical care.
- YNHH will lease space at MH for an initial term of 5 years. There is an option to renew for (2) successive five-year terms.
- YNHH will purchase ancillary services such as pharmacy, laboratory, radiology and special procedures as required at a per diem rate per occupied bed.
- YNHH will make and pay for any required capital improvements to the space.

The Definitive Agreement has been reviewed by OHCA. Due to its confidential nature, it will not be provided in the CON application.

Construction on this space began in December 2014. The construction will be complete by early June 2015.

3. Provide the following information:

- a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

Response

Please refer to completed Table 1.

- b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

Response

Please refer to completed Table 2. The service area towns were included based on historical data for the IRU in its current New Haven location.

4. List the health care facility license(s) that will be needed to implement the proposal;

Response

Inpatient rehabilitation services, as described throughout this CON application, are provided under YNHH's acute care hospital license.

5. Submit the following information as attachments to the application:

- a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

Response

A copy of YNHH's acute care license issued by the State of Connecticut, Department of Public Health (DPH) is provided in Attachment V.

- b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

Response

A list of all key professional, administrative and clinical personnel related to the proposal is provided below. Copies of Curriculum Vitae are provided in Attachment VI.

Key personnel:

- Marna Borgstrom, Chief Executive Officer
- Richard D'Aquila, President and Chief Operating Officer
- James Staten, Senior Vice President, Finance and Chief Financial Officer
- Abe Lopman, Senior Vice President Operations and Executive Director of Smilow Cancer Hospital
- Nycaine Anderson-Peterkin, MD, IRU Medical Director

- **John Tarutis, Executive Director, Rehabilitation Unit**

- c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

Response

Not applicable. This application does not involve the establishment of a new service.

- d. letters of support for the proposal;

Response

Letters of support for the proposal have been included in Attachment VII.

- e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

Response

Not applicable. There are no Standard of Practice Guidelines applicable to the IRU. Care is directed by psychiatrists, physicians specially trained in rehabilitation medicine.

- f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Response

As previously noted, the Definitive Agreement signed by YNHHS and MH related to this proposal has been reviewed by OHCA. This agreement contains confidential information and will not be included in the public record.

Public Need and Access to Care

§ "Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn. Gen. Stat. § 19a-639(a)(1))

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

§ "The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn. Gen. Stat. § 19a-639(a)(2))

Response

This proposal is consistent with all policies and standards in regulations adopted by the Connecticut DPH. Hospitals are permitted to establish satellite service locations under an existing acute care hospital license.

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on [OHCA's website](#).

§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn. Gen. Stat. § 19a-639(a)(3))

Response

Relocation of the IRU from New Haven to Milford is aligned with the Connecticut DPH *Statewide Health Care Facilities and Services Plan*. Specifically, the 2014 update stresses the changes that have occurred in the State of Connecticut since the passage and implementation of the Patient Protection and Affordable Care Act (PPACA). The PPACA has influenced providers to focus on creating new models of care that bring higher quality and greater value. The PPACA has led to affiliations and mergers of health care providers throughout the State to maintain access to needed services, improve financial viability and enhance organizations' ability to meet technology needs.

This proposal is consistent with the affiliation efforts being seen statewide and nationally. It represents a more cost effective way to create inpatient bed space where it is needed, specifically for post-operative musculoskeletal patients on YNHH's Chapel Street campus, and maximize use of available space at MH. The revenue produced by lease payments and purchased ancillary services from YNHH will provide significant benefit to MH. The *Statewide Health Care Facilities and Services Plan* acknowledges that Connecticut has a sufficient number of inpatient beds. This proposal does not require any increase in inpatient beds, but will enhance utilization of those which already exist.

The *Statewide Health Care Facilities and Services Plan* does not include any recommendations specific to inpatient rehabilitation services. One of the acute care recommendations in the plan is:

Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas.

Inpatient rehabilitation services are specialized services provided to individuals after an illness, injury or surgery. Services include intensive physical and occupational therapy along with other medical care to manage comorbid conditions. Patients generally receive 3 hours of therapy services per day along with general medical and nursing care. These services are not provided in all acute care hospitals and therefore existing units receive referrals from multiple institutions. Connecticut has a small number of IRU providers serving patients throughout the state. Location of the YNHH's IRU in Milford will better centralize the IRU between Fairfield and New Haven counties where most YNHHS affiliates and physician practices exist, without compromising access to care for patients who currently utilize the IRU services in New Haven.

8. With respect to the proposal, provide evidence and documentation to support clear public need:

- a. identify the target patient population to be served;

Response

The target patient population for an IRU is based on the 13 medical conditions listed in 42 CFR 412.29(b)(2). As per federal regulations at least 60% of the inpatient rehabilitation patients must have one of these 13 medical conditions:

1. Stroke;
2. Spinal cord injury;
3. Congenital deformity;
4. Amputation;
5. Major multiple trauma;
6. Fracture of femur (hip fracture);
7. Brain injury;
8. Neurological disorders including (Multiple Sclerosis, Motor neuron diseases, Polyneuropathy, Muscular Dystrophy; and Parkinson's Disease);
9. Burns;
10. Arthritis conditions resulting in significant functional impairment;
11. Systemic vasculidities resulting in significant functional impairment;
12. Severe or advanced osteoarthritis; and
13. Knee or hip joint replacement for bilateral joint, extreme obesity or age greater than 85.

In addition to the diagnoses and conditions listed above, patients with complex rehabilitation and medical needs may also be admitted to an IRU if required and patients qualify. To qualify for Medicare coverage of IRU services, patients must be able to tolerate and benefit from at least 3 hours of therapy per day for at least five days per week. Many commercial payers have similar requirements.

- b. discuss how the target patient population is currently being served;

Response

The target patient population is currently being served in YNHH's IRU located on the Chapel Street campus. These same patients will be served at the YNHH IRU in Milford once it is relocated.

- c. document the need for the equipment and/or service in the community;

Response

As previously stated, there are a limited number of IRUs throughout the State of Connecticut. According to DPH's, *Statewide Health Care Facilities and Services Plan* in FY 2013 there were a total of approximately 20,000 rehabilitation patient days in New Haven and Fairfield counties. The plan also identifies that an additional 16 rehabilitation beds will be required in Fairfield County by 2020. Clearly this service is needed and utilized by the community. As the population continues to age, demand for these services will continue to rise as the majority of patients utilizing IRU services are over the age of 65.

- d. explain why the location of the facility or service was chosen;

Response

As previously discussed, MH was selected as the location for relocation of YNHHS's IRU for the following reasons:

- MH has available space that can accommodate the unit;
- MH is more centrally located for Fairfield and New Haven county residents, improving access for patients utilizing YNHHS member hospitals or physician practices;
- MH will benefit significantly from lease and purchased service payments; and
- Renovation of space at MH for the IRU was the least expensive option for YNHHS.

- e. provide incidence, prevalence or other demographic data that demonstrates community need;

Response

According to the Connecticut State Data Center, the population will grow in Fairfield and New Haven counties as shown below:

County	Population 2010	Population 2020	% Change
Fairfield	916,829	944,692	3.0%
New Haven	862,477	898,513	4.3%

The 65+ and the 85+ populations are projected to increase much more substantially, as summarized below. This is the target population for IRU services as older persons suffer from stroke, orthopedic and neurological conditions more frequently.

County	Population 2010 65+	Population 2020 65+	% Change	Population 2010 85+	Population 2020 85+	% Change
Fairfield	124,075	154,328	24%	20,462	23,733	16%
New Haven	123,972	162,063	31%	22,113	23,183	5%

Source: US Census Bureau

- f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

Response

The IRU provides care to those patients who meet the clinical requirements for the service. As previously stated, there are specific diagnoses and conditions that must comprise the majority of the patient population. In addition, patients must be able to tolerate at least 3 hours of therapy each day. The IRU has and will continue to serve low income persons, racial and ethnic minorities, disabled persons and underserved groups. These patient populations will benefit from the proposal in the same ways as other patients in need of IRU services by having easier access at the satellite Milford location along with enhanced patient privacy. MH is accessible by public transportation including bus and train.

- g. list any changes to the clinical services offered by the Applicant(s) and explain why the

change was necessary;

Response

Not applicable. There are no changes to the clinical services offered by YNHH.

- h. explain how access to care will be affected;

Response

YNHH believes access to IRU care will be enhanced with the relocation to MH due to the following reasons:

- MH is located more centrally to residents of both Fairfield and New Haven counties who seek care from YNHHS member hospitals or physician practices;
- MH offers easy access either by car or public transportation such as bus or train; and
- MH offers ample, free onsite parking.

YNHH will provide intra-facility (facilities owned or operated by YNHH) patient transport for any patient being discharged from the YNHH hospital and admitted to the IRU in Milford.

- i. discuss any alternative proposals that were considered.

Response

After careful review, YNHH staff determined that there is no available space on the Chapel Street campus for an additional inpatient unit for the MSC. One option that was evaluated was to relocate the IRU to the Grimes Center, YNHH's skilled nursing facility. The estimated costs to renovate a floor in Grimes to ensure the physical plant is in compliance with acute care hospital code were more than the costs of relocating it to Milford. In order to utilize space at Grimes an entire floor would have to be renovated, wall oxygen and suction installed as well as other modifications. The site also cannot support dialysis patients which is a need that does arise. The square footage at Grimes Center that would have required renovation was 16,000 in order to create an acute care floor. The original space targeted at MH was 8,500. Due to some unforeseen structural issues, the number of square feet being renovated at MH has increased to 14,516, however the renovation costs at MH are still less than they would have been if the Grimes Center unit was utilized. Once the discussions began with MH, no other alternatives were pursued.

§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;"
(Conn.Gen.Stat. § 19a-639(a)(5))

9. Describe how the proposal will:

- a. improve the quality of health care in the region;

Response

The current IRU staff provide high quality care to the patients they serve. The same staff will continue to provide services to IRU patients at the Milford location. High quality health care will continue to be provided in the region. In addition, because MH offers additional square footage to YNHH, a total of 18 private rooms can be created. This is a substantial increase from the existing 2 private rooms on the IRU and will significantly improve patient privacy and comfort.

- b. improve accessibility of health care in the region; and

Response

Relocation of the IRU to Milford will place the unit in a more central location to serve residents of both Fairfield and New Haven counties who utilize YNHHS providers. In addition, accessing the IRU facility in Milford will be significantly less burdensome for patients and families. MH offers ample on-site free parking which is not available in New Haven. The MH campus is much smaller and easier to navigate. The campus is also accessible by public transportation, specifically bus or train. The average length of stay in the IRU is approximately two weeks and these accessibility enhancements will be appreciated by families who visit during this two week timeframe.

- c. improve the cost effectiveness of health care delivery in the region.

Response

This proposal improves cost effectiveness of health care delivery in the region. Specifically, MH currently has available inpatient nursing unit space. YNHH has inpatient capacity needs that it cannot meet on its New Haven campuses. YNHH's utilization of available space at MH is much more cost effective than constructing new inpatient space in New Haven. In addition, the revenue to be paid to MH will help to offset fixed costs that exist in many departments that will support the IRU (e.g. housekeeping, security, dietary, etc.). For all these reasons, this relocation will improve cost effectiveness of health care delivery in the region. This proposal also eliminates the need for YNHH to construct new space to accommodate post-operative MSC patients.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

Response

Because the IRU in Milford will operate as a satellite of YNHH, it will continue to be incorporated into Epic, YNHH's electronic medical record. Epic serves as a powerful tool for the overall coordination of patient care and is used in both inpatient and outpatient settings within the YNHHS. All YNHHS providers who care for IRU patients will have access to patient medical records in the same way they would if the IRU was located in New Haven.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn. Gen. Stat. § 19a-639(a)(10))

Response

The IRU currently serves the Medicaid and indigent patients who meet admission criteria and will continue to do so in Milford. Medicaid patients, those with Medicaid as a primary or secondary payer have been treated to the IRU if they met the clinical admission requirements. As previously stated, YNHH will provide intra-facility (facilities owned or operated by YNHH) patient transport for any patient being discharged from the YNHH hospital and admitted to the IRU in Milford. Public transportation is available to reach MH either by bus or train for patient families.

12. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn. Gen. Stat. § 19a-639(a)(12))

Response

Not applicable, this proposal does not fail to provide and does not reduce access to services for Medicaid recipients or indigent persons. Please refer to the response to question 11.

13. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Response

There will be no change to charges or reimbursement associated with the relocation of IRU services.

Financial Information

§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the application," (Conn. Gen. Stat. § 19a-639(a)(4))

14. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

Response

The impact of this proposal on the financial strength of the state's health care system will be positive. Please refer to responses to questions 1 and 9(c).

15. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

Response

Please refer to OHCA Table 3 for a final version of all capital expenditures. A description of the construction is provided below.

Construction Description

Beginning in late 2014, demolition of the MH's 2nd floor Memorial II West inpatient unit began. The IRU at MH will consist of 24 beds in 21 patient rooms (3 semi private, 18 private), new staff areas, work stations, a therapy gym, occupational therapy room, office space and storage. The unit is serviced by three elevators, two visitor and one patient service related. Many of the existing walls were removed, and abatement completed, in addition all patient room bathrooms were expanded. Mechanical support systems including oxygen, suction, and nurse call are being upgraded. Patient rooms will receive all new furniture and fixtures. A large gym area will be created and have all new equipment to treat a variety of rehabilitation needs. The décor and signage of the unit will be representative of YNHH, separate and distinct from the MH units.

Attachment VIII contains copies of the existing and proposed floor plans.

16. 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

YNHH will fund the capital with operating funds.

17. Include as an attachment:

- a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

Response

YNHH has previously submitted its FY 2014 audited financial statements to OHCA.

- b. a complete **Financial Worksheet A (not-for-profit entity) or B (for-profit entity)**, available on OHCA's website under "**OHCA Forms**," providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.

Response

Financial Worksheet A has been completed and can be found in Attachment IX.

18. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

Response

OHCA Table 4 has been completed utilizing the information reported in the attached Financial Worksheet.

19. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

Response

Assumptions used in developing the financial projections reported in the Financial Worksheet have been provided in Attachment X.

20. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

Response

There are projected incremental losses from operations in FY 2015 and 2016. The losses in FY 2015 are due to the fact that the unit in Milford will only have revenue for a 4 month time frame (opening June 2015) but YNHH has to incur expenses associated with the relocation and renovation of the unit. In addition, the existing IRU unit on the Chapel Street campus will be closed for a time in order to prepare it for use by the MSC. Losses in FY 2016 are essentially due to depreciation costs and therefore the financial impact is basically break-even on a cash basis.

21. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Response

The minimum number of IRU discharges required to show an incremental gain from operations in each projected fiscal year are summarized below:

FY	Minimum Number of IRU Discharges to Show Incremental Gain from Operations
2015	122
2016	505
2017	N/A
2018	N/A

Utilization

*§ "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;"
(Conn. Gen. Stat. § 19a-639(a)(6))*

22. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current

fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

Response

OHCA Tables 5 and 6 have been completed. Please note that in FY 2012 the unit was operated by the Hospital of Saint Raphael. One of the physiatrists left in early 2013 and this limited the unit's ability to care for as many patients. Recruitment efforts were extensive and difficult. YNHH was unable to recruit a physiatrist until late summer in 2014. The added physician coverage will permit census growth.

23. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Tables 4 and 5.

Response

Assumptions used in the derivation/calculation of the projected service volume are provided below.

Volume increases for the IRU are projected due to the following factors:

- **Physician staffing is sufficient to grow the average daily census;**
- **YNHH's MSC will attract new patients, some of which will require IRU services;**
- **Milford Hospital's orthopedic unit is expected to refer to the IRU; and**
- **The growing and aging population will increase the demand for IRU services.**

24. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

Response

The current and projected patient population mix by payer has been provided in OHCA Table 7. The projected payer mix is expected to remain the same. Please note that approximately a dozen patients shown in the Medicare category also have Medicaid (as a secondary payer).

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;"
(Conn.Gen.Stat. § 19a-639(a)(7))

25. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

Response

Please refer to the response to questions 8(a) and 8(e).

26. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed FY. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

Response

OHCA Table 8 has been completed and includes a breakdown of utilization by town for the most recently completed FY.

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))

27. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID, address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

Response

OCHA Table 9 has been completed to identify existing providers in the service area.

28. Describe the effect of the proposal on these existing providers.

Response

There will be no impact on existing providers. This proposal involves the relocation of an existing unit from New Haven to Milford. Projected growth is based on increased volume within the YNHHS and population growth.

29. Describe the existing referral patterns in the area served by the proposal.

Response

Referrals to the IRU are generally made by the discharge planning staff and attending physician caring for a patient during an acute care hospital admission. If additional rehabilitation is required and the patient can tolerate at least 3 hours of therapy per day, a referral is made to an IRU facility. YNHH's IRU is frequently referred to by YNHH discharge planning staff and attending physicians, however, the unit also receives referrals from other area hospitals.

30. Explain how current referral patterns will be affected by the proposal.

Response

Current referral patterns are expected to be maintained. Once the unit relocates to MH, it is expected that MH's orthopedic unit will refer patients to the unit more frequently.

§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))

31. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

Response

The proposal will not result in any unnecessary duplication of services as it represents relocation of an existing service.

§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. . ." (Conn.Gen.Stat. § 19a-639(a)(11))

32. How will the proposal impact the diversity of health care providers and patient choice or reduce competition in the geographic region?

Response

Not applicable. This proposal represents a relocation of existing service. There will be no reduction in patient choice or reduce competition in the geographic area.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Inpatient Rehabilitation Service	1450 Chapel Street, New Haven	Patients in need of rehabilitation services after acute hospitalization	24 hours per day, 7 days per week	Relocation from New Haven to Milford

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TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
New Haven	20% of volume
Hamden	10%
East Haven	10%
West Haven	10%
North Haven	5%
Orange	5%
Milford	5% as well as new location will improve access for Milford area residents
Wallingford	4%
North Branford	4%
Branford	3%
Guilford	3%

* Village or place names are not acceptable. Towns are included above because they represent the top 80% of volume in FY 2014.

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**TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging)	1,687,035
Land/Building Purchase*	0
Construction/Renovation**	3,286,700
Land/Building Purchase*	0
Other (contingency, salaries, prof fees, misc)****	724,900
Total Capital Expenditure (TCE)	5,698,635
Lease (Medical, Non-medical Imaging)***	
Total Capital Cost (TCO)	
Total Project Cost (TCE+TCO)	5,698,635

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

**** Other includes contingency, salaries, professional fees, signage, moving costs.

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**TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES**

	FY 2015	FY 2016	FY 2017
Revenue from Operations	\$699,753	\$11,420,280	\$16,097,076
Total Operating Expenses	\$3,543,654	\$12,073,156	\$14,651,875
Gain/Loss from Operations	(\$2,843,901)	(\$652,876)	\$1,445,201

* Fill in years using those reported in the Financial Worksheet attached.

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**TABLE 5
HISTORICAL UTILIZATION BY SERVICE**

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2012	FY 2013	FY 2014	FY 2015
IRU Discharges	390	257	197	221 (annualized)
Total	390	257	197	221

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.
 ** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
 *** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 6
PROJECTED UTILIZATION BY SERVICE**

Service*	Projected Volume		
	FY 2015	FY 2016	FY 2017
IRU Discharges	221	339	388
Total	221	339	388

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
 ** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX – IRU ONLY**

Payer	Current FY 2015		Projected					
	Discharges ***	%	FY 2016		FY 2017		FY 2018	
			Discharges ***	%	Discharges ***	%	Discharges ***	%
Medicare*	159	72.08%	244	72.08%	279	72.08%	297	72.08%
Medicaid*	1	0.51%	2	0.51%	2	0.51%	2	0.51%
CHAMPUS & TriCare								
Total	160	72.59%	246	72.59%	281	72.59%	299	72.59%

Payer	Current FY 2015		Projected					
	Discharges ***	%	FY 2016		FY 2017		FY 2018	
			Discharges ***	%	Discharges ***	%	Discharges ***	%
Government								
Commercial Insurers	58	26.4%	90	26.4%	102	26.4%	109	26.4%
Uninsured								
Workers Compensation	2	1.02%	3	1.02%	4	1.02%	4	1.02%
Total Non-Government	60	27.41%	93	27.41%	106	27.41%	113	27.41%
Total Payer Mix	221	100%	339	100%	388	100%	412	100%

- * Includes managed care activity.
- ** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.
- *** Slight differences due to rounding

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TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2014 IRU Discharges
New Haven	34
Hamden	21
East Haven	19
West Haven	19
North Haven	10
Orange	9
Milford	9
Wallingford	7
N. Branford	7
Guilford	5
Madison	4
Woodbridge	4
Other	46
Total	197

- * List inpatient/outpatient/ED volumes separately, if applicable
- ** Fill in year if the time period reported is not *identical* to the fiscal year reported on pg. 2 of the application; provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization**
St. Vincent's Medical Center	IRU (10 beds)	1396751616	2800 Main Street, Bridgeport, CT	24/7	32
Bridgeport Hospital	IRU (16 beds)	1649260845	267 Grant Street, Bridgeport	24/7	58
Norwalk Hospital	IRU (12 beds)	1649263880	34 Maple Street, Norwalk	24/7	24
Stamford Hospital	IRU (17 beds)	1356331425	30 Shelburne Road, Stamford	24/7	73

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

** Current utilization based on available CHIME discharge data for DRGs 945 and 946 for FY 2015 (October and November).

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Supplemental CON Application Form
Termination of a Service
Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15)

Applicant: Yale-New Haven Hospital

**Project Name: Relocation of Inpatient Rehabilitation Service from
New Haven to Milford, Connecticut**

2. Project Description: Service Termination

a. Please provide

- i. a description of the history of the services proposed for termination, including when they commenced ,

Response

The IRU commenced service on May 5, 1995 under the license of the Hospital of Saint Raphael. This service became part of YNHH through its acquisition of the Saint Raphael Healthcare System effective September 12, 2012.

- ii. whether CON authorization was received and,

Response

YNHH staff are unable to locate a CON application and therefore are unsure whether one was required at the time the unit opened in 1995 by the Hospital of Saint Raphael.

- iii. if CON authorization was required, the docket number for that approval.

Response

Not applicable. See the response to question 1(a) (ii).

- b. 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

As stated throughout the main CON application, YNHH is not terminating the IRU service, but relocating it from New Haven (Chapel Street campus) to leased space at MH. The rationale for this relocation is summarized below.

YNHH plans to relocate the IRU to leased space in MH's main hospital building, located at 300 Seaside Avenue. YNHH will continue to operate, staff and bill for IRU services provided in the Milford location. The IRU in Milford will operate as a YNHH satellite location, using existing YNHH licensed beds. It is important to stress that the IRU in the Milford location will provide the same services to the same patients by the same staff, just at a different physical location.

The impetus for this relocation is to address physical space constraints on YNHH's New Haven campus and create needed post-operative space for YNHH's Musculoskeletal Center (MSC) being established on the Chapel Street campus. The MSC brings together orthopedics, neurology, rheumatology, physiatry, pain management and podiatry. Physician office space for all of these specialty physicians will be located in one area on the Chapel Street campus. Rehabilitation therapies such as physical, occupational and speech therapy will also be located in the same area. Two existing operating rooms have been renovated and equipped to offer state-of-the art equipment for musculoskeletal surgeries. Musculoskeletal services will also be provided in existing outpatient locations including Guilford, Milford and two locations in New Haven. Inpatient

volume projections for the MSC require an additional inpatient nursing unit and there are no cost effective options on the New Haven campus. Services to be provided by the MSC are considered acute care services and therefore should be located with other related acute care services. The current IRU location is ideal for the MSC unit required. The proposal does not require any additional beds to be added to YNHH's license.

The IRU will be relocated to the second floor at MH's main hospital building. The unit is being renovated to house 24 beds, YNHH's current CMS certified beds. There will be some significant improvements to the unit's configuration and ambiance as compared with the current IRU in New Haven. A total of 18 private rooms will be available as compared to two (2) on the current unit. The unit will have new and pleasant furnishings. All needed support spaces, offices, a conference room, storage, etc. will be located on the same floor close to the unit. A rehabilitation gym will be located in close proximity to the unit.

- c. 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 on.

Response

The proposed relocation did require a vote of the Board of Directors and its resolution has already been referenced in the main CON application.

3. Termination's Impact on Patients and Provider Community

- a. For each provider to which the Applicant proposes transferring or referring clients, provide the below information for the last completed fiscal year and current fiscal year.

Response

Not applicable. YNHH is not proposing to transfer or refer clients to another provider.

Table A
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity	Utilization FY XX**	Utilization Current CFY***

* Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

** Fill in year and identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

- a. 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

Not applicable. There will be no displaced patients.

- b. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons.

Response

The IRU provides services to a specialized patient population based on Federal Regulations (42 CFR 412.29(b)(2)). As stated in the main CON application, federal regulations require that at least 60% of the inpatient rehabilitation patients have one of these 13 medical conditions:

- 1. Stroke;**
- 2. Spinal cord injury;**
- 3. Congenital deformity;**
- 4. Amputation;**
- 5. Major multiple trauma;**
- 6. Fracture of femur (hip fracture);**
- 7. Brain injury;**
- 8. Neurological disorders including (Multiple Sclerosis, Motor neuron diseases, Polyneuropathy, Muscular Dystrophy; and Parkinson's Disease);**
- 9. Burns;**
- 10. Arthritis conditions resulting in significant functional impairment;**
- 11. Systemic vasculidities resulting in significant functional impairment;**
- 12. Sever or advanced osteoarthritis; and**
- 13. Knee or hip joint replacement for bilateral joint, extreme obesity or age greater than 85.**

In addition to the diagnoses and conditions listed above, patients with complex rehabilitation and medical needs may also be admitted to an IRU if required and patients qualify. To qualify for Medicare coverage of IRU services, patients must be able to tolerate and benefit from at least 3 hours of therapy per day for at least five days per week. Many commercial payers have similar requirements.

The IRU has and will continue to be available to all patients, including Medicaid patients, who meet the clinical criteria for admission.

- c. Describe how clients will be notified about the termination and transfer to other providers.

Response

The community will be notified about the IRU relocation through a variety of mechanisms. The table below outlines the mechanisms that will be employed to notify key target audiences.

Inpatient Rehabilitation Unit Relocation to Milford Hospital: Marketing and Communications

OBJECTIVE Announce inpatient rehabilitation unit moving from Yale-New Haven Hospital Saint Raphael Campus to Milford Hospital. The inpatient rehabilitation unit will be operated by YNHH.

Initiative	Description	Audience	Target Date
Media Release	Announce relocation to local media	Media and General Public	TBD
Internal Communications	Bulletin (YNHH Employee Newsletter), Medical Staff Bulletin (YNHH Medical Staff), NEMG CEO update (Online Physician Newsletter for Northeast Medical Group)	YNHH, YMG (employees and medical staff)	TBD
External Communications	Advancing Care (YNHH online community newsletter, Milford Senior Center newsletter)	Consumer	TBD
Brochure	Outline services; available to MDs, care coordinators/social workers/families	Physicians/Consumers	TBD
Social Media	Facebook/Twitter	Consumer	TBD
Webpage	Update on Rehabilitation services page on YNHH.org.	Consumer	TBD
Paid Advertising	Execute print advertising campaign in local newspapers and magazines	Consumer	TBD
Opening Event	Host formal ribbon-cutting ceremony inviting local community	Employees YNHH/Consumers	TBD

- d. For DMHAS-funded programs only, attach 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. The IRU is not a DMHAS-funded program

ATTACHMENTS

Attachment I – Redacted Executive Committee Resolution

REDACTED COPY**YALE-NEW HAVEN HOSPITAL****EXECUTIVE COMMITTEE OF THE
BOARD OF TRUSTEES****RESOLUTIONS RELATING TO THE APPROVAL OF THE TERMS FOR THE
DEVELOPMENT OF A YNHH REHABILITATION UNIT LOCATED WITHIN
MILFORD HOSPITAL**

July 11, 2014

WHEREAS, Yale-New Haven Hospital (the "Hospital,") has determined that the establishment of a satellite inpatient rehabilitation unit ("IRU") will contribute toward improved quality of life for patients who have experienced debilitating conditions;

WHEREAS, Yale-New Haven Health Services Corporation and the Hospital (collectively, "YNHHS") recognize the exceptional care that is provided at Milford Hospital and the quality of Milford Hospital's facilities, and believe that well-structured partnerships between healthcare providers, such as YNHHS and Milford Hospital, will position delivery systems to perform optimally in the current healthcare environment;

WHEREAS, a strategic partnership between Milford Hospital and YNHHS, beginning with the development of a Yale-New Haven Hospital satellite inpatient rehabilitation unit located within Milford Hospital (the "Proposed Transaction"),

will allow the Hospital to utilize resources available at Milford Hospital and Milford Hospital to preserve its independence, and will provide a unique opportunity to reduce costs, deliver better support for patients and their family members, and create a regional resource to accommodate the needs of patients from New Haven, Milford, and the other communities served by Yale New Haven Health System affiliates;

WHEREAS, The Executive Committee of the Board of Trustees is authorized pursuant to Section 5.4(a) of the Hospital's Bylaws to exercise all such powers of the Board of Trustees in the intervals between meetings of the Board of Trustees; and

WHEREAS, in furtherance of the YNHHS's goals, the Board of Trustees has determined that it is in the best interest of the Hospital to enter into a letter of intent with Milford Hospital to conduct exclusive negotiations regarding the Proposed Transaction

and to enter into a definitive agreement with Milford Hospital with respect to the Proposed Transaction (the "IRU Definitive Agreement"), pursuant to the terms set forth in Exhibit A.

THEREFORE, BE IT RESOLVED, as follows:

Section 1. The Board of Trustees hereby authorizes the Hospital to enter into the

IRU Definitive Agreement with Milford Hospital, each substantially consistent

REDACTED COPY

with the terms set forth in Exhibit A, and as more fully described in the materials presented to the Board.

Section 2. The Board of Trustees hereby authorizes the Chief Executive Officer or the President of the Hospital to execute the IRU Definitive Agreement on behalf of the Hospital, and authorizes the Chief Executive Officer, President, Chief Financial Officer, and General Counsel to perform and take such other actions, including, without limitation, executing any other document or agreement required to consummate the Proposed Transaction, as may be necessary and proper to accomplish the intent and purposes expressed in these resolutions.

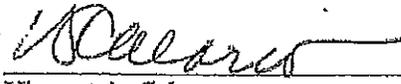
Section 3. Any and all actions previously taken by the officers or employees of the Hospital in connection with the foregoing resolutions are hereby ratified, approved and confirmed in all respects.

Section 4. The Executive Committee of the Board of Trustees hereby recommends that the foregoing resolutions be approved by Yale-New Haven Health Services Corporation.

CERTIFICATION

The undersigned secretary of Yale-New Haven Hospital hereby certifies that the foregoing resolution was adopted by the Executive Committee of the Board of Trustees and remains in full force and effect without amendment as of the date hereof.

Adopted this 11th day of July 2014.



Vincent A. Calarco
Secretary

REDACTED COPYIRU Definitive Agreement: Summary of Proposed Terms

- General:** YNHH will establish an IRU at Milford Hospital as a "hospital within a hospital." YNHH will transfer its existing IRU such that the beds will be re-located from YNHH's Saint Raphael campus in New Haven. The IRU shall be a YNHH service.
- Non-Physician Staffing:** YNHH will employ or engage all technical, nursing and other staff required for the efficient operation of the IRU, except with respect to purchased ancillary services as described below.
- Medical Direction:** YNHH will appoint a medical director to oversee services provided at the IRU and be responsible for all clinical oversight of the IRU.
- Space and Equipment:** YNHH will lease space at Milford Hospital for an initial term of five (5) years at a fair market rent agreed upon by the Parties for the IRU. Such space shall be reasonably acceptable to YNHH in light of regulatory requirements and be appropriate for the level and type of services to be provided within the unit, all as determined appropriate by YNHH.
- At the option of YNHH, the lease shall be renewable for two successive five-year terms, provided YNHH gives written notice of its intent to renew at least one year before the expiration date. Upon expiration of the lease, the premises shall revert to the exclusive use and control of Milford Hospital without any payment due YNHH.
- YNHH and Milford Hospital shall evaluate whether equipment necessary for the unit will be provided by Milford Hospital under a fair market value lease to YNHH or independently procured by YNHH.
- Financial Terms:** YNHH will bill, collect and retain receipts for services provided at the IRU.
- Subject to confirmation that the terms of the arrangement are consistent with fair market value, YNHH will pay an annual fair market value rental fee (estimated at \$ annually),
- for use of the beds including: beds, space, parking, facilities, housekeeping, utilities, security, engineering, admissions, and telecommunications.
- YNHH will purchase from Milford Hospital mutually agreed to ancillary services, such as pharmacy, laboratory, physical therapy, occupational therapy, radiology and special procedures within appropriate quality, safety and service parameters at a per diem rate per occupied bed. This rate shall be determined by a Fair Market Value analysis. Assuming a 90% occupancy rate, the total payment for such services is estimated at \$ annually.
- YNHH will make and pay for the required capital investments to the unit. The configuration and changes will be mutually agreed to with Milford Hospital leadership.

Attachment II – Documentation of Non-Profit Status

Internal Revenue Service

Department of the Treasury

District
Director

P.O. Box 9107

JFK Federal Bldg., Boston, Mass. 02203

Yale-New Haven Hospital Inc.
789 Howard Avenue
New Haven, Ct. 06504

Person to Contact: Daniel T. Valenzano

Telephone Number: (617) 223-1442

Refer Reply to: EO: Processing Unit

Date: JUL 10 1979

Name of Organization: Same

Gentlemen:

This is in reply to your recent letter requesting a copy of an exemption letter for the above-named organization.

Due to our records retention program, a copy of the original letter is not available.

However, records in this office show that a determination letter was issued in November 1966 ruling that the organization was exempt from Federal Income Tax under Section (now) 501(c)(3) of the Internal Revenue Code of 1954.

However, records in this office show that the organization is exempt under Section (now) of the Internal Revenue Code as part of a group ruling issued to _____

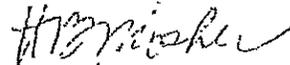
Further, the organization is not a private foundation because it is an organization described under Section 170(b)(1)(a)(vi) and

509(a)(1). This ruling remains in effect as long as there are no changes in the character, purposes, or method of operation of the organization.

I trust the foregoing information will serve your purpose.

If you have any questions, you may contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,



District Director

**Attachment III – CMS Letter for Inpatient Rehabilitation Unit
Bed Increase**

PROVIDER TIE-IN NOTICE

DATE
September 30, 2014

(Addition, Deletion or Correction to the Intermediary List of Providers)

Note: Intermediary should report any items regarding correction to the Health Insurance Regional Office.

I. IDENTIFYING INFORMATION (Complete in all cases)

A. NAME OF PROVIDER <i>Yale-New Haven Hospital</i>	B. PROVIDER NUMBER <i>07-0022</i> <i>07-T022</i>
20 York Street, New Haven, CT 06504	D. EFFECTIVE DATE OF CERTIFICATION

II. NEW PROVIDER CERTIFICATION

A. FISCAL YEAR ENDING DATE	B. AUTHORIZED INTERMEDIARY <i>National Government Services, Inc (NGS)</i>	C. INTERMEDIARY NUMBER <i>13101</i>
----------------------------	--	--

WHERE PROVIDER CERTIFICATION REQUIRED BECAUSE OF A CHANGE IN OWNERSHIP: ALSO COMPLETE THE FOLLOWING

D. EFFECTIVE DATE OF CHANGE OF OWNERSHIP (CHOW)	E. FACILITY'S NAME AND PROVIDER NUMBER PRIOR TO CHANGE OF OWNERSHIP (Write "Unchanged" if applicable)	F. CERTIFICATION DATE OF PREVIOUS OWNER
G. INTERMEDIARY FOR PREVIOUS OWNER (If same as item IIb write "Unchanged")		H. EFFECTIVE DATE OF INTERMEDIARY CHANGE (Complete where IIb and IIg differ)

III. CHANGE OF INTERMEDIARY

A. OUTGOING INTERMEDIARY NUMBER	B. OUTGOING INTERMEDIARY NAME	C. PROVIDER'S FISCAL YEAR END DATE
D. INCOMING INTERMEDIARY NUMBER	E. INCOMING INTERMEDIARY NAME	F. EFFECTIVE DATE OF CHANGE OF INTERMEDIARY

IV. TERMINATIONS

A. CHECK ONE <input type="checkbox"/> VOLUNTARY <input type="checkbox"/> INVOLUNTARY	B. EFFECTIVE DATE OF TERMINATION	C. SERVICING INTERMEDIARY	D. INTERMEDIARY NUMBER
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V. REMARKS (If this notice corrects a previous notice, indicate the date of the notice and the item(s) reported incorrectly)

Yale-New Haven Hospital has increased their PPS excluded Inpatient Rehabilitation Unit (07-T022) from 18 beds to 24 beds; effective, October 18, 2014

Please see attached CMS approval notice

AUTHORIZING OFFICER <i>Kathy Mackin</i>	TITLE <i>Health Insurance Specialists, Survey Branch</i>	REGIONAL OFFICE REGION
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**Attachment IV – CMS Inpatient Rehabilitation Facility
Coverage Criteria**

100 - Treatment for Infertility

(Rev. 1, 10-01-03)

A3-3101.13

Effective for services rendered on or after January 15, 1980, reasonable and necessary services associated with treatment for infertility are covered under Medicare. Like pregnancy (see §80 above), infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally would be expected to be fertile to seek medical consultation and treatment. Contractors should coordinate with QIOs to see that utilization guidelines are established for this treatment if inappropriate utilization or abuse is suspected.

110 - Inpatient Rehabilitation Facility (IRF) Services

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR §§412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR §412.23(b)(2)(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, see

Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care.

110.1 - Documentation Requirements

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

110.1.1 - Required Preadmission Screening

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in this section. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified and qualified to perform the evaluation within their scopes of practice and training. Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information. The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not on how the process is organized.

The "rehabilitation physician" need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician".

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's medical record at the IRF.

"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient's admission to the IRF.

110.1.2 - Required Post-Admission Physician Evaluation (Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician. The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in section 110.1.3). The post-

admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

What to do if there are differences between the preadmission screening and the post-admission physician evaluation (within the first 24 hours of admission to the IRF):

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient since the clinicians fully expect the patient to be able to participate in the intensive rehabilitation program the next day. Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either, for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the 3rd day following the patient's admission to the IRF (considering the day of admission to be the 1st day) are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim for not meeting the criteria in section 110.2 of this chapter, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case mix group (CMG) for IRF patient stays of 3 days or less.

110.1.3 - Required Individualized Overall Plan of Care
(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first 4 days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

110.1.4 - Required Admission Orders
(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

110.1.5 - Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time. The patient need not be expected to achieve complete independence in the domain of self-care nor be

expected to return to his or her prior level of functioning in order to meet this standard.

4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.

110.2.1 - Multiple Therapy Disciplines

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

110.2.2 - Intensive Level of Rehabilitation Services

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a "rule of thumb" for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to

an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or compromise the patient's safety. See below for a brief exceptions policy for temporary and unexpected events.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

Brief Exceptions Policy—While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

110.2.3 - Ability to Actively Participate in Intensive Rehabilitation Therapy Program

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

The information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program that is defined in section 110.2.2.

110.2.4 - Physician Supervision

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least 3 times per week. The required rehabilitation physician visits must be documented in the patient's medical record at the IRF.

110.2.5 - Interdisciplinary Team Approach to the Delivery of Care

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through

periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals (as defined below).

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals;
- Considering possible resolutions to any problems that could impede progress towards the goals;
- Reassessing the validity of the rehabilitation goals previously established; and
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the

infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. Documentation of each team conference must include the names and professional designations of the participants in the team conference. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

110.3 - Definition of Measurable Improvement

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care or return to his or her prior level of functioning. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in section 110.2.2). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

Attachment V – YNHH DPH License

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0044

General Hospital

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

Yale-New Haven Hospital, Inc. of New Haven, CT d/b/a Yale-New Haven Hospital, Inc. is hereby licensed to maintain and operate a General Hospital.

Yale-New Haven Hospital, Inc. is located at 20 York Street, New Haven, CT 06510-3220.

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

134 Bassinets

1407 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time.

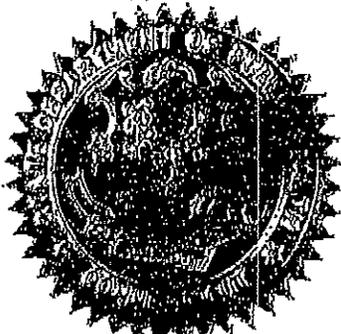
Dated at Hartford, Connecticut, October 1, 2013.

SATELLITES

Hill Regional Career High School, 140 Legion Avenue, New Haven, CT
 Branford High School Based Health Center, 145 East Main Street, Branford, CT
 Walsh Middle School, 185 Danforth Road, Branford, CT
 James Hillhouse High School Based Health Center, 480 Sherman Parkway, New Haven, CT
 Weller Building, 424 George Street, New Haven, CT
 Yale-New Haven Psychiatric Hospital, 184 Liberty Street, New Haven, CT
 Yale-New Haven Shovelus Medical Center, 111 Oosoo Lane, Guilford, CT
 Pediatric Dentistry Center, 1 Long Wharf Drive, New Haven, CT
 YNHASC Temple Surgical Center, 60 Temple Street, New Haven, CT
 YNHASC Women's Surgical Center, 40 Temple Street, New Haven, CT
 Mauro-Sheridan School Based Health Center, 191 Fountain Street, New Haven, CT
 Yale-New Haven Hospital Dental Center, 2550 Dixwell Avenue, Hamden, CT
 Murphy School Based Health Center, 14 Bushy Plain Road, Branford, CT
 YNHCH at Bridgeport, 347 Great Street, 6th Floor, Bridgeport, CT
 Pediatric Primary Care Center, 226 Mill Hill Avenue, Bridgeport, CT
 Yale-New Haven Hospital-Saint Raphael Campus, 1450 Chapel Street, New Haven, CT
 Adolescent Day Hospital, 646 George Street, New Haven, CT
 Psychiatric Day Hospital, 1284 Chapel Street, New Haven, CT
 Children's Psychiatric Day Hospital, 1450 Chapel Street, New Haven, CT
 Elder Care Clinic, Abruzzo Clinic, 26 Auster Street, New Haven, CT
 Elder Care Clinic/Tower One, 16 Tower Lane, New Haven, CT
 Elder Care Clinic/Casa Opium, 131 Sylvan Avenue, New Haven, CT
 Elder Care Clinic/Edith Johnson Tower, 111 Bristol Street, New Haven, CT
 Adult Psychiatric ER and Continuing Care, 1294 Chapel Street, New Haven, CT
 Elder Care Clinic/Sunside, 280 Oak Street, West Haven, CT
 Troop Magnet Academy School-Based Health Center, 259 Edge-wood Avenue, New Haven, CT
 Adult FHE, 1100 Summer Avenue, Hamden, CT
 Project MotherCare @Whitney, 674 Washington Avenue, West Haven, CT
 Barnard Environmental Studies Magnet School, 170 Dethy Avenue, New Haven, CT
 Project Edeycare, 2080 Whitney Avenue, Suite 150, Hamden, CT
 Shoreline Child and Adolescent Mental Health Services, 24 Business Park Drive, Branford, CT

License Revised to Reflect:

*Removed (1) Satellite effective 10/3/13



Jewel Mullen, MD

Jewel Mullen, MD, MPH, MPA
 Commissioner

Attachment VI – Curriculum Vitae

MARNA PARKE BORGSTROM

Home: 458 Three Mile Course
 Guilford, Ct. 06437
 (203) 453-8782

Business: Yale-New Haven Hospital
 20 York Street
 New Haven, CT 06510
 (203) 688-2608

EDUCATION

- 1977-1979 Yale University School of Medicine
 Department of Epidemiology and Public Health
 Program in Hospital Administration, M.P.H.
- 1972-1976 Stanford University
 Bachelor of Arts in Human Biology awarded June, 1976

EXPERIENCE

2005-Present President and Chief Executive Officer: Yale New Haven Health System (YNHHS)

Yale New Haven Health System is a regional, integrated health care delivery system composed of three local health care delivery networks, as well as a physician foundation, Northeast Medical Group. Anchored by Yale-New Haven Hospital, including its York and Chapel Street campuses, the Yale-New Haven Children's Hospital, and the Yale-New Haven Psychiatric Hospital totaling 1517-beds, the System includes a Bridgeport network led by the 425-bed Bridgeport Hospital and a Greenwich network anchored by 180-bed Greenwich Hospital. Northeast Medical Group employs 400 physicians.

Feb. 2012 - Present Chief Executive Officer: Yale-New Haven Hospital and Delivery Network (YNHH)

2005-Feb. 2012 President and Chief Executive Officer: Yale-New Haven Hospital and Delivery Network (YNHH)

Yale-New Haven, a private not-for-profit 1008-bed hospital founded in 1826. It serves as the primary teaching hospital for the Yale University School of Medicine and provides primary through tertiary and quaternary services.

1993-2005 Executive Vice President & Chief Operating Officer: Yale-New Haven Hospital
Executive Vice President and Secretary: Yale-New Haven Health Services Corporation

Responsible for New Haven Delivery Network operations including Yale-New Haven Hospital operations, finance, human resources and planning and marketing; and Yale-New Haven Ambulatory Services Corporation, which operates two independent surgery centers and a large, full-service radiology business in New Haven and Guilford. Served as the senior Hospital interface for Yale School of Medicine operational issues.

Represented the YNHH Delivery Network in all Health System strategic and operational activities.

1992-1993 Senior Vice President, Administration: Yale-New Haven Hospital
Senior Vice President and Secretary: Yale-New Haven Health Services Corporation

Responsible for Hospital strategic planning and marketing, facilities planning and design, risk management and medical-legal affairs, managed care contracting, Service Quality Improvement, Community Relations, Public Affairs and Engineering.

Project Executive for implementation of Yale-New Haven's \$156 million Facilities Renewal Project.

1985-1992 Vice President, Administration: Yale-New Haven Hospital

Responsible for Hospital strategic planning and marketing, facilities planning and design, risk management and medicolegal affairs, managed care contracting, Service Quality Improvement, Community Relations, Public Affairs and Engineering. Provided administrative leadership to Yale-New Haven Health Services Corporation corporate affairs and strategic initiatives.

1984-1985 Assistant Vice President: Yale-New Haven Hospital

Directed the development and implementation of annual Hospital business plan format derived from strategic plan. Completed \$6 million renovation of Hospital clinical laboratories. Represented Hospital on underwriting and eligibility and finance activities in malpractice insurance captive.

Dec. 1982-1984 Associate Administrator: Yale-New Haven Hospital

Responsible for Hospital planning activities, including Strategic Planning and general facilities planning and related capital budget activities. Also responsible for Clinical Laboratories (\$23 million gross revenue and \$11 million expense) and Risk Management and Medicolegal Affairs.

Dec. 1980-Nov. 1982 Assistant Administrator: Yale-New Haven Hospital

Responsible for planning and implementing \$11 million renovation program done in concert with major facility replacement project, and for planning and overseeing the move of five major departments and three clinical services (including 80 ICU beds) to a new \$73 million facility, during the Spring of 1982. Prepared and presented to the Health Systems Agency and Commission on Hospitals and Health Care, three Certificates of Need; all were approved. Also responsible for Hospital space planning and management, and provided general staff support to the Executive Vice President.

Jan. 1980-Dec. 1980 Administrative Associate: Yale-New Haven Hospital

Provided general staff support to Executive Vice President. Major activities included employee fundraising and campaign to support \$73 million facility replacement and renovations program (50% of Hospital employees contributed almost \$500,000) and preparation of capital and operating budget materials.

Jan. 1979-Dec. 1980 Administrative Resident: Yale-New Haven Hospital

Summer 1978 Administrative Intern: Alexian Brothers Hospital, San Jose, California

PROFESSIONAL AWARDS:

1992 Up and Comers Award - Sponsored by Modern Healthcare and 3M Health Systems
 Women In Leadership Award, 1993 - YWCA
 Junior Achievement Hall of Fame, 1998
 20 Noteworthy Women, New Haven Business Times, 1999
 Gateway Community College Hall of Fame, 2002

Hill Health Center Leadership Award, 2006
 Connecticut Women in Leadership, 2009 (Women & Families Center Award)
 Girl Scouts of Connecticut Women of Achievement Award, 2010
 Anti-Defamation League Torch of Liberty Award, 2010
 Business New Haven's Business Person of the Year, 2010
 American Hospital Association 2010 Grassroots Champion Award
 Doctor of Humane Letters, Quinnipiac University, 2011
 Greater New Haven Chamber of Commerce Community Leadership Award, 2012
 United Way Alexis de Tocqueville Herbert H. Pearce Award, 2012

MAJOR PROFESSIONAL AFFILIATIONS, BOARDS AND ACTIVITIES:

Yale-New Haven Hospital Board of Trustees (1994 – present)
 Yale New Haven Health System Board of Directors (2005 - present)
 The Connecticut Hospital Association (2006 – present) Immediate Past Chair, Board of Trustees and member of Executive Committee
 VHA, Inc. (Dallas, Texas), Board of Directors (2009 -)
 Council of Teaching Hospitals Administrative Board (2008 - present) Chair as of 11/12
 Association of American Medical Colleges Board of Directors, 2010-present
 Coalition to Protect America's Health, 2011-present
 Healthcare Executives Study Society (2006-present)
 Fellow – American College of Healthcare Executives

University Appointments

Yale University – Lecturer, Yale School of Public Health, Department of Health Policy and Management.

PERSONAL:

Married: Eric N. Borgstrom (5/27/78)
 Children: Christopher (4/14/85) and Peter (8/4/89)

CURRICULUM VITAE

RICHARD D'AQUILA
282 Boston Post Road
Westbrook, CT 06498
Telephone: (860) 669-0871

PERSONAL DATA:

Married
U.S. Citizen
Birth Date: 6/29/55

BUSINESS ADDRESS:

Yale-New Haven Hospital
20 York Street
New Haven, CT 06510
Telephone: (203)-688-2606

PROFESSIONAL EXPERIENCE:

February, 2012

President and Chief Operating Officer
Yale-New Haven Hospital
Executive Vice President
Yale New Haven Health System

May, 2006 to
February, 2012

Executive Vice President and Chief Operating Officer
Yale-New Haven Hospital/Yale New Haven Health System

Organizational Profile

Yale New Haven Health System (YNHHS) is a 1597-bed delivery network formed in 1995 which consists of Yale-New Haven, Bridgeport and Greenwich Hospitals. YNHHS has revenues in excess of \$2.3 billion in FY '11 based on 90,000 discharges and 1.3 million outpatient visits. Yale-New Haven Hospital is a 1,008-bed tertiary referral medical center that includes the 201-bed Yale New Haven Children's Hospital and the 76-bed Yale New Haven Psychiatric Hospital. Both Yale New Haven Health System and Yale-New Haven Hospital are formally affiliated with Yale University School of Medicine.

Responsibilities

Overall responsibility for all aspects of day to day operations for Yale-New Haven Hospital (YNHH) and the senior network leader at the Yale New Haven Health System representing the YNHHS delivery network. Hospital leadership responsibilities include direct accountability for the senior leadership team, strategic planning, organizational performance, quality improvement, labor relations and human resources management, system integrations, external relations and service line development. Senior leadership and implementation responsibility for all aspects of the hospital's annual business (operating) plan. Senior level oversight of the hospital's facility plan including

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construction of a 112-bed, \$450 million Comprehensive Cancer Pavilion commencing construction in the fall of 2006.

August, 2000 to April, 2006

Senior Vice President/Chief Operating Officer
 New York Presbyterian Hospital/
 Weill Cornell Medical Center
 New York, New York

Organizational Profile

New York Presbyterian Hospital is a 2,369 bed Academic Medical Center created from the merger between the New York Hospital and the Presbyterian Hospital in the City of New York. The Weill Cornell Medical Center consists of an 880 bed acute care facility in Manhattan and the 239 bed Westchester Division campus in White Plains specializing in behavioral health.

Responsibilities

Overall responsibility for all aspects of day to day operations for the Weill Cornell Medical Center and the Westchester Division, a two campus Academic Medical Center of 1120 beds. Direct responsibility for a total operating expense budget in excess of \$450,000,000 and revenues of \$850,000,000. Senior leadership and implementation for all aspects of the Medical Center's operating plan including quaternary and tertiary service development, medical staff relations and recruitment, employee relations and labor strategy. System level member of the Corporate Management Team with involvement in strategic and facilities planning, service line development, information technology and performance improvement.

May 1992 to June 2000

Executive Vice President/Chief Operating Officer
 St. Vincent's Medical Center
 Bridgeport, Connecticut

President
 Vincentures, Inc.

President
 St. Vincent's Development Corporation, Inc.

Chief Operating Officer of 391 bed, university-affiliated acute care hospital and health system. President/CEO of affiliated subsidiaries with management responsibility at

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the Medical Center and corporate level. Medical Center responsibilities including day to day operations oversight for patient care services; support services and facilities planning and development. Corporate responsibilities including information systems, ambulatory network development, managed care contracting network oversight and real estate/satellite facility development.

January 1987-April 1992

President/CEO
Health Initiatives Corporation
Providence, Rhode Island

Chief Executive Officer of a consulting practice specializing in strategic planning, business development and project implementation assistance for acute care and specialty hospitals, state planning agencies and private investors. Specific responsibilities included:

- Practice Leadership
- Engagement Planning and Management
- Project Supervision and Control
- Client Interface
- Practice Marketing and Business Development

June 1984-December 1986

Vice President
The Mount Sinai Hospital Corporation
Hartford, Connecticut

June 1981-June 1984

**Vice President, Division of Planning
and Community Services**
The Mount Sinai Hospital
Hartford, Connecticut

June 1979-June 1981

Assistant Executive Director
The Mount Sinai Hospital
Hartford, Connecticut

January 1979-May 1979

Administrative Resident
The Mount Sinai Hospital
Hartford, Connecticut

OTHER APPOINTMENTS:

November 2000
To Present

Member, Board of Directors
Voluntary Hospitals of America/Metro New York
New Rochelle, New York

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- January 1995-
June 2000
- Member, Board of Directors**
Goodwill Industries
Bridgeport, Connecticut
- December 1993-
June 2000
- Founding Board Member**
Park City Primary Care Center
Bridgeport, Connecticut
- May, 1992-
June 2000
- Member, Board of Directors**
St. Vincent's Development Corporation
Vincentures, Inc.
Omicron, Inc.
Connecticut Health Enterprises
Bridgeport, Connecticut
- January 1992-
December 1994
- Member, Board of Directors**
Visiting Nurses Association of Fairfield County
Bridgeport, Connecticut
- January 1989-
December 1991
- Member, Board of Directors**
Easter Seal Society/Meeting Street Rehabilitation Center,
Inc. of Rhode Island
Providence, Rhode Island
- January 1980-
December 1989
- Member, Board of Directors**
Combined Hospitals Alcohol Program
Hartford, Connecticut
- September 1985-
December 1986
- President, Board of Directors**
Regional Alcohol and Drug Abuse Resources, Inc.
Hartford, Connecticut
- September 1981-
December 1986
- Adjunct Faculty/Lecturer**
University of Hartford, Barney School of Business and
Public Administration
West Hartford, Connecticut
- January 2001 -
Present
- Adjunct Faculty/Residency Preceptor and Lecturer**
Robert F. Wagner Graduate School of Public Service
New York University
New York, N.Y.
- December 2000 -
Present
- Adjunct Faculty/Lecturer**
Weill Medical College of Cornell University
Department of Public Health, New York
New York, N.Y.

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EDUCATION:

Yale University School of Medicine
Graduate Program in Hospital Administration
Academic Distinctions: Research Excellence Award (1979)
1979 Graduate

Central Connecticut State University
Bachelor of Arts: Economics/Business
Academic Distinctions: Omicron Delta Epsilon
Economics Honor Society
1977 Graduate

PROFESSIONAL AFFILIATIONS:

Fellow, American College of Health Care Executives
Yale Hospital Administration Alumni Association
Connecticut Hospital Association
Habitat of Greater New Haven

CURRICULUM VITAE

NAME: James M. Staten
BIRTHDATE: September 26, 1958
EDUCATION: 1980 – B.S. – Business / Economics / State University College of NY

Yale New Haven Health System (YNHHS) and Yale-New Haven Hospital (YNHH)

October 2000 - Present

Executive Vice President of Finance and Corporate Services, YNHHS
 Senior Vice President and CFO, YNHH

Yale New Haven Health system is a regional, integrated health care system composed of three regional health care delivery networks. The New Haven-based delivery system is anchored by Yale-New Haven Hospital, the Yale-New Haven Children's Hospital, and the Yale-New Haven Psychiatric Hospital, which total 944-beds. The system includes a Bridgeport-based delivery system led by the 425-bed Bridgeport Hospital and Greenwich-based delivery system anchored by 160-bed Greenwich Hospital. The System is also affiliated with the Westerly Hospital in Rhode Island. The Yale New Haven Health System has a formal affiliation with the Yale University School of Medicine, as does Yale-New Haven Hospital which serves as the Medical School's primary teaching hospital. System services include acute care hospitals, ambulatory surgery and outpatient diagnostic imaging centers, as well as primary care centers. In total, the System has 1,500 beds, 74,000 admissions, 10,000 employees, assets of \$1.6 billion, and annual net revenues of over \$1.4 billion.

Responsible for financial and corporate services of YNHHS including managed care, information systems, materials management, admitting/registration, and medical records, as well as all financial responsibilities such as accounting, budgeting, financial and operational reporting, tax, reimbursement, and treasury.

OTHER EMPLOYMENT

New York-Presbyterian Hospital (NYPH) and New York-Presbyterian Healthcare System (NYPHS)

July 1999 – October 2000 Senior Vice President of Finance

Responsible for assuring the financial viability of a \$3 billion Health System, including monitoring financial condition of approximately 15 corporately-controlled Sponsored/Member Hospitals and other healthcare related organizations. Report regularly to the NYPHS Board and NYPH Board Executive Committee on financial performance.

January 1997 - June 1999 Vice President of Financial Planning
 June 1993 - December 1996 Director of Financial Planning

Responsible for complete integration of financial planning at all Sponsored Hospital Members including NYPH and leading the financial group of approximately 70 professionals in performing budget, reimbursement, managed care contracting, decision support and business plan development functions.

James M. Staten

Ernst & Young

January 1991 - June 1993 Senior Manager - Consulting Services

Directed and coordinated Ernst & Young's New York State Reimbursement Consulting Services.

Pannell Kerr Forster

October 1980 - December 1990 Partner

Elected Partner in June 1990 after working 10 years in the firm's large healthcare practice as a certified public accountant. 11th Largest Public Accounting Firm in United States during late 1980s.

PROFESSIONAL MEMBERSHIPS

- American Institute of Certified Public Accountants (1982 - 1998)
- New York State Society of Certified Public Accountants (1982 - 1996)
 - Healthcare Committee (1988 - 1991)
 - Chairman of the Hospital Sub-Committee (1990/1991)
- Healthcare Financial Management Association (1984 - 1994)
 - Chairman of various Committees (1984 - 1994)
 - Trustee (1990/1991)
 - President Elect (1993/1994)
- Greater New York Hospital Association
 - Fiscal Policy Committee (1993 - 2000)
 - Managed Care Committee (1995 - 2000)
- Connecticut Hospital Association
 - Finance Committee (2000 - 2004)
 - Special Committee on Medicaid Reimbursement (2000 - 2004)
- Blue Ribbon Committee on the Future of Healthcare in Connecticut (2000 - 2003)

OTHER PROFESSIONAL ACTIVITIES

- Presenter at New Jersey Health Care Financing Authority on Medicare Payment System
- Presenter on Hospital Reimbursement Issues for the NYS Society of CPAs
- Presenter on Accounts Receivable Issues for the Connecticut Hospital Association
- Guest Speaker at NYU's graduate program in Hospital Administration on Healthcare Financing
- Guest speaker at Cornell University's Sloan Program in Health Services on Managed Care
- Presenter on Mergers and Acquisitions to New York State Hudson Valley HFMA
- Guest speaker at Chicago Municipal Bond Analysts Society on New York State Hospital Deregulation
- Guest speaker at Yale's School of Epidemiology and Public Management on Health Systems

Abe Lopman
Sr. Vice President Operation and Executive Director
Smilow Cancer Hospital

Abe Lopman is Sr. Vice President Operations and Executive Director of Smilow Cancer Hospital. Lopman's overall responsibility is for the Oncology Service Line of the Yale-New Haven Oncology program, neurosciences service line, behavioral health services and the development and execution of a musculoskeletal program and service line. This includes both day-to-day operations as well as strategic direction of these service lines. He is responsible for the development of seamless programs with the Yale School of Medicine and community practices. He led the development and implementation of a new 500,000 square foot cancer hospital opened in 2010 and established a statewide and regional cancer network. He served as the Chief Integration Officer in the implementation of the Hospital of St. Raphael acquisition.

Lopman joined Yale-New Haven after many years as the Executive Director of the Regional Care Network at the Memorial Sloan-Kettering Cancer Center in New York where he directed the strategic and daily operations of the Memorial network of cancer care facilities throughout the metropolitan area.

Prior to joining Memorial Sloan-Kettering, Lopman served as Vice President of Acute Care Operations at the Orlando Regional Healthcare system where he planned, built and operated the MD Anderson Cancer Center-Orlando. He has also held positions at MD Anderson Cancer Center in Houston and Montefiore Medical Center in New York.

Lopman earned his B.A. in Biological Sciences from City University of New York and an M.B.A. from the University of St. Thomas in Houston.

NYCAINE ANDERSON-PETERKIN, MD

81 Sentinel Hill Road Derby, CT 06418 ☎ 917 753-5329 ☉ Nycaine.Anderson-Peterkin@ynhh.org

SUMMARY: Compassionate and dedicated Board Certified Physiatrist with leadership and patient care experience in hospital and clinic settings who is able to provide comprehensive care to patients with a wide scope of conditions. Adept at communicating with patients and families and collaborating care with an interdisciplinary team.

SPECIALTY

Physical Medicine and Rehabilitation

POST GRADUATE TRAINING

Residency: The Mount Sinai Medical Center, New York, NY	7/2005-6/2008
Internal Medicine Internship: Staten Island University Hospital, Staten Island, NY	7/2008-6/2005

EDUCATION

Medical: Downstate College of Medicine, Brooklyn, NY: Medical Degree	9/2000-5/2004
Undergraduate: Wesleyan University, Middletown, CT: Bachelor of Economics	9/1994-5/1998

CERTIFICATION

Board Certified American Board of Physical Medicine and Rehabilitation	2010-present
Connecticut State Medical License 049516	2011-present
Connecticut Controlled substance license	2011-present
Federal DEA License	2010-present

PROFESSIONAL AFFILIATIONS

American Academy Of Physical Medicine and Rehabilitation
American Medical Association

HONORS AND AWARDS

Award for Presentation American College of Sports Medicine Student Research Competition	2008
City Council Citation	2010

PROFESSIONAL EXPERIENCE

<i>Medical Director</i>	1/2013-Present
Attending physician	9/2011-12/2013

Yale New Haven Hospital Saint Raphael Campus Intensive Rehabilitation Unit

- Provide medical leadership and daily clinical management of an 18 bed rehabilitation unit.
- Provide inpatient consultations and manage flow of patient admissions
- Provide supervision to medical residents, APRN and physician
- Implement systems to maintain compliance with CMS guidelines
- Help to develop and support relationships with other clinical service lines.

Medical Director/President

Top Tier Physical Medicine and Rehabilitation, PC, Richmond Hill, NY	1/2009-5/2011
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- Oversaw the operations of the practice and supervised a staff of employees including; Physician assistants, physical therapists, administrative and clerical staff
- Evaluated, diagnosed and formulated treatment plans for workers' compensation and no fault patients

Physiatrist

United Cerebral Palsy of New York, New York, NY	1/2009-9/2009
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- Performed physiatric evaluations and devised treatment plans for adult consumers with developmental disabilities such as cerebral palsy at three Article 28 and Article 16 clinics throughout NY
- Supervised the treatment plans 19 clinicians (physical, occupational and speech therapists)

RESEARCH

Research Assistant	
"Medical Therapy of Prostatic Symptoms Trial", Yale University New Haven, CT	1998-2000
"Osteoporosis in a Male Veteran Population" Brooklyn Veterans Hospital, Brooklyn, NY	2001

John L. Tarutis
 58 High Street
 Guilford, Connecticut 06437
 203-214-1063

Objective:

Management and development of exceptional health care facilities and health care systems.

Accomplishments:

Over fifteen years experience in the field of geriatric care as a licensed administrator, specializing in program development, and turn around projects.
 Over 20 years of management experience serving seniors in skilled nursing and assisted living centers.

- **Quality of Care:** Positive survey and quality indicator trends achieved and quality controls developed to maintain excellence. Achieved recognition for facility of the year.
- **Human Resources:** Experienced in policy development, handbooks and programs which have yielded sound personnel practices.
- **Fiscal Responsibility:** Developed many comprehensive facility budgets and implemented cost controls delivering high profit margins.
- **Employee Relations:** Motivated and energized personnel through various transitional situations. Successfully negotiated several collective bargaining agreements.
- **Sub-acute Care:** Management of high volume sub-acute centers which focused on rehabilitation and post operative care and recovery.
- **Dining Services:** Experienced in quality dining systems which deliver a pleasurable dining experience at reasonable expense.
- **Licensure:** Involved with various facility renovations and program licensures.
- **Medicare:** Revision and improvement of rehabilitation services and RUGS level performance. Thorough understanding of the drivers behind the Medicare rate system.
- **Medicaid:** Comprehensive knowledge of Medicaid system and cost center allocation.

Skills & Abilities

- **Innovation:** Ability to develop unique programs and approaches to problem solving.
- **Teamwork:** Recognized as a support to teams, peers and supervisors.
- **Consistency:** Application of consistent policies and fair approach to concerns.
- **Customer Satisfaction:** Creation of programming to achieve a high level of customer satisfaction.
- **Strategic Planning:** Experience in strategic planning and growth strategies, partnering with other providers or physician groups.

Education

Pursuing Masters of Health Administration – University of New Haven
 Bachelor of Science Business Administration, Quinnipiac College, Hamden, CT

Work Experience

September 2012 to Present: Executive Director Rehabilitation Services Yale New Haven Hospital
 July 2005 to September 2012: Assistant Vice President Rehabilitation Services
 Hospital of Saint Raphael
 Inpatient Therapy Services
 Inpatient Rehabilitation Unit (18 bed IRF)
 Sister Anne Virginie Grimes Health Center (120 bed SNF), New Haven CT
 2003- 2005: Administrator, Whitney Manor Rehabilitation Center, (150 bed SNF) Hamden, CT
 2001 - 2003: Executive Director, Laurel Gardens of Orange, Orange, CT
 1998 - 2001: Administrator, Harborside Healthcare Madison House, Madison, CT
 1993 - 1998: Administrator, Talmadge Park Convalescent Center, East Haven, CT
 1987 - 1993: Variety of department head level positions within nursing homes.

Associations

Connecticut Association of Not for Profit Facilities
 Connecticut Association of Health Care Facilities
 New Haven Chamber Health Care Council
 Long Term Care Financial Managers Association
 Appointed to Governor's Task Force- Long Stay Medicaid Patients
 OUPV Captain United States Merchant Marine
 Past Board Member Visiting Nurse Services Inc
 Past Board Member American College of Health Care Administrators
 Past President American College of Health Care Administrators

References

David Rosenblum, M.D., Medical Director, Gaylord Hospital 203-284-2800
 Gerard Kerins, M.D., Section Chief Geriatrics, Yale New Haven Hospital 203-789-3489
 Barbara Slobin R.N., Director of Nursing, Madison House 860-388-3101

Attachment VII – Letters of Support



MILFORD HOSPITAL

March 20, 2015

Hon. Janet M. Brancifort, MPH
Deputy Commissioner
Office of Health Care Access
Division of Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Yale-New Haven Hospital Inpatient Rehabilitation Unit (IRU)

Dear Deputy Commissioner Brancifort:

I am writing to wholeheartedly support Yale-New Haven Hospital's certificate of need application to relocate its 24-bed IRU to Milford Hospital. As OHCA is aware, the approval of this CON would authorize YNHH to relocate its IRU to Milford Hospital. This is essential for the survival of Milford Hospital as a healthcare provider to its community.

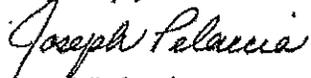
YNHH will transfer operations of its current IRU under its hospital license to a customized space at Milford Hospital. There will be no disruption or discontinuation of services that could negatively impact patient access at either facility. In fact, after the relocation, the same patients who would have been admitted to the IRU on YNHH's St. Raphael campus following an acute care stay will be transported to Milford and admitted to the IRU located at our hospital. Many family members, friends [and community physicians] caring for these patients will find it far more convenient to travel to Milford.

The relocation will improve the financial strength of both institutions. Not only does YNHH save on the cost of constructing new space to house an IRU, Milford Hospital gains much needed revenue from the lease payments. This revenue will assist Milford Hospital in providing acute care services to the community.

Collaborative arrangements like the one we are pursuing through the IRU relocation should be encouraged in today's health care environment. This arrangement fulfills many of the major goals of health reform by promoting quality and accessibility to care while efficiently using existing infrastructure and resources.

On behalf of Milford Hospital, its Board of Directors and the over 800 physicians, nurses and other health care workers it employs, we hope OHCA will grant prompt approval to this vitally important project.

Very truly yours,



Joseph Pelaccia
President & CEO

cc: Kimberly Martone, OHCA Director of Operations



March 20, 2015

Jewell Mullen, MD
Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
PO Box 340308
Hartford CT 06134

Dear Commissioner Mullen,

I am writing to express my support and encourage your approval of Yale-New Haven Hospital's Certificate of Need Application to relocate the Inpatient Rehabilitation Unit (IRU) to leased space within Milford Hospital (MH). It is important to stress that despite the relocation of the IRU to Milford, the unit will serve the same patients, provide the same services, by the same staff. The only difference will be the physical location. The IRU will be housed in renovated leased space at MH and will offer our patients improved patient privacy, with 18 private rooms, as well as an ambience that will support health and healing. The Milford location is easy to access from major highways and offers ample free parking. This will help to minimize stress and the burden for families visiting their loved one.

Our specialized team of caregivers will have a state-of-the-art unit to treat a variety of rehabilitation needs. The unit plays a vital role in the recovery of stroke victims, those injured by trauma, who have undergone spinal surgery, movement disorders and or total joint replacement.

Thank you in advance for your support.

Sincerely,


Nycaine Anderson Peterkin MD
Medical Director
Inpatient Rehabilitation Unit

20 York Street
New Haven, CT 06510-3202

Yale SCHOOL OF MEDICINE
Department of Neurology

March 20, 2015

Jewell Mullen, MD
 Commissioner
 Department of Public Health
 Office of Health Care Access
 410 Capitol Avenue, MS#13HCA
 PO Box 340308
 Hartford CT 06134

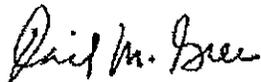
Dear Commissioner Mullen,

I am writing to express my support and encourage your approval of Yale-New Haven Hospital's Certificate of Need Application to relocate the Inpatient Rehabilitation Unit (IRU) to leased space within Milford Hospital (MH). It is important to stress that, despite the relocation of the IRU to Milford, the unit will serve the same patients and provide the same services, by the same staff who currently serve them. The only difference will be the physical location. The IRU will be housed in renovated leased space at MH, and will offer our patients improved patient privacy, with 18 private rooms, as well as an ambience that will support health and healing. The Milford location is easy to access from major highways and offers ample free parking. This will help to minimize the stress and burden for families visiting their loved ones.

Our specialized team of caregivers will have a state-of-the-art unit to treat a variety of rehabilitation needs. The unit plays a vital role in the recovery of victims of stroke or brain trauma, have undergone spinal surgery, or have movement disorders and or a total joint replacement.

Thank you in advance for your support.

Sincerely,



David M. Greer MD, MA, FCCM, FAHA, FNCS, FAAN, FANA

DAVID M. GREER, MD, MA, FCCM,
 FAHA, FNCS, FAAN

*Professor and Vice Chairman
 Department of Neurology*

*Dr. Harry M. Zimmerman and Dr. Nicholas
 and Viola Spinelli Endowed Chair*

Director, Stroke Service

Director of Medical Studies

PO Box 208018
 New Haven CT 06520-8018

T 203 785-5947

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medicine.yale.edu/neurology

courier

Lippard Laboratory
 for Clinical Investigation (LCI)

Room 912

15 York Street

New Haven CT 06510



Attachment VIII – Floor Plans

Attachment IX – Financial Worksheet A

Attachment X – Financial Assumptions

**YALE-NEW HAVEN HOSPITAL
Relocation of Inpatient Rehab Services at
Yale-New Haven Hospital to Milford Hospital
Yale-New Haven Hospital
Assumptions**

Net Revenue Rate Increases

	FY 2015	FY 2016	FY 2017
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%
2) Non-Government	0 - 2.0%	0 - 2.0%	0 - 2.0%

EXPENSES

	FY 2016	FY 2016	0	FY 2017
A. Salaries and Fringe Benefits	3.0%	3.0%		3.0%
B. Non-Salary				
1) Medical and Surgical Supplies	3.0%	3.0%		3.0%
2) Pharmacy and Solutions	3.0%	3.0%		3.0%
3) Malpractice Insurance	3.0%	3.0%		3.0%
4) Professional and Contracted Services	3.0%	3.0%		3.0%
5) All Other Expenses	3.0%	3.0%		3.0%

FTEs

1) Total estimated FTEs	<u>10,432</u>	<u>10,454</u>	<u>10,503</u>
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Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

October 30, 2014

VIA REGULAR & ELECTRONIC MAIL

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106

Re: Yale-New Haven Hospital
Inpatient Rehabilitation Unit at Milford Hospital

Dear Ms. Martone,

Our respective clients, Yale-New Haven Hospital (“YNHH”) and Milford Hospital (“MH”), have requested that we send this letter in follow-up to the October 10, 2014 discussion between YNHH’s representatives and OHCA staff regarding YNHH’s plan to relocate its inpatient rehabilitation unit (“IRU”) to leased space at MH. The purpose of this letter, which is not intended to be a CON Determination request, is to provide the agency with further background on a transaction that is vitally important to both organizations and allay any concerns OHCA may have that this arrangement results in a termination of services or otherwise requires CON approval.

Background

As OHCA is aware, the mandates of the Affordable Care Act and other changes in the health care industry are requiring hospitals and other providers to efficiently utilize resources, control costs and collaborate as never before. In this case, YNHH and MH have entered into an arrangement that achieves these goals for both institutions while, most importantly, also improving patient care.

YNHH currently operates a 24-bed IRU on the hospital’s Saint Raphael’s Campus (“SRC”). The IRU serves as a discharge placement for inpatients in need of rehabilitative care after an acute care stay. The purpose of the transaction is to allow YNHH to relocate the IRU from its current location to 15,000 square feet of leased space on MH’s main campus. Through what is essentially a real estate arrangement, YNHH can free up square footage on the SRC and effectively address physical space constraints that it faces providing non-IRU services in New Haven. At the same time, MH benefits by generating much-needed income from underutilized space on its main campus.

The IRU will operate using YNHH licensed beds and the patients will be YNHH patients. This proposal does not result in an increase in the number of licensed beds at YNHH. YNHH has sufficient unstaffed bed capacity to accommodate the IRU without adding any beds to its license. Nor will the proposal result in an increase in MH's licensed beds.

Professional services will be provided by YNHH clinical staff and IRU patients' records will be part of YNHH's electronic medical record system. Certain ancillary services will be provided by MH pursuant to a services agreement including: Imaging, diagnostic laboratory, pharmacy, respiratory therapy, and rapid response team services. The cost center for the YNHH IRU and billing for the service will remain unchanged with the relocation.

The patient population and payer mix for the YNHH IRU at Milford will be identical to the patient population and payer mix for the IRU at the SRC. As previously mentioned, the IRU is a referral service for patients who are discharged from an acute care setting. Patients come primarily from YNHH, although the program accepts patients from other hospitals as well. Currently, patients discharged from YNHH to the IRU are transported from an acute care floor on one of the New Haven campuses to an IRU bed located at the SRC. Going forward, these same exact patients will be discharged from acute care and transported (at no charge) to the IRU in Milford, similar to intra-facility transports between other YNHH locations (e.g., Shoreline Medical Center in Guilford to New Haven). In addition, any patients from other hospitals who would have been discharged and then transported to YNHH for inpatient rehabilitation services will avoid a trip to downtown New Haven and be transported directly to the YNHH IRU in Milford.

Through this important project, YNHH will enhance care for IRU patients while effectively using existing hospital infrastructure in a nearby community. From MH's perspective, the arrangement creates an important income stream that it needs to sustain the programs and services that it has provided to patients as an independent hospital for more than 85 years. All of these developments are beneficial to the health care delivery system.

Legal Discussion

Based upon our review of the CON laws, relevant legislative history and OHCA precedent, we are confident that the above arrangement does not result in a termination of services or otherwise require the parties to obtain a CON. The relocation of YNHH's inpatient rehabilitation service will not result in any interruption or discontinuation of care for patients and thus does not fit within the plain meaning of C.G.S. Section 19a-638(a)(4) which applies only where there is "[t]he termination of inpatient or outpatient services offered by a hospital."¹ There

¹ Connecticut General Statutes Section 1-2z states as follows: "The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered." *See also, Sarrazin v. Coastal Inc.*, 311 Conn. 581 (2014) ("When construing a statute, [o]ur fundamental objective is to ascertain and give effect to the apparent intent of the legislature... In other words, we seek to determine, in reasoned manner, the meaning of the statutory language as applied to the facts of [the] case. Including the question of whether the

is no mention of the term relocation anywhere in subsection (a)(4) or for that matter anywhere else in 19a-638(a). As previously noted, YNHH will not be terminating its inpatient rehabilitation services as it will continue to offer the exact same services to the exact same patient population.

We also believe OHCA's prior decisions, based upon the agency's interpretation of Section 19a-638(a)(4), support our position. In reviewing recent precedent since the CON laws were overhauled in 2010, we found that the termination of services decisions fell into three general categories:

1. Hospitals that are closing a service (typically an outpatient location) and consolidating patients at existing hospital locations where the same service is offered. By way of example:
 - a. Guilford Pediatric Specialty Center (Docket No. 13-31860-DTR) – The center was closed and patients were consolidated at other YNHH PSC locations.
 - b. L&M Hospital Non-nuclear Stress Testing (Docket No. 13-31863-DTR) – The outpatient location was closed and services and equipment were consolidated into an existing non-nuclear stress testing program at the hospital's main campus.
 - c. Waterbury Hospital & Danbury Hospital Sleep Labs (Docket Nos. 14-31897-DTR & 13-31879-CON) – Each hospital was closing a sleep lab location and consolidating patients at another sleep lab operated by the hospital.
 - d. St. Mary's Hospital MRI (Docket No. 14-31891-DTR) – The hospital closed an outpatient MRI location and consolidated patients at an existing MRI location on the main campus (MRI equipment was relocated as well).

2. Hospitals that are transferring ownership and operation of a service to a non-hospital entity, whether affiliated or unaffiliated. By way of example:
 - a. YNHH Eldercare Clinics (Docket No. 13-31854-DTR) – Operational control of outpatient clinics was transferred from the hospital to a medical foundation.
 - b. L&M Joslin Diabetes Centers (Docket No. 14-31910-DTR) – Services were transferred from the hospital to a physician practice affiliated with the hospital.
 - c. Windham Hospital Prenatal Clinic (Docket No. 12-31782-CON) – Operational control for the prenatal clinic was transferred to an unaffiliated provider.

(Footnote continued from previous page) language actually does apply... [Section] 1-2z directs this court to first consider the text of the statute and its relationship to the other statutes to determine its meaning. If, after such consideration, the meaning is plain and unambiguous and does not yield absurd or unworkable results, we shall not consider extratextual or unworkable results, we shall not consider extratextual evidence of the meaning of the statute. General Statutes § 1-2z; see also *Saunders v. Firtel*, 293 Conn. 515, 525, 978 A.2d 487 (2009). Only if we determine that the statute is not plain and unambiguous or yields absurd or unworkable results may we consider extratextual evidence of its meaning such as the legislative history and circumstances surrounding its enactment ... the legislative policy it was designed to implement ... its relationship to existing legislation and common law principles governing the same general subject matter ... The test to determine ambiguity is whether the statute, when read in context, is susceptible to more than one reasonable interpretation.”)

3. Hospitals that are closing a service altogether and making arrangements for patients (if any) to access services at other providers. By way of example:
 - a. Rockville General Hospital Diagnostic Cardiac Catheterization (Docket No. 12-3177-DTR)
 - b. Sharon Hospital IOP (Docket No. 13-31872-DTR)
 - c. Gaylord Hospital Sleep Labs (Docket Nos. 14-31902-CON, 13-31885-CON, 13-31883-CON & 13-31884-CON)

YNHH's proposed relocation of the IRU does not fit into any of the above categories. The IRU is not being closed and patients consolidated at another YNHH IRU location. Operational control of the IRU is not being transferred to another entity. Nor is the IRU being shut down altogether. Rather, the IRU is being relocated to another location within YNHH's primary service area, to leased space in Milford, where it will continue to operate exactly as it currently operates. In this context, the particular nature of inpatient rehabilitation services is worth noting, as the location in which the services are provided is almost irrelevant. Patients do not access inpatient rehabilitation directly from the community; instead, they are transferred after an acute hospital discharge, and so the change in location would have little impact on patients.

Although the meaning of § 19a-638(a)(4) is plain on its face, the legislation that provides OHCA with its CON jurisdiction under the statute, Public Act No. 11-183, *An Act Requiring Certificate of Need Approval for the Termination of Inpatient and Outpatient Services by a Hospital*, also does not support the law being extended to situations such as here where care will simply be provided at a different physical location. That legislation was passed largely in reaction to a separately licensed Connecticut hospital terminating its labor and delivery services. In the legislative history concerning P.A. 11-183, there is also no discussion of the law applying to service relocations. Instead, discussion on the bill was relegated to service terminations:

Representative Janowski (the primary sponsor of the underlying legislation, H.B. 5048, in introducing the bill to the Public Health Committee on February 4, 2011):

The bill does not introduce any new changes or restrictions. It simply restores the oversight that was – in my opinion, inadvertently eliminated when the hospital termination eliminated – when the hospital termination of inpatient and outpatient services request was removed from the certificate of need process requirement that previously existed.

Representative Ritter (in introducing the bill to the House on June 11, 2011 where it passed by a 93-53 vote):

Mr. Speaker, this bill essentially would require any hospital that seeks to terminate inpatient or outpatient services currently offered, as well as any outpatient surgi center to file a certificate of need application with the Office of Health Care Access.

Similar remarks as to the scope of the legislation were made when the bill was introduced to the State Senate on June 8, 2011 where it passed by a vote of 23-12. There was robust debate on the bill at each step of the legislative process, but at no time did the topic of applying the proposed law to service relocations come up. Indeed, many legislators opposed the bill not only because it appeared to roll back the streamlining of the CON laws that had been achieved in the 2010 session, but because it encroached on the ability of hospitals to address fundamental changes in their business models brought about by, among other things, health care reform. Other opponents felt the bill was already too broad in the sense that it was not limited to the termination of essential services such as emergency departments.

Against this backdrop, there is no legal support for extending the statute's coverage to service relocations such as the one YNHH plans to undertake. We also think the colloquy below between Representatives Perrillo and Janowski in the House – though focusing more on the essential versus non-essential services issue – signals the legislative intent to focus the statute strictly on service terminations and not apply it in cases, such as here, where the hospital is continuing to provide the service:

Rep. Perrillo (113th):

Certainly, Mr. Speaker, thank you. I'm just trying to dig into the depth of what, indeed, hospitals need to utilize the CON process for in terms of terminating services.

And in the specific instance in my question, I asked about sleep centers where they study, where hospitals study sleep disorders. That is not something that appears to emergent to me in any way, shape or form, and perhaps not even something that is vital within a community. You know, the community is going to survive just fine if they don't have somebody to study sleep disorders.

So my question is, would things like that of a non-emergent, non-critical type level of care still have to go through the CON process?

Deputy Speaker Godfrey:

Representative Janowski.

Rep. Janowski (56th):

Thank you. Through you, Mr. Speaker, I believe that if it is part of a department, then it would. But if it's part of a service that's being offered through a general kind of, through another area or part of another area, I don't think that it does.²

² For your convenience, we have attached to this letter each of the transcript pages containing the statements quoted above.

Conclusion

A plain reading of Section 19a-638(a)(4) and legislative history surrounding the reintroduction of termination of services jurisdiction to OHCA in 2011, make it clear that the statute's purpose is to provide for OHCA oversight and public input before access to core hospital services is curtailed. Here, access to services is not affected. Therefore, there is no need for a CON proceeding to address access issues such as whether existing providers have the capacity to absorb patients, whether arrangements have been made to transfer patients and whether patients have been notified that the hospital service is closing. These issues are entirely irrelevant when a referral-only inpatient hospital service is being relocated a short distance away with no changes in patients or clinical staff.

Based on the foregoing, we respectfully submit that no CON is required for YNHH to relocate its IRU to leased space at Milford. To require a CON under these circumstances would be contrary to the intent of CON law reform, which was to streamline the CON process for the benefit of both OHCA and healthcare providers. Hospitals – and in particular urban land-locked hospitals like YNHH that find it difficult to expand within existing campuses to accommodate growth in inpatient services – require the flexibility to relocate services without going through lengthy and expensive CON proceedings in every instance. These relocations allow hospitals to respond to patient demand and ensure that patients have access to all of the services that a hospital offers its community.

When a service is being relocated to address space constraints, and OHCA can verify that there are no changes in the nature of services or the population served, access is maintained and CON review is unnecessary. To establish precedent that any and all service relocations by hospitals potentially require CON approval also creates an additional and unwelcome administrative burden for providers and the agency that is contrary to the goals of both federal and state healthcare reform. If a CON determination request or application is filed every time one of Connecticut's acute-care hospitals relocates a service, OHCA will be overwhelmed with paperwork and hospitals will be unable to operate in the manner necessary to deliver efficient, high-quality patient care.

We thank you for your consideration of this information and welcome the opportunity to discuss it with you further.

Respectfully Submitted,



Jennifer G. Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Tel: (203) 786-8316
Fax: (203) 772-2037



Stephen M. Cowherd
Jeffers Cowherd P.C.
55 Walls Drive
Fairfield, CT 06824
Tel: (203) 259-7900
Fax: (203) 259-1070

REP. JANOWSKI: Good afternoon, Representative Ritter, Senator Stillman and members of the Public Health Committee. I am Representative Claire Janowski and I represent the 56th District of Vernon and Rockville, where Rockville General Hospital is currently -- well currently resides.

I am pleased to speak in support of the House Bill 5048, REQUIRING CERTIFICATION OF NEED APPROVAL FOR THE TERMINATION OF SERVICES BY HOSPITALS. First, I would like to thank the Committee for raising this important bill which was introduced because of the situation that happened in my district following the merger of the Office of Health Care Access with the Public health Department as a result of some changes that were made to the existing -- or previous OHCA oversight regulations.

The bill does not take anything away from OHCA, what it does is -- the purpose of the bill is to restore the public transparency that existed prior to the merger by restoring OHCA's discretion to hold a public hearing which is something they always had the right to do prior to the changes. And also it allows OHCA to honor requests from communities or community leaders to hold such a public hearing as again was the case prior to the changes.

This is particularly important to small community hospitals because it will ensure proper oversight of those hospitals as well as any other hospital that does not currently operate under a certificate of need. Because if the existence of a hospital came about prior to the certificate of need process, they do not operate under a certificate of need and have no protections because of the changes that were made to OHCA last year, when it comes to termination of services.

The bill does not introduce any new changes or restrictions. It simply restores the oversight that was -- in my opinion, inadvertently eliminated when the hospital termination eliminated -- when the hospital termination of inpatient and outpatient services request was removed from the certificate of need process requirement that previously existed. That change became effective October of 2010 and basically eliminated the public hearing process in my opinion, shut out public input and in essence eliminated any OHCA oversight authority making that important decision automatic.

And basically having it rest with the hospital authority themselves. This is what happened recently at Rockville General Hospital when the parent company decided that as a business

House
6/1/11

THE CLERK:

On Page 2, Calendar 71, House Bill Number 5048 AN ACT REQUIRING CERTIFICATE OF NEED APPROVAL FOR THE TERMINATION OF INPATIENT AND OUTPATIENT SERVICES BY A HOSPITAL. Favorable Report of the Committee on Public Health.

DEPUTY SPEAKER GODFREY:

The distinguished Chairman of the Public Health Committee, Representative Betsy Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill.

DEPUTY SPEAKER GODFREY:

The question is on acceptance and passage. Explain the Bill, please, madam.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, this bill essentially would require any hospital that seeks to terminate inpatient or outpatient services currently offered, as well as any outpatient surgi center to file a certificate of need application with the Office of Health Care Access. It is intended to correct an unintentional omission from legislation that we passed last year.

Mr. Speaker, the Clerk has an Amendment, LCO Number 7275, which is not a total strike all, but essentially replaces the heart of the underlying Bill.

I would ask that the Clerk please call the Amendment and I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER GODFREY:

The Clerk is in possession of LCO Number 7275, which will be designated House Amendment Schedule "A". Will the Clerk please call the Amendment.

THE CLERK:

DEPUTY SPEAKER GODFREY:

Representative Janowski.

REP. JANOWSKI (56th):

I'm sorry. (Inaudible) the question, please.

DEPUTY SPEAKER GODFREY:

Representative Perrillo, could you please repeat the question?

REP. PERRILLO (113th):

Certainly, Mr. Speaker, thank you. I'm just trying to dig into the depth of what, indeed, hospitals need to utilize the CON process for in terms of terminating services.

And in the specific instance in my question, I asked about sleep centers where they study, where hospitals study sleep disorders. That is not something that appears to emergent to me in any way, shape or form, and perhaps not even something that is vital within a community. You know, the community is going to survive just fine if they don't have somebody to study sleep disorders.

So my question is, would things like that of a non-emergent, non-critical type level of care still have to go through the CON process?

DEPUTY SPEAKER GODFREY:

Representative Janowski.

REP. JANOWSKI (56th):

Thank you. Through you, Mr. Speaker, I believe that if it is part of a department, then it would. But if it's part of a service that's being offered through a general kind of, through another area or part of another area, I don't think that it does.

DEPUTY SPEAKER GODFREY:

Representative Perrillo.

REP. PERRILLO (113th):

November 14, 2014

VIA REGULAR & ELECTRONIC MAIL

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106

Re: Yale-New Haven Hospital
Inpatient Rehabilitation Unit at Milford Hospital

Dear Ms. Martone,

We are in receipt of OHCA's November 5, 2014 correspondence requesting additional information regarding the relocation of Yale-New Haven Hospital's ("YNHH") Inpatient Rehabilitation Unit ("IRU") to leased space at Milford Hospital ("MH"). This request came in response to our October 30, 2014 letter, which was submitted to OHCA voluntarily and detailed the arrangement between YNHH and MH (collectively, the "Parties"). Please accept this letter as the Parties' joint response to OHCA's request.

Patient Population & Payer Mix Data

OHCA has asked for the following information relative to the YNHH IRU: (a) The percentage of total patient volume by payer source prior to and following the IRU's relocation to Milford; and (b) a list of towns within the IRU service area prior to and following its relocation to Milford.

Table A below shows payer source percentages for the IRU in New Haven for FY2014. This table also shows projected payer source percentages for the IRU once it relocates to Milford in May of 2015. The payer source percentages prior to and after the relocation are identical. This is due to the fact that the IRU is an inpatient referral-only service. Virtually all IRU patients are admitted immediately following an acute care hospital stay. After the relocation, the same exact patients who would have been admitted to the IRU in New Haven will be transported to Milford and admitted to the IRU at MH. Any fluctuations in payer mix going forward are the same year-to-year fluctuations that would occur if the IRU continued to operate in New Haven.

Table A: Payer Source Percentages Prior To and After Relocation

Payer	IRU in New Haven Prior To Relocation (FY 2014)	IRU in Milford After Relocation (Beginning May 2015)
Medicare	72%	72%
Medicaid	0.5%	0.5%
CHAMPUS & TriCare	0%	0%
Total Government	72.5%	72.5%
Commercial Insurers	26%	26%
Uninsured/Self-Pay	0%	0%
Workers Compensation	1.5%	1.5%
Total Non-Government	27.5%	27.5%
Total Payer Mix	100%	100%

Table B below lists towns within the Primary Service Area of the IRU prior to and after its relocation to Milford. The towns collectively represent 80% of patients admitted to the IRU in New Haven in FY 2014. They are expected to remain the top 80% of towns by patient origin once the IRU is relocated to Milford in May of 2015. The patient towns of origin prior to and after the relocation are identical because the IRU is an inpatient referral-only service. As previously mentioned, virtually all IRU patients are admitted immediately following an acute care hospital stay. After the relocation, the same exact patients who would have been admitted to the IRU in New Haven will be transported to Milford and admitted to the IRU at MH. Any fluctuations in patient towns of origin going forward are the same year-to-year fluctuations that would occur if the IRU continued to operate in New Haven.

Table B: Patient Town of Origin Prior To and After Relocation

TOP 80% TOWNS	
IRU in New Haven Prior To Relocation (FY 2014)	IRU in Milford After Relocation (Beginning May 2015)
New Haven	New Haven
Hamden	Hamden
East Haven	East Haven
West Haven	West Haven
North Haven	North Haven
Orange	Orange
Milford	Milford
Wallingford	Wallingford
North Branford	North Branford
Branford	Branford
Guilford	Guilford
Madison	Madison
Woodbridge	Woodbridge

Lease & Services Agreement

OHCA has also requested that the Parties provide *unredacted* copies of any Lease related to the relocation of YNHH's IRU and the Services Agreement between YNHH and MH for ancillary services, as referenced in our October 30 letter. Although we are willing to provide OHCA with these documents on behalf of our clients in the spirit of full transparency to a regulatory body and to further confirm that no CON is required in connection with this relocation, the Parties are justifiably concerned about proprietary and confidential business documents becoming part of a public record. Affording our competitors the ability to access the Lease and Services Agreement, which contain strategic information and reflect the results of private negotiations between the Parties, would be detrimental to both hospitals and contrary to past practices of OHCA.

The Freedom of Information Act ("FOIA") requires public access to records maintained by public agencies such as OHCA, subject to a number of exemptions. Conn. Gen. Stat. § 1-210. In particular, the exemptions to public disclosure under FOIA for commercial or financial information given in confidence, and not required by statute, as well as the trade secrets exemption allow OHCA to keep confidential the requested agreements related to the YNHH-MH transaction. Conn. Gen. Stat. § 1-210(5).

We believe that OHCA and the Parties could structure the submission of the documents to OHCA in their fully unredacted form to fit within the exemption to FOIA for commercial or financial information given in confidence, not required by statute. Conn. Gen. Stat. § 1-210(5)(B); see *Hollbrook v. Freedom of Info. Comm'n*, No. CV960563515S, 1997 WL 187177, at *1 (Conn. Super. Ct. Apr. 9, 1997) (copy attached as Exhibit A). In this case, because the Lease and Services Agreement memorialize the terms and conditions of a business arrangement between YNHH and MH, and include financial provisions, the information meets the "commercial or financial information" requirement of the exemption. The agreements will also be provided to OHCA on a voluntary basis, as the Parties are not the subject of any formal CON proceeding related to the proposed relocation of YNHH's IRU. Nor are the Parties otherwise required by statute to produce these documents. Furthermore, the Lease and Services Agreement would be provided by the Parties through counsel with an expectation of confidentiality given that leadership from both hospitals have already communicated with OHCA staff regarding the importance of the transaction to their organizations and the need to keep the terms of these competitively sensitive agreements from being publicly available.

The forms of Lease and Services Agreement used in this transaction are also compilations of terms and other information that the Parties have developed in the ordinary course to support their respective business operations. These agreements are kept confidential and competitors could obtain economic value from their disclosure. Accordingly, they constitute trade secrets. Trade secret protection under FOIA applies to:

[F]ormulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, customer lists, film or television scripts or detailed production

budgets that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy.

Conn. Gen. Stat. § 1-210(5)(A).

The Appellate Court clarified the definition of trade secret under FOIA in the matter of *Dep't. of Public Utilities of the City of Norwich v. Freedom of Info. Comm'n et al.*, 739 A.2d 328 (Conn. App. Ct. 1999) (copy attached as Exhibit B). This appeal arose from an initial finding by the Freedom of Information Commission ("FOIC") that a cost study conducted by the Department of Public Utilities of the City of Norwich ("DPU") was not a trade secret exempt from FOIA.

The Appellate and Superior Courts adopted the definition of trade secret from the Restatement of Laws, which provides, in part:

A trade secret may consist of any formula, pattern, device or compilation of information which is used in one's business and which gives him an opportunity to obtain an advantage over competitors who do not know or use it.

Some of the factors to be considered in determining whether information is a trade secret are (1) the extent to which the information is a trade secret outside the business; (2) the extent to which it is known by employees and others involved in the business; (3) the extent of measures taken by the employer to guard the secrecy of the information; (4) the value of the information to the employer and to his competitors; (5) the amount of effort or money expended by the employer in developing the information; (6) the ease or difficulty with which the information could be properly acquired or duplicate by others.

Id.; see also *Dep't. of Publ. Utilities, City of Norwich v. Connecticut Freedom of Info. Comm'n*, No. CV970573178, 1998 WL 310874, at *1 (Conn. Super. Ct. June 5, 1998) (copy attached as Exhibit C). In the *DPU* case, the court found that the cost study at issue was viewed by the DPU as confidential, cost a significant amount of money to generate and was not generally available to the public. *Id.* However, the courts also found that it was too widely disseminated for there to be an expectation of confidentiality under the trade secret exemption.

Applying the *DPU* analysis to the Lease and Services Agreement requested by OHCA, the trade secret exemption to FOIA applies. First, just like the *DPU* considered its cost study to be confidential, YNH and MH consider and intend for these agreements to remain confidential. In addition, OHCA has historically afforded confidentiality protection to transactional documents submitted relative to CON matters.

The Parties have also gone to great measure to ensure the confidentiality of the Lease and Services Agreement and the information contained within those agreements has not been widely

disseminated, either within or outside of YNHH and MH. *See Plastic & Metal Fabricators, Inc. v. Roy*, 303 A.2d 725 (Conn. 1972) (“[A] substantial element of secrecy must exist, to the extent that there would be difficulty in acquiring the information except by the use of improper means... [However] absolute secrecy is not essential and the plaintiff does not abandon his secret ‘by delivering it or a copy to another for a restrictive purpose, nor by a limited publication’”). The agreements were negotiated by a small group of hospital administrators with the assistance of in-house and outside counsel. The only non-hospital employees who have seen these documents are attorneys, including the undersigned, who are bound by an ethical obligation to maintain absolute confidentiality. Even the Parties’ boards of trustees have been cautioned about the importance of maintaining confidentiality of the terms of the transaction.

Moreover, the information contained within the Lease and Services Agreement is of significant value to the Parties’ competitors, who would benefit from knowing more about the strategic initiatives of YNHH and MH. Nor are there any proper means (outside of OHCA) for the Parties’ competitors to obtain copies of the Lease and Services Agreement. *See Director, Dep’t. of Info. Tech. of Town of Greenwich v. Freedom of Info. Comm’n*, 874 A2d. 785 (Conn. 2005) (copy attached as Exhibit D). The Parties’ wish to fully cooperate with OHCA and submission of information related to a transaction for which no CON is required should not have the unintended consequence of giving their competitors access to confidential and proprietary information.

Lastly, a significant amount of time and effort went into negotiating and drafting the Lease and Services Agreement, a process that lasted several months. There was also significant cost born by both YNHH and MH related to these documents in the form of attorneys’ fees. When considered in light of the factors from the DPU case set out above, the resources devoted to preparing and negotiating these documents further demonstrate that applying the “trade secrets” exemption to FOIA is appropriate here.

Based on the foregoing, it is our belief that the commercial or financial information given in confidence and/or trade secret exemptions to FOIA allow for confidential submission of the Lease and Services Agreement. The Parties are willing to provide OHCA with unredacted versions of these agreements upon confirmation that they will be kept strictly confidential and not made available to the public. In the alternative, OHCA can view the identical documents that are in the custody of the Attorney General’s office.¹ Either or both options meet with the letter and spirit of the FOIA exemptions and would permit OHCA to further confirm that no CON approval is required for this transaction.

We thank you for your consideration of this information and our requests relative to the confidential treatment of the Lease and Services Agreement. Due to the importance of this transaction for our respective clients, we will be in touch shortly to determine next steps.

¹ These agreements were provided to the Office of the Attorney General and are being maintained confidentially pursuant to Conn. Gen. Stat. § 35-42.

Kimberly R. Martone, Director of Operations
November 13, 2014
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Respectfully Submitted,



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EXHIBIT A

1997 WL 187177

Only the Westlaw citation is currently available.

**UNPUBLISHED OPINION. CHECK
COURT RULES BEFORE CITING.**

Superior Court of Connecticut.

Sidney J. HOLBROOK, Commissioner
of Environmental Protection

v.

FREEDOM of INFORMATION COMMISSION
of the STATE of CONNECTICUT et al.

No. CV960563515S. | April 9, 1997.

Memorandum of Decision

McWEENY, Judge.

*1 In this case the State of Connecticut Department of Environmental Protection (hereinafter "DEP") appeals from the final decision of the State of Connecticut Freedom of Information Commission (hereinafter "FOIC") ordering the DEP to provide Mark Errico access to or copies of information, shellfish harvesters voluntarily provide the DEP, reporting the specific landings of oysters and clams by volume and value.

The parties to this appeal are the DEP, the FOIC and Mr. Errico. The appeal is brought pursuant to General Statutes §§ 1-21i(d) and 4-183.

The dispute was initiated by Mr. Errico's desire to obtain the reports of individual companies revealing the landings of oyster and clams in bushel and dollars. The DEP collects the information on forms provided to the shellfish harvesters. (R. # 1, attachments.) The shellfish harvesters are advised that the information will be aggregated for Connecticut as to total landings of each species, number of workers employed in market shellfish harvesting and number of boats and vessels operated. The harvesters are assured that individual reports are strictly confidential and only aggregate summary data is forwarded to the National Marine Fisheries Service for publication in "Fishery Statistics of the United States." (R. # 16.)

The shellfish harvesters solicited by the DEP for such information are the nineteen commercial shellfish harvesters

licensed by the State of Connecticut Department of Agriculture. Commercial fishing is regulated by the DEP pursuant to Chapter 490 of General Statutes §§ 26-1 to 26-186 relating to Fisheries and Game.

Shellfish harvesting is more akin to farming, while fishing is analogous to hunting (R. # 17, p. 16). Section 26-1 defines fishing as "taking or attempting to take any finfish crustacea or bait species for commercial purposes or by the use of any commercial fishing gear." Crustaceans include lobsters, crabs, shrimp and barnacles; but not edible shellfish, such as clams and oysters which are mollusks. American Heritage Dictionary of the English Language pp. 247, 318, 846, 939 (1975). Also, "commercial fishing gear" defined in § 26-1 does not include dredges, which are used to harvest shellfish (R. # 16). Apparently in recognition of this distinction "The Department of Agriculture shall be the lead agency on shellfish in Connecticut." Chapter 491 State Shell fisheries § 26-192a. The Department of Agriculture, as directed by § 26-192a, "shall coordinate the activities of other state agencies with regard to shellfish." DEP conservation officers are empowered pursuant to § 26-6 to enforce the licensing provision for shellfish harvesters set forth in § 26-192c-26-192h.

A review of this regulatory scheme is if not necessary, educational, in order to consider one of the Plaintiff's claims to exemption of these reports from the Freedom of Information Act's (FOIA) reach.

In that the documents are in the DEP's possession there is no question that they are public records, § 1-18a(d). Public records are disclosable to the public under the general rule of § 1-19. "Except as otherwise provided by any federal law or state statute, all records maintained or kept on file by any public agency ... shall be public records and every person shall have the right to inspect such records ..."

*2 The DEP asserts § 26-157b(c) as the state statutory basis of the exemption of these reports from individual shellfish harvesters. Section 26-157b(c) does specifically exempt reports from fishing licensees described in § 26-157b(a) and reports "submitted voluntarily upon request of the Commissioner ..."

The DEP introduced evidence as to their intent to cover these types of reports in supporting this legislation. The court accepts the testimony as to the DEP, but that is not evidence of the legislative purpose or intent in enacting § 26-157b(c).

Section 26-157b(c) is an exemption to the FOIA. "The general rule under the Freedom of Information Act is disclosure with the exceptions to this rule being narrowly construed. The burden of establishing the applicability of an exemption clearly rests upon the party claiming an exemption." *Perkins v. FOIC*, 228 Conn. 158, 167, 635 A.2d 783 (1993); *Superintendent v. FOIC*, 222 Conn. 621, 626, 609 A.2d 998 (1992); *Rose v. FOIC*, 221 Conn. 217, 232, 602 A.2d 1019; *Ottobian v. FOIC*, 221 Conn. 393, 397, 604 A.2d 351 (1992); *New Haven v. FOIC*, 205 Conn. 767, 775, 535 A.2d 1297 (1988); *Hartford v. FOIC*, 201 Conn. 421, 431, 518 A.2d 49 (1986); *Maher v. FOIC*, 192 Conn. 310, 315, 472 A.2d 321 (1984) and *Wilson v. FOIC*, 181 Conn. 324, 342, 435 A.2d 353 (1980).

Section 26-157b relates to reports from persons licensed by the DEP, specifically commercial fishing licensees. It would require a liberal construction of this exemption to cover all documents voluntarily reported to the DEP. A construction limited to reports from the Department of Agriculture licensee shellfish harvesters is also not apparent from the statutory language, and at odds with the public policy favoring disclosure.

The DEP also asserts the claim that the reports are exempt pursuant to § 1-19b(5) as "commercial or financial information given in confidence, not required by statute."

Prior to considering the merits of the 1-19b(5) exemption claim, the respondents FOIC and Errico raise a procedural issue.

The complaint to the FOIC was filed with that agency on October 13, 1995. A hearing was held on February 27, 1996 before an FOIC hearing officer, Commissioner Carolle Andrews. The DEP at the hearing only raised the § 26-157b(c) claim; neglecting to mention the § 1-19b(5) exemption.

The hearing officer issued a proposed decision (R. # 18) dated June 20, 1996 rejecting the § 26-157b(c) claim. The proposed decision was transmitted to the parties on July 3, 1996 with notice of the Commission's intent to consider and dispose of the matter at its July 24, 1996 meeting. The parties were allowed to file briefs or written memoranda of law prior to the meeting and afforded ten minutes for oral argument (R. # 18). This procedure is in accordance with § 4-179 of the Uniform Administrative Procedure Act (hereinafter UAPA). Section 4-179 provides that when a majority of agency members who

are to render a final decision have not heard the evidence, the proposed final decision transmittal followed by "briefs and oral argument" must be followed.¹ The DEP asserted the § 1-19b(5) exemption after the proposed final decision and hearing, but before the final agency action.

*3 Respondents assert a waiver of such claim by the DEP.

The court finds that under the facts of this case the § 1-19b(5) claim must be considered.

In the first instance the DEP action is not a waiver of a legal right. At the most it is an initial mistaken reliance on one claim of exemption. "Waiver is the intentional abandonment of a known right." *Brown v. Employer's Reinsurance Corp.*, 206 Conn. 668, 675, 539 A.2d 138 (1988). "Waiver is the voluntary relinquishment of a known right. It involves the idea of assent and assent is an act of understanding ... intention to relinquish must appear ..." *Mackey v. Aetna Life Ins. Co.*, 118 Conn. 538, 547-48, 173 A. 783 (1939). Also see, *Phoenix Mutual Life Ins. and Soares v. Max Services, Inc.*, 42 Conn.App. 147, 175, 679 A.2d 37 (1996).

The procedure required by § 179 specifically permits a party to file briefs and make oral arguments which would necessarily include legal claims.

What appears to be envisioned by § 4-179 is the review of the evidentiary factual findings and the legal basis of a proposed decision. There is no reason to preclude a party from making a legal claim on the basis of the existing evidentiary record under § 4-179. A party may not introduce evidence before the full commission or successfully argue legal claims for which there is no evidentiary basis; however, a legal claim apparent from the record is appropriately argued pursuant to § 4-179.

In this case a cursory review of the form provided by the shellfish harvesters is sufficient to invoke the exemption (R. # 14). Specifically requested as to each species of shellfish are number of bushels landed and dollar value. This information is clearly "commercial or financial information." The information is also "given in confidence" and "not required by statute." No statute requires the shellfish harvester to provide such information to the DEP and it is solicited under a pledge of confidentiality (R. # 16). The overwhelming irrefutable evidence establishes the applicability of the § 1-19b(5) exemption to these individual reports.

The UAPA provides in § 4-183(j) that the court shall affirm the agency decision unless it finds that substantial rights of the appellant have been prejudiced because the decision is "(1) In violation of constitutional or statutory authority of the agency."

The FOIC violates § 1-19b(5). The DEP has been ordered to reveal information of a commercial and financial nature which it solicited under a pledge that "individual reports are strictly confidential." The DEP could be exposed to potential

liability for the violation of such commitment. Accordingly, the appeal is sustained.

Pursuant to UAPA § 4-183(k) the court finds that the individual reports from shellfish harvesters are exempted from disclosure pursuant to law (§ 1-19b(5)). The FOIC is ordered to modify its decision and exempt such reports from public disclosure.

Footnotes

1 *Section 4-179. Agency proceedings. Proposed final decision.*(a) When, in an agency proceeding, a majority of the members of the agency who are to render the final decision have not heard the matter or read the record, the decision, if adverse to a party, shall not be rendered until a proposed final decision is served upon the parties, and an opportunity is afforded to each party adversely affected to file exceptions and present briefs and oral argument to the members of the agency who are to render the final decision.

(b) A proposed final decision made under this section shall be in writing and contain a statement of the reasons for the decision and a finding of facts and conclusion of law on each issue of fact or law necessary to the decision.

(c) Except when authorized by law to render a final decision for an agency, a hearing officer shall, after hearing a matter, make a proposed final decision.

(d) The parties and the agency conducting the proceeding, by written stipulation, may waive compliance with this section.

EXHIBIT B

55 Conn.App. 527
Appellate Court of Connecticut.

DEPARTMENT OF PUBLIC
UTILITIES OF the CITY OF NORWICH
v.
FREEDOM OF INFORMATION
COMMISSION et al.

No. 18549. | Argued April 20,
1999. | Decided Nov. 2, 1999.

City department of public utilities appealed order of the Freedom of Information Commission requiring disclosure to a competitor of a study that included a formula to determine the cost of supplying natural gas to a specific customer. The Superior Court, Judicial District of Hartford, McWeeny, J., dismissed. City department appealed. The Appellate Court, Francis X. Hennessy, J., held that the study was not a "trade secret" exempt from disclosure under the Freedom of Information Act (FOIA).

Affirmed.

West Headnotes (7)

[1] **Records**

↔ Judicial enforcement in general

Appellate Court is required to defer to the subordinate facts found by the Freedom of Information Commission, if there is substantial evidence to support those findings.

Cases that cite this headnote

[2] **Statutes**

↔ Questions of law or fact

The determination of the meaning of a statute presents a question of law, which is within the province of the trial court and of the Appellate Court.

1 Cases that cite this headnote

[3] **Records**

↔ Trade secrets and commercial or financial information

City department of public utilities did not sufficiently limit the dissemination of a study reflecting a specific formula to determine the cost of supplying natural gas to an Indian tribe for study to qualify as "trade secret" exempt from disclosure under the Freedom of Information Act (FOIA) upon application of competitor; though the study was not available to the public or to competitors, essential element of secrecy necessary to fall within FOIA's disclosure exemption was compromised by the study's availability to various tribal members, the department's employees, the city utility commission, and the Bureau of Indian Affairs without any obligation to keep the contents confidential. C.G.S.A. § 1-19 (1998).

3 Cases that cite this headnote

[4] **Records**

↔ Access to records or files in general

Records

↔ Matters Subject to Disclosure; Exemptions

The general rule under the Freedom of Information Act (FOIA) is disclosure, and any exception to that rule will be narrowly construed in light of the general policy of openness expressed in the FOIA legislation. C.G.S.A. § 1-200 et seq.

Cases that cite this headnote

[5] **Records**

↔ Evidence and burden of proof

The burden of proving the applicability of an exception to the Freedom of Information Act (FOIA) rests upon the party claiming it. C.G.S.A. § 1-200 et seq.

Cases that cite this headnote

[6] **Records**

↔ Trade secrets and commercial or financial information

A substantial element of secrecy must exist in order for a document to be exempt from

disclosure as a trade secret under the Freedom of Information Act (FOIA), to the extent that there would be difficulty in acquiring the information except by the use of improper means. C.G.S.A. § 1-19 (1998).

1 Cases that cite this headnote

[7] **Records**

↔ Trade secrets and commercial or financial information

Absolute secrecy is not essential in order for a document to be exempt from disclosure as a trade secret under the Freedom of Information Act (FOIA) and the plaintiff does not abandon his secret by delivering it or a copy to another for a restrictive purpose, nor by a limited publication. C.G.S.A. § 1-19 (1998).

2 Cases that cite this headnote

Attorneys and Law Firms

****329 *528** Roger E. Koontz, Hartford, for the appellant (plaintiff).

Victor Perpetua, appellate counsel, with whom, on the brief, was Mitchell W. Pearlman, general counsel, for the appellee (named defendant).

Joseph J. Cassidy, pro se, the appellee (defendant), with whom, on the brief, was Jodi M. Thomas, Hartford.

Before FOTI, SPEAR and FRANCIS X. HENNESSY, JJ.

Opinion

FRANCIS X. HENNESSY, J.

The plaintiff department of public utilities of the city of Norwich (Norwich) appeals from the judgment of the trial court upholding an order of the defendant freedom of information commission (commission)¹ requiring the plaintiff to disclose a study concerning the cost of serving a particular customer (study). The plaintiff specifically claims that the court improperly held that the study is not exempt from disclosure as a trade secret² pursuant to ****330**

General Statutes (Rev. to 1997) § 1-19(b)(5), now § 1-210(b)(5).³ We affirm the judgment of the trial court.

***529** The following facts are relevant to this appeal. Yankee Gas Services Company (Yankee) supplies natural gas to the Tribal Utility Authority of the Mashantucket Pequot Tribe (Tribal Utility). Norwich, a supplier of natural gas and a competitor of Yankee, had entered into an agreement with Tribal Utility to provide it with natural gas by building a pipeline. Yankee thereafter requested a copy of the agreement between Norwich and Tribal Utility, but was provided only a copy without the portion that contained the study. The study is a fifteen to twenty page document that reflects a specific formula to allocate costs to deliver a volume of product at a determined rate. Norwich claims that the study contains confidential and proprietary information, as well as feasibility estimates and evaluations describing the cost of providing the contracted gas service to the Mashantucket Pequot Reservation. Norwich further claims that such information is not readily available from other sources, and disclosure would give its competitors, including Yankee, an unfair business advantage in knowing the methodology used to adjust the cost of the contracted gas service.

The defendant attorney Joseph J. Cassidy, representing Yankee, complained to the commission, which ordered the disclosure of the study. Norwich appealed from that order to the Superior Court, which affirmed the order of the commission. Norwich now appeals to this court.

Norwich claims that the study is a trade secret and, as such, is exempt from disclosure pursuant to § 1-19(b)(5). Norwich relies on the reasoning of our Supreme Court in *Triangle Sheet Metal Works, Inc. v. Silver*, 154 Conn. 116, 125-26, 222 A.2d 220 (1966), which held that a corporation's costs, pricing and bidding procedures ***530** constitute confidential "trade secrets." Norwich also cites *Town & Country House & Homes Service, Inc. v. Evans*, 150 Conn. 314, 318-19, 189 A.2d 390 (1963), in which the court adopted the definition of trade secrets set forth in 4 Restatement, Torts § 757, comment (b), pp. 5-6 (1939), which provides in relevant part: "A trade secret may consist of any formula, pattern, device or compilation of information which is used in one's business, and which gives him an opportunity to obtain an advantage over competitors who do not know or use it.... Some factors to be considered in determining whether given information is one's trade secret are (1) the extent to which the information is known outside of his business; (2) the extent to which it is known by employees and others involved in his business;

(3) the extent of measures taken by him to guard the secrecy of the information; (4) the value of the information to him and to his competitors; (5) the amount of effort or money expended by him in developing the information; [and] (6) the ease or difficulty with which the information could be properly acquired or duplicated by others.” Norwich agrees that the court properly relied on *Town & Country House & Homes Service, Inc. v. Evans*, supra, at 314, 189 A.2d 390, in determining the meaning of “trade secret,” but with respect to the element of secrecy, claims that the court went beyond the ruling in *Town & Country House & Homes Service, Inc.*, in apparently requiring a formal confidentiality agreement to demonstrate secrecy.

Applying the criteria set forth in *Town & Country House & Homes Service, Inc.*, the court found that “(1) cost of service studies are routinely viewed as confidential by [the department of public utility control]; (2) the agreement is available to [the] plaintiff’s personnel, the Norwich utility commissioner, the tribal personnel and the [United States] Bureau of Indian Affairs; (3) no evidence of confidentiality agreements *531 or internal controls is in the record. There is testimony that it would not generally be available to the public; (4) the cost of service study was paid for by the plaintiff at a cost of thousands of dollars and is desired by a competitor, Yankee Gas; (5) the cost of the consultant was incurred by the plaintiff; (6) the information is available to various members of the Mashantucket tribe, [the] plaintiff’s employees, the Norwich Utility Commission and the Bureau of Indian Affairs.”

On the basis of these findings, the court concluded that “[t]he evidence of dissemination of the study and the absence of any confidentiality agreement or any steps taken to limit its dissemination defeat the claim of secrecy or confidentiality essential to the definition of ‘trade secret.’ The plaintiff failed to meet its burden of establishing the application of the exemption.”

[1] [2] General Statutes § 1-21i(d), now § 1-206(d), provides that “appeals from the decisions of the commission are taken pursuant to the Uniform Administrative Procedure Act (UAPA). General Statutes §§ 4-166 through 4-189.... This court is required to defer to the subordinate facts found by the commission, if there is substantial evidence to support those findings. *Dufraine v. Commission on Human Rights & Opportunities*, 236 Conn. 250, 259, 673 A.2d 101 (1996); *Newtown v. Keeney*, 234 Conn. 312, 319-20, 661 A.2d 589 (1995).” (Citations omitted; internal quotation marks

omitted.) *Furhman v. Freedom of Information Commission*, 243 Conn. 427, 430-31, 703 A.2d 624 (1997). In the present case, the subordinate facts are not in dispute. Rather, it is the meaning of the statute that is disputed. “The determination of the meaning of a statute presents a question of law, which is within the province of the trial court and of this court.” *Id.*, at 431, 703 A.2d 624.

[3] The court found, and Norwich agrees, that the definition of trade secrets adopted by our Supreme Court in *532 *Town & Country House & Homes Service, Inc. v. Evans*, supra, 150 Conn. at 318-19, 189 A.2d 390, is applicable. Norwich’s claim turns, however, on the interpretation of the secrecy or confidentiality portion of the term “trade secrets.”

[4] [5] “[I]t is well established that the general rule under the Freedom of Information Act [FOIA] is disclosure, and any exception to that rule will be narrowly construed in light of the ‘general policy of openness expressed in the FOIA legislation.’ *Board of Education v. Freedom of Information Commission*, [208 Conn. 442, 450, 545 A.2d 1064 (1988)]. ‘The burden of proving the applicability of an exception to the FOIA rests upon the party claiming it.’ *Rose v. Freedom of Information Commission*, 221 Conn. 217, 232, 602 A.2d 1019 (1992).” *Ottochian v. Freedom of Information Commission*, 221 Conn. 393, 398, 604 A.2d 351 (1992).

[6] [7] Norwich contends that the fact that some public officials reviewed the study does not defeat a claim of secrecy and, furthermore, that there was no evidence to show that access to it was allowed to the general public. See *Plastic & Metal Fabricators, Inc. v. Roy*, 163 Conn. 257, 269, 303 A.2d 725 (1972) (inspection by public official does not contradict element *332 of secrecy). “[A] substantial element of secrecy must exist, to the extent that there would be difficulty in acquiring the information except by the use of improper means.” (Internal quotation marks omitted.) *Id.*, at 265, 303 A.2d 725. However, “absolute secrecy is not essential and the plaintiff does not abandon his secret ‘by delivering it or a copy to another for a restrictive purpose, nor by a limited publication.’ ” *Id.*, at 268, 303 A.2d 725.

Here, the trial court found that there was no evidence that the study was to be kept confidential. Although the court cited the lack of a confidentiality agreement as part of its reasoning for such a conclusion, it coupled *533 that with a finding that there were no efforts to limit the study’s dissemination. Although we recognize that a thorough review of applicable case law reveals no case stating that a formal confidentiality

agreement is essential to preserve the secrecy of a document, when the facts do not reveal discernable measures taken to guard the secrecy of the information, as evidenced by a lack of warnings alerting individuals to the confidentiality of the information, as well as a lack of a requirement that strict limits be placed on its distribution, the essential element of secrecy is compromised. The fact that the study was available to various members of the Mashantucket Pequot Tribe, Norwich employees, the Norwich utility commission and the Bureau of Indian Affairs demonstrates that the study was given wide distribution. Although these entities had an interest in the contents of the study and it was not shown that either Norwich's competitors or members of the general public had access to the study, there was no evidence that those who were

provided with the study were under any obligation to keep the contents confidential or to curtail its distribution. The court reasonably could have found, therefore, that Norwich failed to meet its burden of establishing the application of the statutory exemption from disclosure.

The judgment is affirmed.

In this opinion the other judges concurred.

Parallel Citations

739 A.2d 328

Footnotes

- 1 Attorney Joseph J. Cassidy, acting on behalf of Yankee Gas Services Company, requested the cost of service study from Norwich. After Norwich denied his request, he appealed to the commission, which ordered disclosure. Cassidy is a defendant in this appeal.
- 2 Norwich also claims that the court improperly determined that the study was not held in confidence where it was available only to Norwich, its customer and essential regulatory agencies. This claim is subsumed in the arguments addressed to the main issue of whether the study was a trade secret and whether it was exempt from disclosure under the statute.
- 3 General Statutes (Rev. to 1997) § 1-19, now § 1-210, provides in relevant part: "(a) Except as otherwise provided by any federal law or state statute, all records maintained or kept on file by any public agency, whether or not such records are required by any law or by any rule or regulation, shall be public records and every person shall have the right to inspect such records promptly during regular office or business hours or to receive a copy of such records..."

"(b) Nothing in [the Freedom of Information Act] shall be construed to require disclosure of ... (5) trade secrets, which for purposes of [the Freedom of Information Act], are defined as unpatented, secret, commercially valuable plans, appliances, formulas or processes, which are used for the making, preparing, compounding, treating or processing of articles or materials which are trade commodities obtained from a person and which are recognized by law as confidential, and commercial or financial information given in confidence, not required by statute...."

EXHIBIT C

1998 WL 310874

UNPUBLISHED OPINION. CHECK COURT RULES
BEFORE CITING.

Superior Court of Connecticut.

DEPARTMENT OF PUBLIC
UTILITIES, City of Norwich

v.

CONNECTICUT FREEDOM OF INFORMATION
COMMISSION and Joseph J. Cassidy.

No. CV97 0573178. | June 5, 1998.

Memorandum of Decision

ROBERT F. MCWEENY, J.

*1 The plaintiff Department of Public Utilities, City of Norwich (Norwich) appeals from a Freedom of Information Commission (FOIC) order requiring the disclosure of a document. The document in issue is an exhibit to a gas supply contract dated August 1, 1996, between Norwich and the Tribal Utility Authority of the Mashantucket Pequot Tribe (Utility Authority). Joseph J. Cassidy, Esq., who requested the document and complained to the FOIC, is also a party to this appeal. Mr. Cassidy is the attorney for Yankee Gas Service Company, which is a competitor of Norwich in the gas supply business. This appeal is brought pursuant to General Statutes § 1-211(d) of the Freedom of Information Act (FOIA), General Statutes §§ 1-7 through 1-211 and General Statutes § 4-183 of the Uniform Administrative Procedure Act (UAPA), §§ 4-166 through 4-189. For the reasons set forth below, the appeal is dismissed.

Norwich is a public agency within the meaning of General Statutes § 1-18a(a) of the FOIA.

Cassidy by letter of November 7, 1996, requested of Norwich copies of three agreements including the Transportation Standby and Balancing Agreement (agreement) between Norwich and the Utility Authority. Norwich, by letter of November 13, 1996, indicated that the agreement would be provided except for "Exhibit 1" which Norwich claimed to be exempt from disclosure under General Statutes 1-19(b)(5).¹

Cassidy by letter of November 22, 1996, complained to the FOIC of the denial of the requested document (Exhibit 1). The

FOIC pursuant to § 1-19 heard this dispute as a contested case April 14, 1997.

In its decision the FOIC found that Norwich failed to prove that Exhibit 1 to the agreement constitutes a trade secret under § 1-19(b)(5) and that it was exempt as a feasibility study or evaluation under § 1-19(b)(7).

The subordinate facts in this case are not substantially in dispute. Yankee Gas had been the gas supplier for the Mashantucket Pequot Tribe (the tribe). Norwich entered into a contract with the tribe for supplying gas over a ten-year period. In order to effectuate the contract, Norwich would construct a gas pipeline to the tribal facility. The terms of the arrangement between Norwich and the Mashantucket Pequot Tribe are set forth in the August 1, 1996 agreement. (Return of Record (ROR), Item 5, Ex. C.)

The exhibit at issue is a 15-20 page cost of service study which measures Norwich's marginal or incremental costs. The cost of service study reflects a specific formula to allocate costs to deliver volume of product at a determined rate. Thus, the contract price of \$0.75 per/MCF (cubic feet of gas) is adjusted based on volume. (ROR, Item 5, Ex. C, p. 15.)

The exhibit was produced by a consultant. It consists of a cost of service study obtained by Norwich for several thousands of dollars. (ROR, Item 9, p. 24.) The exhibit is not directly available to the public. (ROR, Item 9, p. 25.) It reflects a specific formula which allocates costs to deliver a volume of product within a rate determined. (ROR, Item 9, p. 22.) Norwich is not regulated by the Connecticut Department of Public Utility Control (Connecticut DPUC) and is not required by statute to file such information. (ROR, Item 9, pp. 8, 10-11, 14, 20.) Although it is a public agency, Norwich exists in a competitive environment and competes with Yankee Gas for the commercial business of supplying gas to the Mashantucket tribe. The Connecticut DPUC routinely treats cost of service studies as confidential information.

*2 In its final decision dated July 9, 1997, and mailed July 23, 1997, the FOIC ordered the disclosure of "Exhibit 1." Norwich is aggrieved by such decision. Norwich appealed the decision on August 26, 1997. The answer and record were filed on February 23, 1997. Briefs were filed by Norwich on January 22, 1998, Cassidy, on February 23, 1998, and the FOIC, on February 25, 1998. The parties were heard in oral argument on May 19, 1998.

Sections 1-19(b)(5) and 1-19(b)(7) as exceptions to the general FOIA principle of disclosure are to be narrowly construed. *New Haven v. FOIC*, 205 Conn. 767, 774, 535 A.2d 1297 (1998); *Perkins v. FOIC*, 228 Conn. 158, 167, 635 A.2d 783 (1993). To prevail on its claim that these exemptions apply, the plaintiff must meet the burden of proof to establish its applicability. *Superintendent of Police v. FOIC*, 222 Conn. 621, 626, 609 A.2d 998 (1992); *Ottochian v. FOIC*, 221 Conn. 393, 397, 604 A.2d 351 (1992).

The FOIC refers to the plaintiff's failure to prove the application of the exemptions. The court is required to defer to the facts found by the FOIC. *Dufraine v. Commission on Human Rights & Opportunities*, 236 Conn. 250, 259, 673 A.2d 101 (1996); *Newtown v. Keeney*, 234 Conn. 312, 319-20, 661 A.2d 589 (1995). "Here, however, the subordinate facts ... are not in dispute. Rather, it is the meaning of the statute that is disputed. The determination of the meaning of a statute is within the province of the trial court ..." *Furhman v. Freedom of Information Commission*, 243 Conn. 427, 43 (1997) citing *Board of Education v. FOIC*, 217 Conn. 153, 158, 585 A.2d 82 (1991); *New Haven v. FOIC*, 205 Conn. 767, 773-74, 535 A.2d 1297. The statutory exemptions at issue have not been previously subjected to judicial review. Thus the deference normally afforded an agency's statutory construction is not applicable. *Connecticut Light & Power v. Texas-Ohio Power, Inc.*, 243 Conn. 635, 644, 708 A.2d 202 (1998); *Assn. of Not-for-Profit Providers for the Aging v. Dept. of Social Services*, 244 Conn. 378, 389 (1998).

Connecticut law has adopted the definition of trade secrets from the Restatement of Laws. *Town & Country House & Home Service, Inc. v. Evans*, 150 Conn. 314, 189 A.2d 390 (1963). The definition in Restatement, 4 Torts § 757, Comment b, provides in part:

A trade secret may consist of any formula, pattern, device or compilation of information which is used in one's business, and which gives him an opportunity to obtain an advantage over competitors who do not know or use it.

Some of the factors to be considered in determining whether given information is a trade secret are (1) the extent to which the information is a trade secret outside the business; (2) the extent to which it is known by employees and others involved in the business; (3) the extent of measures taken by the employer to guard the secrecy of the information; (4) the value of the information to the employer and to his

competitors; (5) the amount of effort or money expended by the employer in developing the information; (6) the ease or difficulty with which the information could be properly acquired or duplicated by others.

*3 Applying such criteria to the facts of this case the court finds the following. (1) Cost of service studies are routinely viewed as confidential by DPUC. (2) The agreement is available to plaintiff's personnel, the Norwich utility commissioner, the tribal personnel, and the Bureau of Indian Affairs (R. Ex. 5 p. 33). (3) No evidence of confidentiality agreements or internal controls is in the record. There is testimony that it would not generally be available to the public. (ROR, Item 9, p. 25.) (4) The cost of service study was paid for by plaintiff at a cost of thousands of dollars and is desired by a competitor Yankee Gas. (5) The cost of the consultant was incurred by the plaintiff. (6) The information is available to various members of the Mashantucket Tribe, plaintiff's employees; the Norwich Utility Commission and the Bureau of Indian Affairs.

The evidence of dissemination of the study and the absence of any confidentiality agreement or any steps taken to limit its dissemination, defeat the claim of secrecy or confidentiality essential to the definition of trade secret. The plaintiff failed to meet its burden of establishing the application of the exemption.

Similarly, the plaintiff failed to establish the applicability of the § 1-19(b)(7)² exemption. The cost of service study related to a contract which was dated August 1, 1996. The cost of service study was not a feasibility estimate or evaluation when requested in November of 1996. The contractual provision for an additional cost of service study during the term of the contract would also indicate that it is not a feasibility estimate. (ROR, Item 5, Ex. C, P. 15.) The cost of service study is a cost allocation formula rather than an appraisal or engineering estimate. The supply of gas to the Mashantucket Tribe would also seem to constitute a private as opposed to the "public supply" contract referenced in § 1-19(b)(7).

The FOIC decision is affirmed and the appeal is dismissed.

Parallel Citations

22 Conn. L. Rptr. 192

Footnotes

- 1 General Statutes § 1-19(b)(5) provides in pertinent part: "trade secrets, which for purposes of sections 1-15, 1-18a, 1-19 to 1-19b, inclusive, and 1-21 to 1-21k, inclusive, are defined as unpatented, secret, commercially valuable plans, appliances, formulas or processes, which are used for the making, preparing, compounding, treating or processing of articles or materials which are trade commodities obtained from a person and which are recognized by law as confidential, and commercial or financial information given in confidence, not required by statute ..."
- 2 General Statutes § 1-19(b)(7): "the contents of real estate appraisals, engineering or feasibility estimates and evaluations made for or by an agency relative to the acquisition of property or to prospective public supply and construction contracts, until such time as all of the property has been acquired or all proceedings or transactions have been terminated or abandoned, provided the law of eminent domain shall not be affected by this provision ..."

End of Document

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EXHIBIT D

274 Conn. 179
Supreme Court of Connecticut.

DIRECTOR, DEPARTMENT OF INFORMATION
TECHNOLOGY OF THE TOWN OF GREENWICH,
v.
FREEDOM OF INFORMATION
COMMISSION et al.

No. 17262. | Argued Jan. 6,
2005. | Decided June 21, 2005.

Synopsis

Background: Director of town's department of information technology appealed from decision of the Freedom of Information Commission ordering director to provide complainant with requested copies of computerized data from the town's geographic information system (GIS). The Superior Court, Judicial District of Stamford-Norwalk, Owens, J., dismissed the appeal, and director appealed.

Holdings: After transferring the appeal from the Appellate Court, the Supreme Court, Vertefeuille, J., held that:

[1] director had the burden to seek a public safety determination from the Commissioner of Public Works in support of his claim that the GIS data were protected from disclosure under the public safety exemption of the Freedom of Information Act;

[2] in determining whether public safety exemption applied, trial court was not required to balance the town's interest in public safety with the public's right to accessible information;

[3] the GIS data did not constitute a "trade secret" within meaning of the Act's trade secret exemption; and

[4] director failed to meet his burden to show that security or integrity of town's information technology system would be compromised by disclosure of the GIS data.

Affirmed.

West Headnotes (13)

[1] **Records**

⊖ In General; Freedom of Information Laws in General

The Freedom of Information Act makes disclosure of public records the statutory norm. C.G.S.A. § 1-200 et seq.

2 Cases that cite this headnote

[2] **Records**

⊖ In General; Freedom of Information Laws in General

Records

⊖ Matters Subject to Disclosure; Exemptions

The general rule under the Freedom of Information Act is disclosure, and any exception to that rule will be narrowly construed in light of the general policy of openness expressed in the Act. C.G.S.A. § 1-200 et seq.

2 Cases that cite this headnote

[3] **Records**

⊖ Evidence and Burden of Proof

The burden of proving the applicability of an exception to disclosure under the Freedom of Information Act rests upon the party claiming it. C.G.S.A. § 1-210(b).

Cases that cite this headnote

[4] **Records**

⊖ Judicial Enforcement in General

In an appeal involving the application of the well-settled meaning of the exemptions to disclosure under the Freedom of Information Act to the facts of the particular case, the appropriate standard of judicial review was whether the Freedom of Information Commission's factual determinations were reasonably supported by substantial evidence, in the record taken as a whole. C.G.S.A. § 1-210(b).

1 Cases that cite this headnote

[5] Records

⚡ Judicial Enforcement in General

When trial court issued decision upon review of Freedom of Information Commission's order requiring director of town's department of information technology to disclose certain records, the appropriate remedy for director's dissatisfaction with trial court's failure to elaborate on the applicability of the Freedom of Information Act's public safety exemption was to file a motion for articulation. C.G.S.A. § 1-210(b)(19).

2 Cases that cite this headnote

[6] Records

⚡ Matters Subject to Disclosure; Exemptions

Director of town's department of information technology had the burden to seek a public safety determination from the Commissioner of Public Works in support of his claim that computerized data from the town's geographic information system (GIS) were protected from disclosure under the public safety exemption of the Freedom of Information Act. C.G.S.A. § 1-210(b)(19).

Cases that cite this headnote

[7] Records

⚡ In General; Request and Compliance

Claimant of an exemption from disclosure under the Freedom of Information Act must provide more than conclusory language, generalized allegations or mere arguments of counsel; rather, a sufficiently detailed record must reflect the reasons why an exemption applies to the materials requested. C.G.S.A. § 1-210(b).

6 Cases that cite this headnote

[8] Records

⚡ Matters Subject to Disclosure; Exemptions
Records

⚡ Discretion and Equitable Considerations; Balancing Interests

In deciding whether the Freedom of Information Act's public safety exemption applied to data from town's geographic information system (GIS), trial court was not required to balance the town's interest in public safety with the public's right to accessible information; Act's exemptions already incorporated the judgment of legislature with regard to balancing the public interest in disclosure of records with the need for confidentiality. C.G.S.A. § 1-210(b)(19).

2 Cases that cite this headnote

[9] Records

⚡ Judicial Enforcement in General

In concluding that Freedom of Information Act's public safety exemption did not apply to data from town's geographic information system (GIS), trial court did not impose an inappropriate burden on the director of town's department of information technology when it suggested that director could have demonstrated safety risk by using statistical data correlating criminal or terrorist activity with the disclosure of GIS data; trial court did not require the director to provide such statistical data. C.G.S.A. § 1-210(b)(19).

1 Cases that cite this headnote

[10] Records

⚡ Matters Subject to Disclosure; Exemptions

Generalized testimony of town's police chief, expressing his concerns regarding potential threat to the safety of town's residents if computerized data from the town's geographic information system (GIS) were disclosed, was insufficient to prove applicability of public safety exemption from disclosure under the Freedom of Information Act. C.G.S.A. § 1-210(b)(19).

Cases that cite this headnote

[11] Records

⚡ Trade Secrets and Commercial or Financial Information

Data from town's geographic information system (GIS) did not constitute a "trade secret" within meaning of trade secret exemption from disclosure under the Freedom of Information Act; the GIS database was a compilation of information that was already available to the public through various town departments, such that the GIS data failed to meet threshold test for trade secrets, i.e., that the information not be generally ascertainable by others. C.G.S.A. § 1-210(5)(A).

1 Cases that cite this headnote

[12] Records

☞ Trade Secrets and Commercial or Financial Information

To qualify for a trade secret exemption from disclosure under the Freedom of Information Act, a substantial element of secrecy must exist, to the extent that there would be difficulty in acquiring the information except by the use of improper means. C.G.S.A. § 1-210(5)(A).

2 Cases that cite this headnote

[13] Records

☞ Matters Subject to Disclosure; Exemptions
Director of town's department of information technology failed to meet his burden to show that security or integrity of town's information technology system would be compromised by disclosure of computerized data from town's geographic information system (GIS), as required to invoke pertinent exemption under the Freedom of Information Act; director testified that he was concerned about vulnerability of town's network to a security breach and that computer firewalls were not foolproof, but did not provide specific examples of security breaches or evidence that any such breaches had been caused by disclosure of GIS data. C.G.S.A. § 1-210(b)(20).

Cases that cite this headnote

Attorneys and Law Firms

**787 Haden P. Gerrish, assistant town attorney, with whom were John K. Wetmore, Greenwich, town attorney, and Robert M. Shields, Jr., Hartford, for the appellant (plaintiff).

Clifton A. Leonhardt, chief counsel, with whom were M. Dean Montgomery and, on the brief, Mitchell W. Pearlman, general counsel, for the appellee (named defendant).

Daniel J. Klau, Lucy Dalglisch, pro hac vice, David B. Smallman and Andrew L. Deutsch, pro hac vice, filed a brief for the Reporters Committee for Freedom of the Press et al. as amici curiae.

SULLIVAN, C.J., and NORCOTT, KATZ, PALMER and VERTEFEUILLE, Js.

Opinion

VERTEFEUILLE, J.

*181 The plaintiff, the director of the department of information technology of the town of Greenwich (town), appeals from the trial court's judgment dismissing his administrative appeal from a final decision of the named defendant, the freedom of information commission (commission). In its decision, the commission ordered the plaintiff to provide the complainant, Stephen Whitaker,¹ with copies of certain computerized data from the town's geographic information system (GIS). We affirm the judgment of the trial court.

*182 The trial court relied on the following relevant facts from the administrative record. In December, 2001, Whitaker submitted a written request to the town's board of estimate and taxation, asking for a copy of all GIS data concerning orthophotography, arc info coverages, structured query language server databases, and all documentation created to support and define coverages for the arc info data **788 set.² His request was forwarded to the plaintiff, who subsequently denied Whitaker's request, claiming that the data was exempt from disclosure under the Freedom of Information Act (act), General Statutes § 1-200 et seq. Specifically, the plaintiff claimed that the data requested by Whitaker was exempt from disclosure pursuant to General Statutes § 1-210(b)(5)(A),³ which provides an exemption from *183 disclosure for trade secrets, and § 1-210(b)(20),⁴ which exempts from disclosure information that

would compromise the security of an information technology system. Whitaker subsequently filed a complaint with the commission, claiming that the plaintiff refused to provide him with a copy of the town's computerized GIS records that he requested. The commission held a hearing in January, 2002, at which it found that the information requested by Whitaker was not exempt because it did not constitute either a trade secret within the meaning of § 1-210(b)(5)(A), or the type of information that would pose a threat to the security of the town's information technology system within the meaning of § 1-210(b)(20). Accordingly, the commission issued a final decision in November, 2002, in which it ordered the plaintiff to disclose the requested records, excluding only medical information and social security numbers, should any appear in the requested data.

The plaintiff subsequently appealed from the commission's decision to the trial court, which concluded, after a hearing, **789 that the plaintiff had failed to substantiate his claim that the requested records were exempt from disclosure. Specifically, the trial court found that the plaintiff had failed to provide any specific evidence that would demonstrate that disclosure of the requested data would compromise the security or integrity of the town's information technology system. Further, the trial court found that the records did not constitute trade secrets within the meaning of § 1-210(b)(5)(A), *184 because the requested data was merely a computerized compilation of the town's records that otherwise could be obtained by requesting the information piecemeal from various individual town departments. The trial court therefore dismissed the plaintiff's appeal. The plaintiff appealed from the trial court's judgment to the Appellate Court, and we thereafter transferred the appeal to this court pursuant to General Statutes § 51-199(c) and Practice Book § 65-1.

On appeal, the plaintiff claims that the trial court improperly determined that the commission was correct in concluding that the data requested by Whitaker was not exempt pursuant to § 1-210(b)(5)(A), (19) and (20). The plaintiff first argues that No. 02-133, § 1, of the 2002 Public Acts (P.A. 02-133)⁵ amended § 1-210(b)(19)⁶ to **790 broaden the public safety exemption such *185 that the data requested by Whitaker were exempt from disclosure, and the legislative history surrounding the enactment of the public act demonstrates that it was intended to address exactly this type of case.⁷ Thus, the plaintiff claims that the commission improperly failed to *186 apply the expanded exemption in this case. The plaintiff further claims that,

although the act does not expressly require a balancing of the government's and the public's interests, the trial court failed to weigh appropriately the public's interest in disclosure against the town's public safety interest, and that the trial court improperly required the plaintiff to present statistical data showing a correlation between the disclosure of GIS data and a threat of criminal or terrorist activity. The plaintiff also contends that the requested GIS data satisfies the requirements of the trade secret exemption to the act in § 1-210(b)(5)(A), because the data constitutes a compilation that derives intrinsic economic value by not being readily ascertainable by those wishing to obtain economic value from its use. Finally, the plaintiff claims that the disclosure of the requested GIS data would compromise the integrity of the town's information technology system, possibly exposing it to computer hackers, which in turn would create a security risk for the town.

The commission counters that the policy of the act favors free access to government records, and, although the commission's final decision and the trial court's memorandum of decision did not discuss at length P.A. 02-133, § 1, both the commission and the trial court considered the public act in analyzing the existence of any threat to public safety posed by the disclosure of the requested data. Further, the commission claims that the trial court correctly balanced any possible safety risk against the public's right to access the requested data, and the trial court did not require statistical data correlating criminal and terrorist activity with disclosure, but, rather, merely observed that such correlation data would have been a method by which the plaintiff could have met his burden of showing the existence of a safety risk. The commission also argues that the right to information under P.A. 02-133, § 1, includes the right *187 to access the data in the same computerized form that the government agency itself uses. In addition, the commission claims that disclosure of the requested GIS data will not reveal any exempt trade secrets in violation of § 1-210(b)(5)(A), because the plaintiff **791 is not engaged in a trade and is not protecting secrets of such a trade. The commission further argues that there is no evidence that the disclosure of the GIS data presents a security threat to the town's information technology system within the meaning of § 1-210(b)(20). We agree with the commission, and, accordingly, we affirm the judgment of the trial court.

[1] [2] [3] By way of background, we cite briefly the policy of the act and the burden of a party claiming exemption from disclosure under the act. The act "makes disclosure of public records the statutory norm." (Internal quotation

marks omitted.) *Chairman, Criminal Justice Commission v. Freedom of Information Commission*, 217 Conn. 193, 196, 585 A.2d 96 (1991). “[I]t is well established that the general rule under the [act] is disclosure, and any exception to that rule will be narrowly construed in light of the general policy of openness expressed in the [act].... [Thus] [t]he burden of proving the applicability of an exception [to disclosure under the act] rests upon the party claiming it.” (Citation omitted; internal quotation marks omitted.) *Ottochian v. Freedom of Information Commission*, 221 Conn. 393, 398, 604 A.2d 351 (1992).

[4] As a preliminary matter, we set forth the applicable standard of review. “[T]he present case involves applying the well settled meaning of [the exemptions laid out in] § 1-210(b) ... to the facts of this particular case. The appropriate standard of judicial review, therefore, is whether the commission’s factual determinations are reasonably supported by substantial evidence in the record taken as a whole.” *188 *Rocque v. Freedom of Information Commission*, 255 Conn. 651, 659-60, 774 A.2d 957 (2001).

I

[5] We begin by addressing whether the trial court improperly failed to consider the applicability of P.A. 02-133, § 1, to the records sought by Whitaker. The plaintiff claims that the trial court did not apply § 1-210(b)(19) as amended by P.A. 02-133, § 1, and it improperly failed to remand the matter to the commission to determine whether the requested records were exempt under the public act. The commission counters that the trial court properly considered the applicability of P.A. 02-133, § 1. We agree with the commission. In setting forth the standard of review applicable to the commission’s decision, the trial court explicitly referenced § 1-210(b)(19), as amended, and it analyzed whether the requested GIS data were exempt due to public safety concerns. The trial court decision thereby implicated § 1-210(b)(19) and (20), both of which subdivisions provide exemptions from disclosure under certain circumstances when public safety is at risk. Accordingly, contrary to the plaintiff’s claim, the trial court did consider the amended version of § 1-210(b)(19).⁸

**792 [6] Section 1-210(b)(19) sets forth the procedure through which a state or municipal agency may pursue an exemption from disclosure under the act when there *189 are reasonable grounds to believe that disclosure would pose a safety risk to any person or government-owned facility.

When there are reasonable grounds to believe disclosure may pose a risk to public safety, “[s]uch reasonable grounds shall be determined ... with respect to records concerning any executive branch agency of the state or any municipal, district or regional agency, by the Commissioner of Public Works, after consultation with the chief executive officer of the agency” General Statutes § 1-210(b)(19)(A). In the present case, the plaintiff specifically argues that he was not afforded the opportunity to have the requested GIS data reviewed by the commissioner of public works in order to ascertain whether its disclosure would pose a safety risk within the meaning of § 1-210(b)(19) as amended. The plaintiff claims that the trial court was remiss in not remanding the matter to the commission so that the commissioner of public works could conduct such a review. We disagree.

Although § 1-210(b)(19) does not specifically provide which party is to seek a public safety determination by the commissioner of public works, we conclude that the plaintiff bore the burden of seeking such a determination. It is axiomatic that the burden of proving the applicability of any exemption in the act rests with the party claiming the exemption. See *Ottochian v. Freedom of Information Commission*, supra, 221 Conn. at 398, 604 A.2d 351. Here, that is the plaintiff. It follows that the plaintiff, therefore, was obligated to seek a public safety determination from the commissioner of public works in support of his claim that the GIS records were exempt from disclosure. Moreover, we note that the floor debate in the legislature regarding the passage of P.A. 02-133, § 1, described the law as providing that municipalities, certain state agencies, public service companies, telecommunication companies and water utilities may *apply* for permission to keep sensitive documents from *190 the public. 45 H.R. Proc., Pt. 15, 2002 Sess., pp. 4580-81. The use of the word “apply” makes clear the legislative intent that the party claiming a public safety exemption must seek the determination from the commissioner. The plaintiff never sought the required consultation with the commissioner of public works. Nor did he at any time request that the trial court remand the case so that the public works commissioner could make a public safety determination. Accordingly, we conclude that the plaintiff’s first claim on appeal is unavailing.

II

We turn next to the plaintiff’s assertion that the trial court improperly failed to balance the town’s interest in public

safety with the public's right to disclosure under the act, and that the trial court improperly required the plaintiff to present statistical data correlating criminal or terrorist activity with the disclosure of GIS data. The commission responds that the trial court did balance appropriately the town's interest in public safety with the public's right to accessible information, and that the trial court did not "require" the plaintiff to produce statistical data. We conclude that the trial court was not required to undertake any balancing to resolve the public safety exemption and that the trial court did not require that the plaintiff submit statistical data.

The following additional facts are relevant to the resolution of this issue. At the hearing before the commission, Peter J. Robbins, the town's chief of police, testified **793 generally about his concerns regarding the potential threat to the safety of the town's residents if the requested GIS data were to be disclosed. Robbins testified that, "[b]ecause of [the town's] affluence [it is] frequently targeted for criminal activity" He further testified that the town's proximity to the Merritt Parkway, Interstate 95, and the waterfront made the *191 town an inviting target for professional thieves. When asked how the disclosure of the GIS data would assist in such criminal activities, Robbins responded, "that type of information can certainly have a severe impact on the community," and that he thought that "it also can provide some serious risk for homeowners because that access ... would provide overhead views of structures, the footprints of those structures, fence lines, the topography, in some cases it may, depending on when those photos were taken from the air, could reveal some security measures that individual homeowners have put in place." Robbins further testified that the GIS data might be used to carry out identity theft or disturb the privacy of public figures who live in the town, or it could be used to interfere with the safety and security of town residents or to allow someone to compromise the police radio system and communications network.

In assessing whether this testimony was sufficient to establish the existence of a legitimate public safety risk, the trial court observed that "[t]here is no nexus between [Robbins'] opinion and the ultimate conclusion. More importantly, [the] plaintiff fails to provide through [Robbins'] testimony any specific statistical data that correlates criminal activity or potential terrorist type activity with disclosure of GIS data. Additionally, no specific evidence was provided to demonstrate how disclosure of the requested data would compromise the security or integrity of the GIS."

[7] As we noted previously, "[t]he burden of proving the applicability of an exception [to disclosure under the act] rests upon the party claiming it." (Internal quotation marks omitted.) *Ottochian v. Freedom of Information Commission*, supra, 221 Conn. at 398, 604 A.2d 351. In particular, "[t]his burden requires the claimant of the exemption to provide more than conclusory language, generalized allegations or mere arguments of counsel. Rather, a *192 sufficiently detailed record must reflect the reasons why an exemption applies to the materials requested." *New Haven v. Freedom of Information Commission*, 205 Conn. 767, 776, 535 A.2d 1297 (1988). With regard to weighing the interests of a party claiming an exemption against the public's interest in disclosure, this court has stated that "within the language itself of the [act], the legislature has [already balanced] the public's right to know and the private needs for confidentiality.... Therefore, neither the [commission] nor the courts are required to engage in a separate balancing procedure beyond the limits of the statute." (Citation omitted; internal quotation marks omitted.) *Chairman, Criminal Justice Commission v. Freedom of Information Commission*, supra, 217 Conn. at 200-201, 585 A.2d 96.

[8] The exemptions provided in § 1-210(b) of the act incorporate the judgment of the legislature with regard to balancing the public interest in disclosure of records with the need for confidentiality. As the passage of P.A. 02-133, § 1, demonstrates, the legislature adjusts the balance between the right to know and the need for confidentiality as circumstances change. The text of § 1-210(b)(19), as amended, does not require the courts to conduct any balancing in order to determine the applicability of that exemption. The silence on this issue is in contrast to exemptions where such a balancing explicitly is required, **794 such as, for example, § 1-210(b)(1). We find no merit to the plaintiff's unsupported claim that the trial court's judgment should be reversed for the court's failure to undertake a balancing of public interest disclosure against necessary confidentiality when the statute providing the exemption does not require such a balancing.

[9] [10] We further conclude, contrary to the plaintiff's contention, that the trial court did not *require* specific statistical data correlating criminal and terrorist activity with the disclosure of GIS data. The trial court stated *193 that it did not find convincing the generalized testimony by Robbins as the plaintiff's sole evidence to support his argument that the release of the GIS data would pose a legitimate public safety concern. Such generalized claims of a possible safety risk do not satisfy the plaintiff's burden of

proving the applicability of an exemption from disclosure under the act. See *New Haven v. Freedom of Information Commission*, supra, 205 Conn. at 776, 535 A.2d 1297. In explaining why it was not convinced by Robbins' testimony at the commission hearing, the trial court stated that the town did not present any evidence through the police chief to establish a nexus between his opinion and the conclusion that the release of the data would pose a safety risk. In doing so, the trial court merely suggested that one way of demonstrating the safety risk would have been through the use of statistical data correlating criminal or terrorist activity with the disclosure of GIS data. The trial court similarly suggested that the plaintiff could have provided evidence demonstrating how the disclosure of GIS data would compromise the security or integrity of GIS. Nowhere in its opinion, however, did the trial court require the plaintiff to provide such statistical data to prove a correlation between criminal or terrorist activity and the disclosure of GIS data. Accordingly, the trial court did not improperly impose an inappropriate burden on the plaintiff.

III

Finally, we address the issue of whether the trial court properly found that the plaintiff failed to meet his burden of proof to show that the requested GIS data were exempt under the act because disclosure would either reveal a trade secret within the meaning of § 1-210(b)(5)(A), or pose a threat to the security of the town's information technology system within the meaning of § 1-210(b)(20). The plaintiff contends that the requested documents fall within the definition of a *194 trade secret under the act because the GIS database derives its economic value from not being available to members of the public, such as Whitaker, who may use the information for their own economic gain. The plaintiff further claims that the requested information falls within the § 1-210(b)(20) security exemption under the act because its disclosure would pose a security risk to the town's information technology system. The commission counters that neither exemption applies to the records sought in this case. We agree with the commission.

As we have noted previously, the party claiming an exemption from disclosure under the act has the burden of proving its applicability, and in order to meet that burden, the party claiming the exemption must provide more than general or conclusory statements in support of its contention. See *Chairman, Criminal Justice Commission v. Freedom of Information Commission*, supra, 217 Conn. at 196, 585

A.2d 96; *New Haven v. Freedom of Information Commission*, supra, 205 Conn. at 776, 535 A.2d 1297.

[11] [12] To qualify for an exemption within the meaning of § 1-210(b)(5)(A), **795 the requested records must constitute a trade secret within the meaning of the act, which is defined as "information, including formulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, or customer lists that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy ..." In order to qualify for a trade secret exemption under § 1-210(b)(5)(A), "[a] substantial element of secrecy must exist, to the extent that there would be difficulty in acquiring the information except by the use of improper means." (Internal quotation marks omitted.) *Dept. of *195 Public Utilities v. Freedom of Information Commission*, 55 Conn.App. 527, 532, 739 A.2d 328 (1999). The requested GIS data in the present case, however, is readily available to the public, and, accordingly, it does not fall within the plain language of § 1-210(b)(5)(A) as a trade secret. As the trial court noted, the GIS database is an electronic compilation of the records of many of the town's departments. Members of the public seeking the GIS data could obtain separate portions of the data from various town departments, where that data is available for disclosure. The requested GIS database simply is a convenient compilation of information that is already available to the public. The records therefore fail to meet the threshold test for trade secrets, that the information is not generally ascertainable by others.

[13] We turn now to the plaintiff's claim that the trial court improperly found that the plaintiff did not meet his burden of proof that the records were exempt under § 1-210(b)(20). That subsection provides an exemption to disclosure for "[r]ecords of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system" General Statutes § 1-210(b)(20). The trial court found that the plaintiff did not meet his burden in attempting to show that the requested disclosure would compromise the security of the town's entire information technology system. As the trial court noted, the plaintiff did not present any specific evidence to demonstrate how the disclosure of the requested GIS data would compromise the overall security of the town's information technology

system. The plaintiff testified that he was concerned about the vulnerability of the town's network to a security breach should the network become available to the public. In support of this concern, the plaintiff stated that computer firewalls are not foolproof, and that the firewalls of "[m]any high *196 security agencies" had been breached. The plaintiff, however, did not provide specific examples of such security breaches, or evidence that any such breaches had been caused by the disclosure of GIS data.

We agree with the trial court that the plaintiff failed to meet his burden to show that the security or integrity of the town's information technology system would be compromised by

disclosure of the GIS data. Accordingly, the evidence presented in this case was insufficient to establish that the requested GIS data were exempt from public disclosure under the act.

The judgment is affirmed.

In this opinion the other justices concurred.

Parallel Citations

874 A.2d 785, 33 Media L. Rep. 2128

Footnotes

- 1 Whitaker is also named as a defendant in this appeal. For purposes of clarity, we refer to him by name.
- 2 Orthophotography consists of high resolution photographic images of the town taken from aircraft flying overhead. Arc info coverages are data compiled by the town for its use with the GIS software, including points, lines, and polygons depicting road center lines, building footprints, possibly water and sewer lines, planned fiber optic networks, and survey points, which can be overlaid on the orthophotography. The structured query language server databases consist of data compiled by the town for use in its tax assessment databases, which includes information about property ownership, assessed value, prior assessed value, and addresses. The support documentation consists of records of when the data was input, what source was used, who input the data, the accuracy of the data, and how often the data is updated. During testimony before the trial court, the data was summarized as a "composite" of maps of individual and commercial properties and high resolution aerial photographs of the town.
- 3 General Statutes § 1-210(b) provides in relevant part: "Nothing in the Freedom of Information Act shall be construed to require disclosure of ...
"(5)(A) Trade secrets, which for purposes of the Freedom of Information Act, are defined as information, including formulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, or customer lists that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy"
We note that since December, 2001, when Whitaker first sought disclosure of the requested information, § 1-210 has been amended several times, however, subsection (b)(5)(A) has remained virtually unchanged. For purposes of clarity, we refer herein to the current revision of the statute.
- 4 General Statutes § 1-210(b) provides in relevant part: "Nothing in the Freedom of Information Act shall be construed to require disclosure of ...
"(20) Records of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system"
We note that since December, 2001, when Whitaker first sought disclosure of the requested information, § 1-210 has been amended several times, however, subsection (b)(20) has remained virtually unchanged. For purposes of clarity, we refer herein to the current revision of the statute.
- 5 Public Act 02-133, § 1, added to § 1-210(b)(19) a list of factors to be considered in determining whether reasonable grounds exist to believe that disclosure of records may result in a safety risk.
- 6 General Statutes § 1-210(b) provides in relevant part: "Nothing in the Freedom of Information Act shall be construed to require disclosure of ...
"(19) Records when there are reasonable grounds to believe disclosure may result in a safety risk, including the risk of harm to any person, any government-owned or leased institution or facility or any fixture or appurtenance and equipment attached to, or contained in, such institution or facility, except that such records shall be disclosed to a law enforcement agency upon the request of the law enforcement agency. Such reasonable grounds shall be determined (A) with respect to records concerning any executive

branch agency of the state or any municipal, district or regional agency, by the Commissioner of Public Works, after consultation with the chief executive officer of the agency; (B) with respect to records concerning Judicial Department facilities, by the Chief Court Administrator; and (C) with respect to records concerning the Legislative Department, by the executive director of the Joint Committee on Legislative Management. As used in this section, 'government-owned or leased institution or facility' includes, but is not limited to, an institution or facility owned or leased by a public service company, as defined in section 16-1, a certified telecommunications provider, as defined in section 16-1, a water company, as defined in section 25-32a, or a municipal utility that furnishes electric, gas or water service, but does not include an institution or facility owned or leased by the federal government, and 'chief executive officer' includes, but is not limited to, an agency head, department head, executive director or chief executive officer. Such records include, but are not limited to:

- “(i) Security manuals or reports;
- “(ii) Engineering and architectural drawings of government-owned or leased institutions or facilities;
- “(iii) Operational specifications of security systems utilized at any government-owned or leased institution or facility, except that a general description of any such security system and the cost and quality of such system, may be disclosed;
- “(iv) Training manuals prepared for government-owned or leased institutions or facilities that describe, in any manner, security procedures, emergency plans or security equipment;
- “(v) Internal security audits of government-owned or leased institutions or facilities;
- “(vi) Minutes or records of meetings, or portions of such minutes or records, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;
- “(vii) Logs or other documents that contain information on the movement or assignment of security personnel at government-owned or leased institutions or facilities;
- “(viii) Emergency plans and emergency recovery or response plans; and
- “(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, operational plans, portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection reports, technical specifications and other materials that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply”

In addition to the changes effected by P.A. 02-133, § 1, subsection (b)(19) of § 1-210 was further amended in 2003. See Public Acts, Spec. Sess., June, 2003, No. 03-6, § 104. For purposes of clarity, we refer herein to the current revision of the statute.

7 Public Act 02-133, § 1, was enacted in October, 2002, as part of the state's effort to bolster security in the wake of the September 11, 2001 terrorist attacks. See 45 H.R. Proc., Pt. 15, 2002 Sess., p. 4579. The public act was not in effect at the time of the proceedings before the commission, but it took effect in October, 2002, shortly before the commission issued its final decision. The plaintiff did not amend his answer before the commission to request an exemption under the public act, and, hence, the plaintiff did not formally inject the newly amended § 1-210(b)(19) into the proceedings.

8 We note that the plaintiff did not expressly mention § 1-210(b)(19) in his posttrial brief to the trial court. Rather, the first mention of that statutory section was made by the *commission* in its brief to the trial court. In addition to his failure to raise the section on which he now relies, the plaintiff did not file a motion for articulation when the trial court issued its decision without discussing in detail the applicability of the exemption of § 1-210(b)(19) as amended by P.A. 02-133, § 1. Although the trial court's consideration of § 1-210(b)(19) provides a record sufficient to preserve the claim, the appropriate remedy for the plaintiff's dissatisfaction with the trial court's failure to elaborate would have been to file a motion for articulation. See, e.g., *McLaughlin v. Bronson*, 206 Conn. 267, 277, 537 A.2d 1004 (1988).

February 4, 2015

VIA REGULAR & ELECTRONIC MAIL

Marianne I. Horn, Esq., Legal Director
Department of Public Health
410 Capital Avenue, MS #12HSR
P. O. Box 340308
Hartford, CT 06106

Re: Yale-New Haven Hospital
Inpatient Rehabilitation Unit at Milford Hospital

Dear Ms. Horn:

The undersigned counsel for Yale-New Haven Hospital (“YNHH”) and Milford Hospital (“MH”) respectfully submit the following supplemental information for your review in this matter. We understand that a decision is forthcoming with respect to whether the relocation of YNHH’s inpatient rehabilitation unit (“IRU”) to leased space at MH requires CON approval. We believe that this information is relevant to OHCA’s decision and ask that it be considered prior to a determination of jurisdiction by the agency.

As a threshold matter, we would like to reiterate that there is no legal basis for OHCA to conclude that the relocation of YNHH’s IRU is a “termination of inpatient or outpatient services offered by a hospital” under Section 19a-638(a)(4) of the Connecticut General Statutes. The word “termination” is not defined in the OHCA statutes. However, it is a well-accepted rule of statutory construction that in the absence of any ambiguity, the “plain meaning” of a statute controls its interpretation.

This concept has been codified in Connecticut General Statutes Section 1-2z as follows:

The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered.

Similarly, Section 1-1(a) of the General Statutes states as follows:

In the construction of the statutes, words and phrases shall be construed according to the commonly approved usage of the language; and technical words and phrases, and such as have acquired a peculiar and appropriate meaning in the law, shall be construed and understood accordingly.

The plain meaning and commonly approved usage of the word “termination,” per the Oxford Dictionary, is “[t]he action of bringing something or coming to an end.” Section 19a-638(a)(4) therefore mandates CON approval only when a hospital is ending or discontinuing a service. Relocating a service does not bring it to an end, particularly when there will be no changes in the nature of the service, staffing or patient population once it is relocated. To find that a relocation of services is a “termination” would be contrary to the plain meaning and common usage of the word and would yield the absurd and unworkable results that Section 1-2z seeks to avoid as OHCA and the entities it regulates would then be in the equally untenable positions of determining how much of a service relocation (e.g., across campus, across town, etc.) constitutes a service termination without any legislative guidance on the issue. This would clearly be detrimental to the health care delivery system and it would also be inconsistent with the legislative history of Section 19a-638 as discussed in our previous submissions.

In addition, an agency’s construction of a statute is not entitled to any special deference, and is a question of law for the courts, where it has not previously been subjected to judicial scrutiny or “time-tested” interpretation by the agency. *Connecticut State Medical Society et al. v. Connecticut Board of Examiners in Podiatry et al.*, 208 Conn. 709, 718 (1988) (Exhibit A). A court will only accord deference to a “time-tested” agency interpretation of a statute when the agency has consistently followed its construction over a long period of time, the statutory language is ambiguous and the agency’s interpretation is reasonable. *Connecticut State Medical Society et al.*, at 719. As mentioned above, the language of 19a-638(a)(4) is unambiguous. In addition, OHCA has not consistently interpreted relocations of services by hospitals to be terminations requiring CON approval, as the examples below demonstrate. Moreover, interpreting the word “termination” to encompass relocations is not a reasonable interpretation of the plain language of Section 19a-638(a)(4).

OHCA has previously allowed the relocation of hospital services without CON approval. For example, OHCA authorized the relocation of Hartford Hospital’s Child and Adolescent Partial Hospital Program from Bloomfield to the Institute of Living in Hartford (Report No. 11-31704-DTR, attached as Exhibit B; *see also* Report Nos. 11-31729 DTR (L&M outpatient cancer services); 13-31881-DTR (L&M blood draw services); & 14-31936-DTR (St. Vincent’s heart and vascular testing services). In the Hartford Hospital example, the relocation of the program was not considered a termination of services under Section 19a-638(a)(4) despite the fact that the service was no longer available in Bloomfield. Instead, OHCA determined that the patient population and payer mix were not changing with the relocation and approved it under Section 19a-639c of the General Statutes. The situation with YNHHS’s IRU is no different. In fact, because the YNHHS IRU is an inpatient referral-only service, the impact of relocation on access is far less significant than in the outpatient context described above. Finally, we note that even under prior law that was more restrictive in terms of service relocations, OHCA issued

determinations that permitted relocations to proceed without CON approval. See Exhibit C, OHCA Report 05-30501-DTR (relocation of MH's urgent care center did not require a CON).

Alternatively, based on the exigent circumstances facing both hospitals and the need to avoid the time and expense of a CON process, YNHH would be willing to accept the characterization of its IRU as a "facility" for purposes of Section 19a-639c. Federal regulations under 42 CFR Part 412 define a PPS exempt rehabilitation unit of an acute care hospital as an Inpatient Rehabilitation Facility. A copy of a September 30, 2014 CMS letter to YNHH confirming the IRU's certification as an IRF is attached as Exhibit D.¹ YNHH has shown that neither the payer mix nor the patient population for this "facility" will change with the relocation. Therefore, no CON is required.

We thank you for the opportunity to submit this additional information. We believe that this information, along with the prior submissions of our clients, demonstrate that no CON approval is required for relocation of the YNHH IRU. We would welcome the opportunity to discuss this with you in greater detail prior to the issuance of any decision by OHCA.

¹ Please note that the six bed increase referenced in the CMS letter was accommodated within YNHH's total licensed bed capacity and did not result in an increase in licensed beds.



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EXHIBIT A

208 Conn. 709
Supreme Court of Connecticut.

CONNECTICUT STATE MEDICAL SOCIETY et al.

v.

CONNECTICUT BOARD OF
EXAMINERS IN PODIATRY et al.

Nos. 13334, 13335. | Argued June
9, 1988. | Decided Aug. 23, 1988.

Medical Society and physician members appealed from declaratory ruling of Board of Examiners in Podiatry with regard to scope of podiatry practice in state. On remand, 203 Conn. 295, 524 A.2d 636, the Superior Court, in the Judicial District of New Haven, J. Flanagan, J., sustained appeal, and defendants appealed. The Supreme Court, Hull, J., held that notwithstanding contrary interpretation by Board of Examiners in Podiatry, statute defining scope of podiatry practice in state, as treating ailments "of the foot," did not include treatment of ankle.

No error.

West Headnotes (5)

[1] **Administrative Law and Procedure**
↔ Discretion of Administrative Agency

Administrative Law and Procedure

↔ Fact Questions

Administrative agency's factual and discretionary determinations are accorded considerable weight by reviewing courts.

30 Cases that cite this headnote

[2] **Health**
↔ Regulation of Professional Conduct;
Boards and Officers

Interpretation of podiatry practice statute by Board of Examiners in Podiatry was not entitled to any special deference by reviewing court in that statutory definition of podiatry practice was question of law, which had not yet been

subjected to judicial scrutiny or time-tested agency interpretations. C.G.S.A. § 20-50.

39 Cases that cite this headnote

[3] **Health**
↔ Regulation of Professional Conduct;
Boards and Officers

Board of Examiner's knowledge of and acquiescence in certain podiatric practices did not rise to level of statutory construction entitled to judicial deference when court reviewed statute defining scope of podiatric practice. C.G.S.A. § 20-50.

2 Cases that cite this headnote

[4] **Health**
↔ Regulation of Professional Conduct;
Boards and Officers

Court reviewing Board of Examiner's interpretation of statute defining podiatric practice did not fail to give proper deference to Attorney General opinion, in that opinion merely referred matter to Board for "factual determination" and contained no legal analysis of type to which court traditionally granted deference.

8 Cases that cite this headnote

[5] **Health**
↔ Regulation of Professional Conduct;
Boards and Officers

Notwithstanding contrary interpretation by Board of Examiners in Podiatry, statute defining scope of podiatry practice in state, as treating ailments "of the foot," did not include treatment of ankle. C.G.S.A. § 20-50.

1 Cases that cite this headnote

Attorneys and Law Firms

**830 *710 William J. McCullough, Asst. Atty. Gen., with whom, on the brief, were Joseph I. Lieberman, Atty. Gen.,

and Robert E. Walsh and Richard J. Lynch, Asst. Attys. Gen., for appellant (named defendant).

****831** William H. Narwold, with whom were Eric Watt Wiechmann and, on the brief, Karen L. Goldthwaite, Hartford, for appellants (defendant Steven Perlmutter et al.).

Linda L. Randell, with whom were Jeanette C. Schreiber, New Haven, and Andrew W. Roraback, Litchfield, for appellees (plaintiffs).

Before ***709** PETERS, C.J., and CALLAHAN, GLASS, COVELLO and HULL, JJ.

Opinion

***711** HULL, Associate Justice.

The dispositive issue in this appeal is whether the trial court erred in sustaining the appeal of the plaintiffs, the Connecticut State Medical Society and Enzo Sella, M.D., from a declaratory ruling of the defendant Connecticut Board of Examiners in Podiatry (board). In proceedings to determine whether the scope of podiatry practice, as defined in General Statutes § 20-50,¹ includes treatment of the ankle in certain respects,² the board had declared that "the ankle is part of the foot and the foot is part of the ankle." We conclude that the court applied the correct standard of review of the board's ruling in determining that as a matter of law the board had erroneously construed the applicable statute. Accordingly, we find no error.

***712** This case has its genesis in the following ruling by a Medicare intermediary in January, 1984: "Podiatrists meet the Medicare definition of physician to the extent that state law permits their practice. In Connecticut that practice is limited to the diagnosis, prevention and treatment of foot ailments; therefore, services involving the ankle are not covered by Medicare." This ruling caused great concern to doctors of podiatric medicine. In a letter dated March 18, 1984, the board sought an opinion from the attorney general on the following question: "Is the diagnosis and treatment of sprains, strains and positional abnormalities of the ankle ... within the scope of podiatry practice in Connecticut?" In its request, the board noted that "[p]odiatrists in Connecticut have conservatively treated minor sprains, strains and fractures of the foot and ankle for many years without any regulatory or reimbursement questions being raised."

The attorney general responded by letter dated May 30, 1984, and stated that the "question posed in the request for advice is one which calls for a factual determination. In order to respond, analysis must first be conducted of the human anatomy to ascertain whether the ankle is, in fact, part of the foot, or vice-versa. Once accomplished, the analysis would have to continue with the determination of whether a sprain or strain of the ankle is, in fact, an 'ailment of the foot.' Conn.Gen.Stat. § 20-50." 62 Op.Conn.Atty.Gen. 229, 231 (1984). The attorney general concluded that "[these] factual issues identified above are best addressed ****832** by the Board of Examiners in Podiatry directly." Id. The attorney general's opinion then set forth three mechanisms that the board could utilize to resolve these factual issues: (1) a declaratory ruling pursuant to General Statutes § 4-176; (2) regulations pursuant to General Statutes § 19a-14(a)(4); or (3) adjudication of a disciplinary complaint concerning a podiatrist claimed to ***713** be acting beyond the scope of his licensure, pursuant to General Statutes § 20-59. Id.

After issuance of the attorney general's opinion, three doctors of podiatric medicine, the defendants Steven Perlmutter, Kove J. Schwartz and Harvey D. Lederman, wrote separately to the board requesting clarification of the opinion. In September, 1984, the board issued a notice of hearing, pursuant to § 4-176,³ stating that a hearing would be held "for the purpose of issuing a declaratory ruling as requested on the issue of: Whether the diagnosis and treatment of sprains, strains and positional abnormalities of the ankle [are] within the scope of podiatry practice in Connecticut." The commissioner of health services and the three named doctors of podiatric medicine were designated as parties to the proceedings.

The board conducted the hearing on November 7, 1984, and received fifteen exhibits and heard testimony from eleven witnesses, both podiatrists and medical doctors, concerning the anatomical relationship between the foot and the ankle.⁴ It subsequently issued a declaratory ruling that the ankle is part of the foot and that podiatrists could, therefore, treat ankle ailments. The ***714** plaintiffs appealed from the board's ruling, pursuant to General Statutes § 4-183(a).⁵ The defendants moved to dismiss the appeals on the ground that the plaintiffs failed to allege sufficient facts from which aggravement could be found. The trial court granted the motion to dismiss. On the plaintiffs' appeal from the judgment of dismissal, we reversed and remanded, holding that the allegations of the plaintiffs' complaint satisfied the pleading requirements for aggravement. *Connecticut State Medical*

Society v. Board of Examiners in Podiatry, 203 Conn. 295, 303-304, 524 A.2d 636 (1987).

On remand, the trial court found that the plaintiffs were aggrieved and sustained their administrative appeal. The court characterized the issue as whether the board's actions represented a valid interpretation of the statute or an impermissible attempt to expand the scope of podiatry practice. It acknowledged that the board, as an agency within the meaning of General Statutes § 4-166(1), may properly issue declaratory rulings, pursuant to § 4-176, predicated on its interpretation of statutes made for its guidance and which it is charged with administering. It noted, however, that such an agency must act strictly ****833** within its statutory authority and cannot modify, abridge or otherwise change the statutory provisions under which it acquires authority. The court stated that its review was not limited to a determination of whether the board's declaratory ruling interpreting a statute was clearly ***715** erroneous in view of the reliable, probative and substantial evidence on the whole record, but that while the court should not substitute its judgment for that of the agency on factual issues, it may disturb the agency's ruling if it is in violation of statutory provisions or affected by other **error of law**. The court concluded that, since General Statutes § 20-50 has not previously been subjected to judicial scrutiny, its construction was a question of law on which an administrative ruling is not entitled to special deference and that the court may review the ruling to determine whether it was correct as a matter of law.

The court then considered § 20-50, noting that it concerned "foot ailments" and, in four separate areas, referred to "feet." It reasoned that words and phrases are to be construed according to the commonly approved usage of the language. It further concluded that where language is clear and unambiguous, there is no room for construction, and that a statute does not become ambiguous merely because the parties argue for or would prefer different meanings. The court finally concluded that the statute clearly and specifically limits the practice of podiatry to diagnosis of foot ailments and surgery on the feet. In doing so it relied on common understanding and the definition of "foot" contained in Webster's Third New International Dictionary. The court decided that "foot" has a well accepted and common meaning that does not include the ankle, and therefore, the board's ruling clearly expanded the ambit of podiatry practice as defined in § 20-50 because it is contrary to the **plain meaning** of the statutes.

The board and the podiatrists filed separate appeals to the Appellate Court. Pursuant to Practice Book § 4023, we transferred these appeals to this court.

On appeal, the podiatrists claim that: (1) the trial court erred in reviewing the board's declaratory ruling ***716** under a de novo standard of review, rather than under the statutory review criteria contained in § **4-183(g)**; and (2) the board correctly concluded, on the basis of the facts found at the evidentiary hearing held on November 7, 1984, that the diagnosis and treatment of sprains, strains and positional abnormalities of the ankle are within the scope of podiatry practice in Connecticut.

The board assigns as error: (1) the trial court's ruling that the proper interpretation of the term "foot" as used in § 20-50 is purely a question of law rather than a mixed question of law and fact; (2) the trial court's conclusion that the board's declaratory ruling served to expand the ambit of podiatry practice as set forth in § 20-50; and (3) the trial court's ruling that the term "foot" as used in § 20-50 is to be accorded its commonly understood meaning as reflected in Webster's Dictionary.

For clarification, we construe these various claims of error as two issues: (1) whether the trial court applied the appropriate standard of review to the board's rulings; and (2) whether the trial court correctly interpreted § 20-50.

STANDARD OF REVIEW

The podiatrists argue that the trial court conducted a de novo review of the board's declaratory ruling and disregarded entirely the opinion of the attorney general and the board's factual findings and conclusions of law. They claim that the court substituted its judgment for that of the agency as to the weight of the evidence on questions of fact in violation of General Statutes § **4-183(g)**. They further claim that the court erred in failing to afford "special deference" to the board's factual findings, and to time-tested agency interpretations.

717 [1]** The standard of judicial review of administrative agency rulings is well established. Section **4-183(g)** permits modification or reversal of an agency's decision "if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions *834** are: (1) In violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the

agency; (3) made upon unlawful procedure; (4) affected by other **error of law**; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (6) **arbitrary** or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion." The trial court may not retry the case or substitute its judgment for that of the agency on the weight of the evidence or questions of fact. General Statutes § 4-183(g); *Griffin Hospital v. Commission on Hospitals & Health Care*, 200 Conn. 489, 496, 512 A.2d 199, appeal dismissed, 479 U.S. 1023, 107 S.Ct. 781, 93 L.Ed.2d 819 (1986); *Hospital of St. Raphael v. Commission on Hospitals & Health Care*, 182 Conn. 314, 318, 438 A.2d 103 (1980); *Madow v. Muzio*, 176 Conn. 374, 376, 407 A.2d 997 (1978). Rather, an agency's factual and discretionary determinations are to be accorded considerable weight by the courts. *Connecticut Hospital Assn., Inc. v. Commission on Hospitals & Health Care*, 200 Conn. 133, 140, 509 A.2d 1050 (1986); *Board of Aldermen v. Bridgeport Community Antennae Television Co.*, 168 Conn. 294, 298-99, 362 A.2d 529 (1975); *Westport v. Norwalk*, 167 Conn. 151, 355 A.2d 25 (1974).

On the other hand, it is the function of the courts to expound and apply governing principles of law. *N.L.R.B. v. Brown*, 380 U.S. 278, 291, 85 S.Ct. 980, 988, 13 L.Ed.2d 839 (1965); *International Brotherhood of Electrical Workers v. N.L.R.B.*, 487 F.2d 1143, 1170-71 (D.C.Cir.1973), *aff'd* sub nom. *718 *Florida Power & Light Co. v. International Brotherhood of Electrical Workers*, 417 U.S. 790, 94 S.Ct. 2737, 41 L.Ed.2d 477 (1974); *Connecticut Hospital Assn., Inc. v. Commission on Hospitals & Health Care*, *supra*; *Real Estate Listing Service, Inc. v. Real Estate Commission*, 179 Conn. 128, 138-39, 425 A.2d 581 (1979). This case presents a question of law turning upon the interpretation of a statute. See *Brannigan v. Administrator*, 139 Conn. 572, 577, 95 A.2d 798 (1953); *Bridgeport v. United Illuminating Co.*, 131 Conn. 368, 371, 40 A.2d 272 (1944). Both the board and the trial court had to construe § 20-50 to determine the permissible scope of podiatry practice in Connecticut. In our view, this is purely a question of law, requiring that the intent of the legislature be discerned. Such a question invokes a broader standard of review than is ordinarily involved in deciding whether, in light of the evidence, the agency has acted unreasonably, arbitrarily, illegally or in abuse of its discretion. *Robinson v. Unemployment Security Board of Review*, 181 Conn. 1, 5, 434 A.2d 293 (1980).

[2] Ordinarily, we give great deference to the construction given a statute by the the agency charged with its

enforcement. *Griffin Hospital v. Commission on Hospitals & Health Care*, *supra*, 200 Conn. at 496-97, 512 A.2d 199; *Corey v. Avco-Lycoming Division*, 163 Conn. 309, 326, 307 A.2d 155 (1972) (*Loiselle, J.*, concurring), cert. denied, 409 U.S. 1116, 93 S.Ct. 903, 34 L.Ed.2d 699 (1973). We agree with the trial court, however, that, in this case, the board's interpretation of § 20-50 is not entitled to any special deference. "Ordinarily, the construction and interpretation of a statute is a question of law for the courts where the administrative decision is not entitled to special deference, particularly where, as here, the statute has not previously been subjected to judicial scrutiny or time-tested agency interpretations. *Texaco Refining & Marketing Co. v. Commissioner*, 202 Conn. 583, 599, 522 A.2d 771 (1987); *719 *Schlumberger Technology Corporation v. Dubno*, 202 Conn. 412, 423, 521 A.2d 569 (1987); see also *Board of Education v. Board of Labor Relations*, 201 Conn. 685, 698-99, 519 A.2d 41 (1986); *Wilson v. Freedom of Information Commission*, 181 Conn. 324, 342-43, 435 A.2d 353 (1980)." *New Haven v. Freedom of Information Commission*, 205 Conn. 767, 773-74, 535 A.2d 1297 (1988).

Neither the board nor the courts have previously ruled on the issue presented here. Accordingly, such deference is not due the board's construction of § 20-50.

[3] The podiatrists also argue the related principle of deference to a time-tested **835 agency interpretation of a statute. They claim that "a practical construction placed on legislation over many years" will be accorded special deference by a reviewing court, citing *Schieffelin & Co. v. Department of Liquor Control*, 194 Conn. 165, 174, 479 A.2d 1191 (1984). We have accorded deference to such a time-tested agency interpretation of a statute, but only when the agency has consistently followed its construction over a long period of time, the statutory language is ambiguous, and the agency's interpretation is reasonable. *Texaco Refining & Marketing Co. v. Commissioner*, *supra*; *Sutton v. Lopes*, 201 Conn. 115, 120, 513 A.2d 139, cert. denied sub nom. *McCarthy v. Lopes*, 479 U.S. 964, 107 S.Ct. 466, 93 L.Ed.2d 410 (1986); *Schieffelin & Co. v. Department of Liquor Control*, *supra*; *Clark v. Town Council*, 145 Conn. 476, 485, 144 A.2d 327 (1958); *Wilson v. West Haven*, 142 Conn. 646, 657, 116 A.2d 420 (1955). The defendants rely on the fact that podiatrists have long performed the procedures in question in this case. We disagree that such practices constitute time-tested agency interpretation of the statute. Further, we do not consider the board's knowledge of and acquiescence in certain

podiatric practices to rise to the level of statutory construction entitled to judicial deference.

*720 [4] We also disagree that the court failed to give proper deference to the opinion of the attorney general. "Although an opinion of the attorney general is not binding on a court, it is entitled to careful consideration and is generally regarded as highly persuasive." *Connecticut Hospital Assn., Inc. v. Commission on Hospitals & Health Care*, supra, 200 Conn. at 143, 509 A.2d 1050. We note that the opinion of the attorney general, although so labeled and published in 62 Op.Conn.Atty.Gen. 229, 231 (1984), is an opinion in name only. It contains no legal analysis of a contested issue for the guidance of those interested. Rather, the "opinion" merely referred the matter to the board for a "factual determination" and contained no legal analysis of the type to which our court has earlier granted deference. See *Connecticut Hospital Assn., Inc. v. Commission on Hospitals & Health Care*, supra.

The board's contention that the issue presented was a mixed question of law and fact is also without merit. Interpretation of the statute should effect the intent of the legislature and not expand the law's meaning to accommodate unauthorized practices simply because they have been performed in the past.

Since we consider the issue in this case to be one of statutory interpretation to determine the legislature's intent with regard to the scope of podiatry practice, we conclude that the trial court applied the appropriate standard in reviewing the board's construction of § 20-50.

INTERPRETATION OF THE TERM "FOOT"

[5] General Statutes § 20-50 defines podiatry as "the diagnosis, prevention and treatment of foot ailments ... the practice of surgery upon the feet ... the dressing, padding and strapping of the feet; the making of models of the feet and the palliative and mechanical treatment of functional and structural ailments of *721 the feet, not including the amputation of the leg, foot or toes or the treatment of systemic diseases other than local manifestations in the foot." Our principal objective in construing statutory language is to ascertain the apparent intent of the legislature. *Rawling v. New Haven*, 206 Conn. 100, 105, 537 A.2d 439 (1988). "In construing a statute, this court will consider its plain language, its legislative history, its purpose and the circumstances

surrounding its enactment." *State v. Parmalee*, 197 Conn. 158, 161, 496 A.2d 186 (1985).

General Statutes § 1-1(a) requires that "[i]n the construction of the statutes, words and phrases shall be construed according to the commonly approved usage of the language; and technical words and phrases, and such as have acquired a peculiar and appropriate meaning in the law, shall be construed and understood accordingly." If the statutory language is clear and unambiguous, there is no room for construction. **836 *New Haven v. United Illuminating Co.*, 168 Conn. 478, 485, 362 A.2d 785 (1975). If there is no ambiguity in the language of the statute, it does not become ambiguous merely because the parties argue for or would prefer different meanings. *Caldor, Inc. v. Heffernan*, 183 Conn. 566, 570, 440 A.2d 767 (1981). When language used in a statute is clear and unambiguous, its meaning is not subject to modification or construction. *Cilley v. Lamphere*, 206 Conn. 6, 9-10, 535 A.2d 1305 (1988). When a statute does not define a term, it is appropriate to look to the common understanding expressed in the law and in dictionaries. *Doe v. Manson*, 183 Conn. 183, 186, 438 A.2d 859 (1981).

Webster's Third New International Dictionary defines "foot" as "[t]he terminal part of the vertebrate leg upon which an individual stands consisting in most bipeds (as man) and in many quadrupeds (as the cat) of all the structures (as heel, arches, and digits) below the ankle joint..." The podiatrists argue, however, *722 that the board's ruling, rather than the dictionary definition, is consistent with the legislative intent underlying the podiatry statutes. We are not so persuaded.

In 1915, the legislature passed the first statute licensing chiropody. Public Acts 1915, c. 229. Prior to that time anyone could practice chiropody in Connecticut. *Connecticut Chiropody Society, Inc. v. Murray*, 146 Conn. 613, 616, 153 A.2d 412 (1959). The practice of chiropody was not defined, however, until the enactment of § 1188c of the 1935 Cumulative Supplement to the Public Acts of 1915. The statutory language adopted in 1935 equated chiropody and podiatry and delineated the areas of practice as follows: diagnosis of foot ailments and the practice of minor surgery on the feet, including all structures of the phalanges but limited to those structures of the foot superficial to the inner layer of the fascia of the foot;⁶ dressing, padding and strapping of the feet; and making of plaster models of the feet and the palliative and mechanical treatment of functional disturbances of the feet as taught and practiced in the schools of chiropody recognized by

the examining board. The reference to the teaching and practice in schools of chiropody was eliminated by § 1023e of the 1937 Cumulative Supplement to the General Statutes. The podiatrists, relying on the testimony of the state health commissioner (commissioner) at a hearing before the Joint Standing Committee on Public Health and Safety, claim that this change was made to authorize the board to define the scope of podiatric practice in Connecticut. Conn. Joint Standing Committee Hearings, Public Health and Safety, 1937 Sess., p. 135. They argue that the fact that the commissioner *723 was instrumental in fashioning the definition lends strong support to the board's ruling.

We are unconvinced that the assertions of the commissioner are entitled to the weight the podiatrists urge us to accord them. See *Hartford Electric Light Co. v. Water Resources Commission*, 162 Conn. 89, 291 A.2d 721 (1971). "While relevant to our inquiry, [excerpts from legislative proceedings] are by no means conclusive in determining legislative intent.... As to occurrences at legislative public hearings, these are not admissible as a means of interpreting a legislative act and may not be considered." *Id.*, at 98, 291 A.2d 721. Further, our examination of the statutory scheme as it now exists belies such a conclusion.

A centrifugal professional force tending to expand podiatry may be seen from the early legislative history of the podiatry statutes. For instance, Public Acts 1969, No. 578, amended the pertinent drug statute to allow podiatrists, for the first time, to administer drugs, and Public Acts 1976, No. 76-99, made a major change in the podiatry statutes by eliminating the word "minor" from the surgery on the feet authorized for podiatrists. Presently, the podiatry statutes, General Statutes §§ 20-50 **837 through 20-65, both authorize the practice of podiatry and define its limits. The provisions limiting the scope of podiatry and, thus, tempering the expansion, however, are the predominant theme of the statutes. This is in marked contrast to chapter 370 of the General Statutes, entitled "Medicine and Surgery," wherein the scope of practice of medicine and surgery is not defined, and chapter 371 concerning osteopathy where no such specific definitions limiting the scope of practice are contained. To the contrary, specific limitations on the practice of podiatry are contained in § 20-50. That the thrust of the podiatry statutes is primarily limiting in nature is made clear by General Statutes § 20-63 which provides that "[n]o person granted *724 a certificate under this chapter shall display or use the title 'Doctor' or its synonym without the designation 'Podiatrist' and shall not mislead the public as to the limited professional qualifications

to treat human ailments." Further, among the grounds for revocation of a podiatrist's license or for disciplinary action against a podiatrist, General Statutes § 20-59(9) includes "undertaking or engaging in any medical practice beyond the privileges and rights accorded to the practitioner of podiatry by the provisions of this chapter...." A final example of such a limitation is the provision in § 20-50, as amended by Public Acts 1976, No. 76-99, authorizing "the practice of surgery upon the feet, provided if an anesthetic other than a local anesthetic is required, such surgery shall be performed in a general hospital accredited by the Joint Commission on Accreditation of Hospitals by a licensed podiatrist who is accredited by the credentials committee of the medical staff of said hospital to perform podiatric surgery in conformance with rules promulgated by the chief of the surgical department of said hospital, taking into account the training, experience, demonstrated competence and judgment of each such licensed podiatrist, and *such podiatrist shall comply with such rules....*" (Emphasis added.) The subjection of podiatrists to hospital rules is a striking example of a legislative intent to restrain any expansion of the scope of podiatry practice that is not statutorily authorized. We conclude, therefore, that it was not the intention of the legislature to empower the board to define the scope of podiatry practice in Connecticut.

The podiatrists and the board also contend that the term "foot" should be construed according to its technical or anatomical definition, and be understood to include the ankle.⁷ We discern no support for this position in either the statute or case law.

*725 All parties, as well as the trial court, cite *Rivera v. I.S. Spencer's Sons, Inc.*, 154 Conn. 162, 223 A.2d 808 (1966). *Rivera* involved compensation for disfigurement under the then Workmen's Compensation Act, General Statutes (Rev. to 1962) § 31-308. We were asked to determine whether the phrase "legs below the knees" in the statute included the foot. We found that, in common usage, the leg sometimes does and sometimes does not include the foot, but concluded that the issue could not be resolved solely on the basis of common usage. Our examination of the legislative history disclosed several amendments expanding the coverage, under the disfigurement provisions, by the enumeration of additional specific portions of the body, consistent with increasing exposure of modern dress. Bearing in mind that a scar on the foot was less likely to be exposed to view than one above the foot but below the knee, we concluded that the foot was not contemplated by the statutory language. *Id.*, at 164-66,

223 A.2d 808. *Rivera* is nonetheless inapposite to the present case, since the result in *Rivera* was compelled by legislative development quite different from that underlying the podiatry statutes.

The podiatrists rely heavily on *Finoia v. Winchester Repeating Arms Co.*, 130 Conn. 381, 385, 34 A.2d 636 (1943), in which we interpreted “hands” as used in a workers’ compensation statute in its common anatomical sense as including the wrist and not the forearm. *Finoia*, like *Rivera*, **838 sheds no light on the case before us. In *Finoia*, the question presented was whether, in the context of an award of compensation for disfigurement, the term “hand” was to be accorded its common meaning or a broader one, suggested by its use in the statutory provisions covering loss of use of a member, to include the forearm. *Id.*, at 382–83, 34 A.2d 636. Based on the intent we found in the history of the workers’ compensation *726 statutes, we concluded that different legislative purposes were reflected in the loss of use and disfigurement provisions and that application of the broader definition was unwarranted. *Id.*, at 383–84, 34 A.2d 636. As the podiatrists note, we stated, in *Finoia*, that “hand,” when used in its common anatomical sense, included the wrist but not the forearm. We can see no basis, however, for translating that statement into a declaration that the legislature intended the foot to include the ankle within the meaning of the podiatry statutes.

The podiatrists also propose that we adopt the Washington Court of Appeals’ reasoning in *Jaramillo v. Morris*, 50 Wash.App. 822, 750 P.2d 1301, reh. denied, — Wash. —, — P.2d — (July 5, 1988). In *Jaramillo*, a podiatrist was sued for malpractice in ankle surgery. The trial court refused to submit to the state podiatry board the question of whether the ankle surgery was outside the scope of the podiatrist’s license, and held that “[i]t is plain to see from the exhibits and from the affidavits of medical experts that where the leg bones end the foot begins and vice versa.” *Id.*, 750 P.2d at 1305. The Court of Appeals found this refusal to be error, citing the special competence of the board to determine the meaning of the ambiguous term “foot.” In so ruling, the court relied on the doctrine of primary jurisdiction which “does not displace the jurisdiction of a court, but merely allocates power between courts and agencies to make initial determinations; the court normally retains power to make the final decision.” *Id.*, 750

P.2d at 1304. In reaching its conclusion, the *Jaramillo* court stated that “[t]his is not a case ... wherein the practitioners of a medical specialty are attempting to expand their license authority beyond statutory bounds.” *Id.*, 750 P.2d at 1306.

We find *Jaramillo* inapplicable to this case and conclude that the term “foot” should be construed according *727 to its commonly understood meaning. In light of our statutory scheme governing podiatry practice, the construction we give to the term “foot” must not expand the scope of podiatry practice beyond the intent of the legislature. Moreover, § 20–50 expressly authorizes treatment of foot ailments and performance of surgical procedures, other than amputation, on the foot or feet and makes no mention of the ankle, nor has treatment of the ankle been expressly included in the definition of podiatry practice in any of the predecessors to § 20–50. Had the legislature intended to include the ankle in the definition of “foot,” it could easily have done so. “The intent of the legislature, as this court has repeatedly observed, is to be found not in what the legislature meant to say, but in the meaning of what it did say. *Frazier v. Manson*, 176 Conn. 638, 642, 410 A.2d 475 (1979); *Kulis v. Moll*, 172 Conn. 104, 110, 374 A.2d 133 (1976); *Colli v. Real Estate Commission*, 169 Conn. 445, 452, 364 A.2d 167 (1975); *United Aircraft Corporation v. Fusari*, 163 Conn. 401, 410–11, 311 A.2d 65 (1972). Where there is no ambiguity in the legislative commandment, this court cannot, in the interest of public policy, engraft amendments onto the statutory language.” *Burnham v. Administrator*, 184 Conn. 317, 325, 439 A.2d 1008 (1981).

We, therefore, conclude that the trial court did not err in sustaining the plaintiffs’ appeal and that it properly relied on common usage and the dictionary definition of “foot” in construing General Statutes § 20–50.

There is no error.

In this opinion the other Justices concurred.

Parallel Citations

546 A.2d 830

Footnotes

- 1 “[General Statutes] Sec. 20–50. **PODIATRY DEFINED. REQUIREMENTS FOR SURGERY.** . Podiatry is defined to be the diagnosis, prevention and treatment of foot ailments including the prescription, administering and dispensing of drugs and controlled substances in schedules II, III, IV or V, in accordance with subsection (d) of section 21a–252, in connection therewith; the practice of surgery upon the feet, provided if an anesthetic other than a local anesthetic is required, such surgery shall be performed in a general hospital accredited by the Joint Commission on Accreditation of Hospitals by a licensed podiatrist who is accredited by the credentials committee of the medical staff of said hospital to perform podiatric surgery in conformance with rules promulgated by the chief of the surgical department of said hospital, taking into account the training, experience, demonstrated competence and judgment of each such licensed podiatrist, and such podiatrist shall comply with such rules; the dressing, padding and strapping of the feet; the making of models of the feet and the palliative and mechanical treatment of functional and structural ailments of the feet, not including the amputation of the leg, foot or toes or the treatment of systemic diseases other than local manifestations in the foot.”
- 2 The memorandum of decision of the board is as follows: “It is the ruling of the Board of Examiners in Podiatry, after reviewing all the testimony, exhibits and supporting statements offered in connection with the hearing held 7 November 1984, that the ankle is part of the foot, and the foot is part of the ankle. The Board further rules that sprains, strains, and positional abnormalities of the ankle constitute ailments of the foot, and that diagnosis and treatment of sprains, strains, and positional abnormalities of the ankle are therefore within the scope of podiatry practice in Connecticut.”
- 3 “[General Statutes] Sec. 4–176. **DECLARATORY RULINGS.** Each agency may, in its discretion, issue declaratory rulings as to the applicability of any statutory provision or of any regulation or order of the agency, and each agency shall provide by regulation for the filing and prompt disposition of petitions seeking such rulings. If the agency issues an adverse ruling, the remedy for an aggrieved person shall be an action for declaratory judgment under section 4–175 unless the agency conducted a hearing pursuant to sections 4–177 and 4–178 for the purpose of finding facts as a basis for such ruling, in which case the remedy for an aggrieved person shall be an appeal pursuant to section 4–183. If the agency fails to exercise its discretion to issue such a ruling, such failure shall be deemed a sufficient request by the plaintiff for the purposes of section 4–175. Rulings disposing of petitions have the same status as agency decisions or orders in contested cases.”
- 4 The plaintiff Enzo Sella, M.D., was granted intervenor status and testified at the hearing.
- 5 General Statutes § 4–176 authorizes an appeal, pursuant to General Statutes § 4–183, from a declaratory ruling where, as here, the agency conducted a hearing. Section § 4–183(a) provides: “A person who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review by way of appeal under this chapter, provided, in case of conflict between this chapter and federal statutes or regulations relating to limitations of periods of time, procedures for filing appeals or jurisdiction or venue of any court or tribunal, such federal provisions shall prevail. A preliminary, procedural or intermediate agency action or ruling is immediately reviewable if review of the final agency decision would not provide an adequate remedy.”
- 6 Public Acts 1971, No. 859, deleted the reference in General Statutes § 20–50 to the “phalanges but limited to those structures of foot superficial to the inner layer of the fascia of the foot,” and substituted “forefoot forward of the tarsal bones, but excluding operations on the bones of the tarsus.” This latter language was excised by Public Acts 1976, No. 76–99. Since then, the statute has contained no language qualifying the term “foot.”
- 7 In its declaratory ruling, the board found that “the ankle and foot are inseparable.” In so finding, the board expressly credited the testimony of Gary P. Jolly, D.P.M., who stated that it is impossible, from a clinical standpoint, to treat the foot as separate from the ankle.

EXHIBIT B



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

July 14, 2011

Mark Cesaro
Director, Strategic Planning and Business Development
Hartford Hospital
80 Seymour Street
P.O. Box 5037
Hartford, CT 06102-2127

Re: Certificate of Need Determination; Report Number: 11-31704-DTR
Hartford Hospital
Relocate Hartford Hospital/Institute of Living's Child and Adolescent Partial Hospital
Program from Bloomfield to Hartford

Dear Mr. Cesaro:

On June 15, 2011, the Office of Health Care Access ("OHCA") received your determination request on behalf of Hartford Hospital ("Hospital"), a subsidiary of Hartford HealthCare Corporation ("HHC"), with respect to whether a certificate of need ("CON") is required for the Hospital to relocate its Child and Adolescent Partial Hospital Program ("Program") from Bloomfield to HHC's Institute of Living in Hartford.

The Program offers partial hospital, intensive outpatient and traditional outpatient psychiatric services to children and adolescents between the ages of 8 and 17. During FY 2010, 36% of its patients came from Hartford compared to 6% from Bloomfield. The only other town with greater than 10% patient population during FY 2010 was the town of West Hartford with 11%. The Program's current payer mix is 43% commercial insurance and 57% Medicaid. Since the Program's current patient population is primarily from Hartford and the surrounding towns, the Applicant does not expect a change in the patient population or the payer mix.

Based upon the foregoing, it appears that the proposed relocation of the Program from Bloomfield to Hartford will not result in a significant change in population or payer mix; therefore, a CON is not required for this proposal pursuant to General Statutes § 19a-639c.

Thank you for informing OHCA of your plans and if you have any questions regarding this letter, please contact Steven W. Lazarus, Associate Health Care Analyst at (860) 418-7012.

Sincerely,



Kimberly R. Martone
Director of Operations, OHCA

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

EXHIBIT C



STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

File

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 21, 2005

RECEIVED

JUN 24 2005

V.P. FINANCE

Joseph Pelaccia,
Vice President, Finance
Milford Hospital, Inc.
300 Seaside Avenue
P.O. Box 3015
Milford, CT 06460-0815

Re: Certificate of Need Determination; Report Number 05-30501-DTR
Milford Hospital, Inc.
Relocation of Urgent Care Center

Dear Mr. Pelaccia:

The Office of Health Care Access ("OHCA") is in receipt of your request for a CON Determination Report for the relocation of Milford Hospital's urgent care center from 300 Seaside Avenue to 831-849 Boston Post Road in Milford.

Upon review of the information contained in the request, OHCA finds the following:

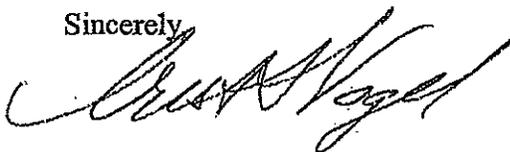
1. Milford Hospital, Inc. ("Hospital") is a non-profit healthcare provider offering a full range of inpatient and outpatient services.
2. The Hospital proposes to relocate its Urgent Care Center to an offsite facility at 831-849 Boston Post Road in Milford.
3. As part of the Emergency Department, the Hospital provides a dedicated urgent care center called Quick Care ("Center"). The center is open from 9:00 am to 10:00 pm, seven days a week. The Center provides non-emergency sick visits and minor trauma services to approximately 14,000 patients annually.
4. The Hospital stated that the Center's total visits totaled 19,000 annually since 1998. The Center's volume has increased by 68% to over 32,000 visits annually, which is far in excess of the planned growth capacity.

5. The Hospital plans to rent approximately 3,500 square feet of space located at 831-849 Boston Post Road in Milford for the Center, which is approximately 1.5 miles from the Hospital.
6. The facility will be owned by Torry Corp., a for-profit non-licensed real estate entity owned by the Hospital's parent corporation, Milford Health and Medical.
7. The existing urgent care treatment space will be utilized by the Emergency Department to expedite and improve timely care for patients in need of acute emergency services.
8. The total capital expenditure associated with the relocation is \$583,230 for equipment.
9. There are no new services to be provided at the new site of the Center.
10. The Center will serve the same population as currently served at the Hospital.
11. The staffing level will be the same as currently experienced at the current site on the Hospital campus.

Based on these findings, OHCA has determined that CON approval is not required for the relocation of the Hospital's Urgent Care Center to 831-849 Boston Post Road in Milford, pursuant to Section 19a-638 of the Connecticut General Statutes.

If you have any questions concerning the above, please feel free to contact Kim Martone, CON Supervisor, at (860) 418-7029.

Sincerely,



Cristine A. Vogel
Commissioner

c: Rose McLellan, Licensing Examination Assistant, DPH, DCBR

CAV:km

EXHIBIT D

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203



Northeast Division of Survey & Certification

September 30, 2014

Richard D'Aquila, President & Chief Operating Officer
Yale-New Haven Hospital
20 York Street
New Haven, CT 06504

RE: CMS Certification Number: 07-T022

Dear Mr. D'Aquila:

On Tuesday, September 23, 2014, we received your letter dated September 18, 2014 wherein you request a six bed increase of Yale-New Haven Hospitals' inpatient rehabilitation unit (IRF) prospective payment system (PPS) excluded unit, effective October 1, 2014. Federal regulations at 42 CFR 412.25(b) states in part, "...changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and CMS RO in writing of the planned change at least 30 days before the date of change..." In accordance with 42 CFR 412.25(b), the 30 day notification requirement will be applied in determining the effective date of this request.

The Centers for Medicare & Medicaid Services (CMS) has approved an increase in the number of beds excluded from the prospective payment systems specified under 42 CFR 412.1(a)(1) in order to be paid under the prospective payment system specified at 42 CFR 412.1(a)(3) for rehabilitation hospitals and units. Effective October 18, 2014, the total number of excluded beds is 24. The additional beds are located in rooms 375, 3588 and 4538 (two beds each) located at the St. Raphael Campus.

Exclusion status for all hospitals and units is reviewed annually. You will be notified if there is a change in your facility's exclusion status as a result of the annual review. Please note that all Inpatient Rehabilitation Facilities (IRFs) must notify their Medicare Administrative Contractor and the CMS Regional Office (RO) in writing before making any changes to their operations (e.g., increase in bed size or square footage, relocation to a new location, change of ownership, etc.). Generally, changes in the size of an excluded unit are "allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the

planned change at least 30 days before the date of the change." Please see Federal regulations at 42 CFR Part 412, Subpart B.

If you have any questions, please contact Kathy Mackin at (617) 565-1211.

Sincerely,

A handwritten signature in cursive script that reads "Kathy Mackin".

Kathy Mackin, Health Insurance Specialist
Survey Branch

cc: CT Department of Public Health
NGS

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Based upon Connecticut General Statutes § 19a-638(a)(4) and the legislative history surrounding terminations, the cessation of IRU services at the SRC campus constitutes a termination of inpatient services offered by YNHH. Based upon the foregoing, OHCA concludes that *a CON is required* for the aforementioned proposal.

Sincerely,



Kimberly R. Martone
Director of Operations

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