June 8, 2022

Department of Public Health
Office of Health Strategy
450 Capitol Avenue
Hartford, CT 06134-0308

RE: Certificate of Need Application: Connecticut Children's Medical Center, Increase in Licensed Bed Capacity

Dear Mr. Wang:

Enclosed is the Certificate of Need Application for our request to increase our licensed bed capacity.

All required questions have been submitted to the Office of Health Strategy through the Certificate of Need Portal.

Please do not hesitate to contact me if you have any questions.

Thank you for your consideration.

Sincerely,

Robert Moses Vargas
Senior Vice President and Chief Legal Officer
860-837-5552
Mvargas@connecticutchildrens.org

IMPORTANT

All Office of Health Strategy (OHS) Certificate Of Need (CON)-related documents (**Determinations, Applications, Completeness Letter Responses and Modifications**) ***must be filed electronically*** through OHS's single point of access, its CON Web Portal.

First time Portal users must register prior to submitting any documents. To register, click here: Certificate of Need Web Portal

To access the portal, click on the link above or and click https://portal.ct.gov/OHS on the "Certificate of Need Program" link and then click on the "https://dphconwebportal.ct.gov" link.

OHS may, at its discretion, utilize data from Hospital Reporting System (HRS) and the Connecticut All Payer Claims Database (APCD) to supplement the administrative record and the hearing record associated with an application. OHS may also reference and cite HRS and APCD data in its agreed settlements and final decisions.

For any questions, please email HSP@ct.gov or call (860) 418-7001.

OHS Waiver

Please be advised that the Office of Health Strategy (OHS) is in the process of revising its regulations (19a-639a-3(b)) to enable it to accept new CON filings **via OHS's website**.

While proceeding through this legal process, OHS waives the requirement for applicant(s) to file paper copies pursuant to Sec. 149 of Public Act No, 21-2 (June Special Session). All new CON applications filed electronically with OHS should be submitted via OHS's website (Certificate of Need Web Portal) and include the following:

1. A scanned copy of each submission in its entirety*, including all attachments, properly executed and notarized where necessary, in Adobe (.pdf) format.

2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

***All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated.**

Note: Should anyone not have the ability to file electronically, the present paper submission process may still be used.

If you have any questions regarding a CON filing with OHS, please contact us by email at HSP@ct.gov or call us directly at (860) 418-7001.

Checklist

Instructions: Review each item below and check box when completed. **[Checklist *must* be submitted as the first page of the CON application.]**

☑ A completed CON Main Form, including an affidavit for each applicant, signed and notarized by the appropriate individuals. CON forms can be found at OHS Forms.

☑ A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).

☑ A filing fee using Master Card or Visa submitted electronically via OHS's website (Certificate of Need Web Portal) in the amount of $**500.00.**

Note: Should anyone not have the ability to pay electronically using Master Card or Visa, contact us at (860) 418-7001 for further instructions.

☑ Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: Connecticut newspapers. **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

The following information **must** be included in the public notice:

- A statement that the applicant is applying for a certificate of need pursuant to section § 19a-638 of the Connecticut General Statutes;
- A description of the scope and nature of the project;
- The street address where the project is to be located; and
- The total capital expenditure for the project.

(Please fax (860-418-7054) or email (HSP@ct.gov) a courtesy copy of the newspaper order confirmation to OHS at the time of publication.)

☑ A completed Financial Worksheet specific to the application type.

☑ All confidential or personally identifiable information (e.g., Social Security number) has been redacted.

☑ All material should be submitted via OHS's website (OHS Web Portal) and include:

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 application) and MS Excel (the Financial Worksheet).

*__All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated__.

Note: OHS hereby waives requirement to file any paper copies.

OHS CONNECTICUT Office of Health Strategy

CON Application - Main Form

Required for all CON applications

Contents:

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHS main number (860-418-7001) for assistance. All CON forms can be found on OHS's website at CON Forms and Submission.

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
☐	(1)	**Establishment of a new health care facility** (mental health and/or substance abuse) - *see note below**
☐	(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
☐	(3)	**Transfer of ownership of a group practice**
☐	(4)	**Establishment of a freestanding emergency department**
☐	(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
☐	(6)	**Establishment of an outpatient surgical facility**
☐	(9)	**Establishment of cardiac services**
☐	(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
☒	(12)	**Increase in licensed bed capacity** of a health care facility
☐	(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
☐	(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
☐	Other	**Transfer of Ownership / Sale of Hospital**

*****This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume or a subspecialty is being terminated, a CON is not required.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHS main number (860-418-7001) for assistance.

Proposal Type (select from dropdown)	Increase in licensed bed capacity
Brief Description	The market has shown there is a need for additional Level IV neonatal intensive care services and pediatric medical/surgical services. The market has also shown that there is a gap of certain pediatric health care services that are not offered in the state. Pregnant people whose fetus requires procedural or surgical services are currently required to leave the state for these specialized services. Moreover, there are specialized treatments for children with certain types of cancer that can help these children better respond to and tolerate the vast number of medications they receive that are not offered in the state, including being able to receive bone marrow transplants without the need to transfer care to another provider. Connecticut Children's is proposing to build a new medical tower attached to its current main campus in Hartford, CT that will offer all of these services. The new tower will require the addition of 33 new bassinets and 26 new inpatient beds to accommodate the various services highlighted above.
Proposal Address	282 Washington Street Hartford, CT 06106
Capital Expenditure	$ 276,107,039

Is this Application the result of a Determination indicating a CON application must be filed?

☒ No

☐ Yes, Docket Number: Click here to enter text.

Applicant(s) Information

	Applicant One	**Applicant Two** (if applicable)
Applicant's Full Legal Name* & Address:	Connecticut Children's Medical Center 282 Washington Street Hartford, CT 06106	
Applicant Tax Status: (check one box)	☐ For Profit ☒ Not-for-Profit	☐ For Profit ☐ Not-for-Profit
Parent Corporation Full Legal Name & Address:	CCMC Corporation 282 Washington Street Hartford, CT 06106	

(if applicable)		
New Company: **(if applicable)**	n/a	
Contact Person: **(provide only one contact person per application)**		
Name:	R. Moses Vargas	
Title:	Senior Vice President & Chief Legal Officer	
Address:	10 Columbus Boulevard, 5th Floor	
Email:	mvargas@connecticutchildrens.org	
Phone number:	860-837-5552	

**For more than two applicants, attach a separate sheet providing the following information: applicant's full legal name, address, tax status and, if applicable, the parent company's name and address.*

Affidavit

Applicant: Connecticut Children's Medical Center

Project Title: Increased Bed Capacity – New Medical Tower

I, James E. Shmerling, President and Chief Executive Officer of Connecticut Children's Medical Center in Hartford, CT being duly sworn, depose and state that Connecticut Children's Medical Center complies with the appropriate and applicable criteria as set forth in Sections 19a-630, 19a-637, 19a-638, 19a-639 of the Connecticut General Statutes, and that all facts contained in the submitted Certificate of Need application are true and correct to the best of my knowledge.

Signature

06/08/2022
Date

Subscribed and sworn to before me on 08 June 2022.

Notary Public/Commissioner of Superior Court

B. Mojos Vargas
Juris No 427621

~~My commission expires:~~ _____

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. Please click here to reference the 2020 CON Guidebook while completing the application.

Providing care closer to home is a philosophy that Connecticut Children's embraces at its core. We are constantly analyzing which services the children of Connecticut need, as well as where and how to provide those services. In fact, Connecticut Children's recently filed a separate certificate of need application for the creation of a new inpatient medical/psychiatric unit in response to the mental health crisis and the increased need for these inpatient services.

On a similar note, the market has shown us that there is a gap of certain types of pediatric health care services that are not offered in any hospital in the state of Connecticut, as well as an increased need for certain pediatric medical/surgical services and level 4 neonatal intensive care services. After much analysis and preparation and as further described herein, Connecticut Children's is now prepared to offer these rare services to the children of Connecticut and the region, while also undertaking a desperately needed expansion of capacity to provide Level 4 NICU services and medical/surgical services. These new services are responsive to what the market has told us it needs. The provision of such services will also make Connecticut Children's a destination center that will attract people from outside of Connecticut to receive care at Connecticut Children's and attract a diverse group of qualified clinicians to come and work in Connecticut.

The first of the rare services is fetal care services. Women who are faced with extremely high risk pregnancies are currently required to go out of state in the event their fetus requires surgical services prior to delivery. Connecticut Children's has hired Dr. Timothy Crombleholme, who is one of the national leaders and pioneers of fetal surgery. He founded (i) Children's Hospital of Philadelphia's Fetal Diagnosis and Treatment Center with Dr. Scott Adzick, (ii) the Fetal Care Center of Cincinnati, (iii) the Fetal Care Center of Colorado, and (iv) the Fetal Care Center Dallas. He has pioneered treatments in Twin-Twin Transfusion Syndrome, Sacrococcygeal Teratoma, Congenital Diaphragmatic Hernia, Congenital Pulmonary Airway Malformation, and Bladder Outlet Obstruction. He is among the most experienced fetal surgeons in the world.

The second of the rare services is advanced cellular and gene therapy services. Advanced cellular therapies can be used to increase the chances of children who are fighting aggressive forms of cancer to maximize the medications' effectiveness and minimize the potential damage that is caused to the child's health from receiving those medications. Additionally, children who have certain types of cancers like leukemia and who require bone marrow transplants are currently required to transition their care to a different provider (that is not affiliated with Connecticut Children's, the only licensed children's hospital in the state) or in some circumstances even leave the state to receive such services. The creation of the Advanced Cellular and Gene Therapy Unit will offer these kids the opportunity to stay close to home and have this type of care integrated with all of the other care they receive at Connecticut Children's from the doctors and nurses they already know and love.

As for the expansion of capacity, Connecticut Children's cares for the tiniest of neonates who are born so early in their lives that they are at the very edge of survivability. These neonates weigh barely more than a pound and are small enough to fit in the palm of their parent's hand. Our Level IV neonatal intensive care unit is frequently operating at or above bed capacity and does not offer private rooms to the neonates and their families. We are proposing to expand this unit so that a child leaving the womb prematurely with undeveloped organs and multiple life-threatening conditions has the best possible circumstances to grow and develop properly. Clinical studies have shown that NICU babies survive at higher rates if they are in a private room that is better able to replicate womb conditions: a place that is quiet, calm, controlled and private. This is what all neonates deserve and what Connecticut Children's is prepared to offer.

Connecticut Children's medical/surgical bed capacity is also often at its limit. Not only has there been an increased need of pediatric medical/surgical beds due to an uptick in pediatric medical complexities, but as the mental health crisis has forced more children with complex mental health needs to come to the Emergency Department, Connecticut Children's often houses many of the kids who are awaiting an inpatient psychiatric bed (and who have other medical needs) in its existing medical/surgical beds in Hartford. This has led to multiple surges where Connecticut Children's is faced with a higher demand of medical/surgical beds, but not enough beds to accommodate those needs. In light of this, Connecticut Children's is prepared to build a new inpatient medical/surgical unit with rooms that can also adapt to provide intensive care services (in accordance with the necessary regulatory standards and requirements). The addition of these beds will open up the existing medical/surgical beds to house mental health patients who are awaiting inpatient placement (with the assumption that there will still be a higher demand of inpatient mental health beds than are available – even with the addition of Connecticut Children's new 12-bed medical/psychiatric unit).

To accommodate each of the foregoing services, Connecticut Children's is proposing to build a new tower that will attach to its existing hospital facility at 282 Washington Street in Hartford, CT. The new tower will include the addition of 33 new bassinets and 26 new inpatient beds.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Strategy is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" 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 to the public and for each applicant, separately. 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, anticipated start date, and why the proposal is needed in the community.

Connecticut Children's is an academic, non-profit, 187-bed teaching hospital dedicated to clinical care, education, research, and advocacy on behalf of children. For over 100 years, Connecticut Children's has provided a full range of pediatric diagnostic and treatment services to the children of the greater Hartford area and the region. Connecticut Children's is the only freestanding licensed pediatric hospital in the state of Connecticut that offers comprehensive, world-class health care to children and adolescents in a patient- and family-centered environment. Connecticut Children's also serves as the primary pediatric teaching hospital for the UConn School of Medicine.

Connecticut Children's is a Level 1 trauma center and the hospital facility at 282 Washington Street in Hartford, CT currently houses 83 medical surgical beds, 18 pediatric intensive care beds, 7 operating rooms, a hematologic cancer center, and 30+ specialty services. The existing facility was built in 1996 and is currently operating at capacity with no further room to grow in volume or expand its services.

In 2016 Connecticut Children's engaged in a master planning effort to create a strategic vision for the future of the organization. After three years of extensive review and analysis, the priorities were ultimately categorized into three tiers: (i) high priority programs, (ii) potential growth high priority programs, and (iii) secondary needs. The "high priority programs" included, without limitation (1) the relocation of its neonatal intensive care unit that is currently located in Hartford Hospital (the "Hartford NICU") to Connecticut Children's hospital campus, (2) an increase in ambulatory capacity, and (3) the expansion of clinical support departments such as pharmacy and bio-med. The "potential growth high priority programs" included (1) the development of a fetal care program, (2) the creation of a behavioral health inpatient unit, and (3) the addition of an advanced cellular and gene therapy unit that could also accommodate kids requiring bone marrow transplants. The "secondary needs" included (1) the creation of a full commercial kitchen to support the campus, (2) the expansion of conferencing capabilities for the hospital, (3) the expansion of the public amenities such as a gift shop, and (4) an increase of support for patient transport.

The above priorities led Connecticut Children's to make the decision to undertake a major expansion of our existing hospital facility (the "Project"). The Project will include the following:

- The addition of a new medical tower consisting of 194,000 square feet that will attach to the existing hospital building ("New Tower").
- The addition of 33 bassinets and 26 inpatient beds to its existing children's hospital

license.

- Creating a new, state-of-the-art Level IV Neonatal Intensive Care Unit in the New Tower that will accommodate 50 private room bassinets. The 50 bassinets will include relocating 17 of the existing bassinets located in the Hartford NICU into the New Tower with an addition of 33 new bassinets. 15 bassinets will remain at Hartford Hospital for low acuity neonates who do not require care in the new higher acuity unit.
- Expanding the medical/surgical bed capacity by 14 beds with the potential of creating acuity adaptable rooms that can also accommodate intensive care needs.
- Creating an advanced cellular and gene therapy unit that will include 6 new inpatient beds that will support Connecticut Children's existing Cancer Center.
- Creating a Fetal Care Center which will include 6 new inpatient beds dedicated to labor/delivery/recovery/postpartum ("LDRP") patients, a c-section operating room, a fetal operating room, and outpatient diagnostic ECHO and ultrasound rooms.
- Expanding and right-sizing the food service department to support the expanded bed capacity, provide on-demand room service, and improve operational efficiencies.
- Expanding and right-sizing clinical support services such as Pharmacy, Materials Management, Environmental Services, Information Solutions, and others to grow and better serve the growing facility.

Connecticut Children's has begun working with architecture and related companies to come up with the design of the New Tower. Implementation of the Project (i.e., breaking ground) would commence as soon as the Office of Healthcare Strategy approves this certificate of need application.

The Proposal is necessary because the market has shown us that there is an increased need for certain pediatric medical/surgical services and neonatal intensive care services, as well as an existing gap of certain types of pediatric health care services that are not offered in any hospital in the state of Connecticut. Connecticut Children's is now prepared to invest in and offer each of these services to the children of Connecticut and the region.

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?).

In 2016 Connecticut Children's engaged in a master planning effort to create a strategic vision for the future of the organization. After a few years of analysis and categorizing the main priorities, the Connecticut Children's Board of Directors approved the programming efforts and provided direction to move forward with the next phase of planning and design. Connecticut Children's subsequently engaged a consultant to help make the Project become a reality. Schematic design of the new tower began in Spring 2022.

3. Provide the following information:

   a. utilizing **OHS 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;

OHS TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Level IV Neonatal Intensive Care Unit (additional beds)	Connecticut Children's 282 Washington Street Hartford, CT 06106	Neonates requiring intensive care	24/7	Expansion of existing Level IV NICU under Connecticut Children's existing hospital license (additional beds required)
Advanced Cellular & Gene Therapy (new service)	Connecticut Children's 282 Washington Street Hartford, CT 06106	Patients 0 – 17 years old	24/7	New service under Connecticut Children's existing hospital license (additional beds required)
Fetal Care Center (new service)	Connecticut Children's 282 Washington Street Hartford, CT 06106	Fetuses with conditions requiring surgery or other interventions	24/7	New service under Connecticut Children's existing hospital license (additional beds required)
Additional Medical/Surgical Unit (additional beds)	Connecticut Children's 282 Washington Street Hartford, CT 06106	Patients 0 – 17 years old	24/7	Expansion of existing medical/surgical and PICU bed capacity (additional beds required)

b. utilizing **OHS Table 2**, identify the service area towns (i.e., use **ONLY** official town names) and explain the reason for their inclusion (e.g., market share).

Please note: use of village or area names instead of an official town name (Connecticut has 169 official towns) will not be accepted and will require revision/resubmission of the table.

OHS TABLE 2
SERVICE AREA TOWNS

Official Town Name	Reason for Inclusion
Andover* Ansonia Ashford* Avon Barkhamsted* Beacon Falls Berlin Bethany Bethel Bethlehem* Bloomfield Bolton* Bozrah Branford Bridgeport Bridgewater*	All 169 Connecticut towns have been listed. Those within Connecticut Children's Primary Service Area have been marked with an asterisk (*). The new services that will be provided in the new medical tower are niche services that are either not currently available at all or have only very limited availability within the state. Accordingly, it is reasonable to expect that patients from any town within the state (and in some cases from outside of Connecticut) may travel to Connecticut Children's to receive these services. Additionally, as the only licensed children's hospital in the state, patients can and do travel to seek our services from every town in the state.

Bristol Brookfield Brooklyn* Burlington Canaan* Canterbury* Canton Chaplin* Cheshire Chester Clinton Colchester Colebrook* Columbia* Cornwall* Coventry* Cromwell Danbury Darien Deep River Derby Durham East Granby* East Haddam East Hampton East Hartford* East Haven East Lyme East Windsor* Eastford* Easton Ellington* Enfield* Essex Fairfield Farmington* Franklin Glastonbury* Goshen* Granby* Greenwich Griswold Groton Guilford Haddam Hamden Hampton* Hartford* Hartland* Harwinton* Hebron* Kent* Killingly* Killingworth Lebanon Ledyard Lisbon Litchfield* Lyme Madison Manchester* Mansfield	

Marlborough* Meriden Middlebury Middlefield Middletown Milford Monroe Montville Morris* Naugatuck New Britain* New Canaan New Fairfield New Hartford* New Haven New London New Milford* Newington* Newtown Norfolk* North Branford North Canaan* North Haven North Stonington Norwalk Norwich Old Lyme Old Saybrook Orange Oxford Plainfield* Plainville* Plymouth* Pomfret* Portland Preston Prospect Putnam* Redding Ridgefield Rocky Hill* Roxbury* Salem Salisbury* Scotland* Seymour Sharon* Shelton Sherman Simsbury* Somers* South Windsor* Southbury Southington* Sprague Stafford* Stamford Sterling* Stonington Stratford Suffield* Thomaston*	

Thompson* Tolland* Torrington* Trumbull Union* Vernon* Voluntown Wallingford Warren Washington* Waterbury Waterford Watertown* West Hartford* West Haven Westbrook Weston Westport Wethersfield* Willington* Wilton Winchester* Windham* Windsor* Windsor Locks* Wolcott Woodbridge Woodbury* Woodstock*	

4. List all health care facility license(s) that the applicant current holds. If the license is inactive or is "not in good standing," please explain why and provide a recent corrective action plan. List all health care facility licenses that will be needed to implement the proposal (i.e., include licenses required by the Department of Public Health, Department of Children and Families, etc.).

Connecticut Children's Medical Center has only one children's hospital license that is in good standing. The Project will not require any additional licenses.

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

   a. a copy of all Connecticut Department of Public Health, Department of Children and Families license(s) currently held by the applicant(s); **SEE ATTACHMENT 5a**

   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; **SEE ATTACHMENT 5b**

      - James E. Shmerling, President and Chief Executive Officer
      - Bridgett Feagin, Executive Vice President and Chief Financial Officer
      - R. Moses Vargas, Senior Vice President and Chief Legal Officer
      - Larry Milan, Senior Vice President and Chief Human Resources Officer
      - Christine Finck, MD, Executive Vice President and Surgeon in Chief
      - Juan Salazar, MD, Executive Vice President and Physician in Chief
      - James E. Moore, MD, PhD, President, Connecticut Children's Specialty Group, Inc.
      - Timothy Cromblehome, MD, Clinical Director, Fetal Care Center

- Matthew Farr, Vice President, Ambulatory Operations, Connecticut Children's Specialty Group, Inc.
- Ryan Calhoun, Vice President, Strategy and Care Integration
- Aimee Monroy Smith, Senior Vice President, Government Relations
- Deb Pappas, Vice President, Chief Marketing and Communications Officer
- William Agostinucci, Vice President, Clinical Support Services
- Bob Duncan, Executive Vice President, Chief Operating Officer
- Jung Park, Senior Vice President, Chief Information Officer
- Sarah Matney, Senior Vice President, Chief Nursing Officer
- David Kinahan, President, Connecticut Children's Foundation, Inc.
- Karri May, Senior Director, Facilities Management

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 articles;

Below is a list describing a representative sample of articles supporting the need for the proposed services along with a brief explanation regarding the relevance to the proposal. The full text of each article is included in **Attachments 5c (1-12)**.

1	Fact Sheet: Connecticut Health Foundation. **Health Disparities in Connecticut: Infant & Maternal Health**. Accessed at https://www.cthealth.org/wp-content/uploads/2020/08/Health-disparities-fact-sheet-infant-mortality.pdf Report illustrating that while Connecticut's maternal and infant health statistics are among the nation's best, a closer look into the data reveals enormous disparities that persist in the health care experienced by residents of color. Babies born to Black mothers in Connecticut are more than three times as likely to die before their first birthday as babies born to non-Hispanic white women. They are also twice as likely to be born with low birthweight, which can put them at higher risk for serious health and developmental consequences.
2	Research Article: **Sigurdson K, Mitchell B, Liu J, et al. Racial/Ethnic Disparities in Neonatal Intensive Care: A Systematic Review**. Pediatrics. 2019;144(2):e20183114. Published April 10, 2019. DOI: https://doi.org/10.1542/peds.2018-3114 Systematic literature review indicating that racial and ethnic disparities in health outcomes persist specifically among infants requiring NICU care. Black and Hispanic infants requiring NICU care tend to have worse outcomes according to a variety of measures and are more likely to be treated in quality-challenged hospitals.
3	Research Article: Vohr B, McGowan E, McKinley L, Tucker R, Keszler L, Alksninis B. **Differential Effects of the Single-Family Room Neonatal Intensive Care Unit on 18- to 24-Month Bayley Scores of Preterm Infants**. J Pediatr. 2017 Jun;185:42-48.e1. doi: 10.1016/j.jpeds.2017.01.056. Epub 2017 Feb 24. PMID: 28238479. Discusses positive outcomes associated with single-family room NICUs, including increased rates of breastfeeding and increased Bayley scores.

4	Research Article: O'Callaghan N, Dee A, Philip RK. **Evidence-based design for neonatal units: a systematic review**. Matern Health Neonatol Perinatol. 2019 Apr 30;5:6. doi: 10.1186/s40748-019-0101-0. PMID: 31061714; PMCID: PMC6492317. Systematic literature review indicating that the NICU design and care environment have implications on the health of babies, the mothers, and their families. The authors' remarks suggest that an optimally designed NICU can positively impact parental involvement, assist with infection control, and improve neonatal morbidity and mortality.
5	Issue Brief: Kaiser Family Foundation. **Racial Disparities in Maternal and Infant Health: An Overview**. November 10, 2020. The Kaiser Family Foundation issued a brief highlighting the longstanding disparities in maternal and infant health outcomes in the United States. The publication reports significantly higher rates of pregnancy-related mortality and morbidity and infant mortality among people of color. The brief suggests that while the impact factors are complex and multifactorial, it urges clinicians and policy makers to prioritize equity in access to care.
6	Research Article: Wilpers A, Lynn A, Y, Eichhorn B, Powne A, B, Lagueux M, Batten J, Bahtiyar M, O, Gross C, P: **Understanding Sociodemographic Disparities in Maternal-Fetal Surgery Study Participation**. Fetal Diagn Ther 2022;49:125-137. doi: 10.1159/000523867. Although this study ultimately found that it was difficult to examine potential health disparities in maternal-fetal medicine due to the newness of the field and lack of sociodemographic reporting, it makes a number of salient observations in support of the conclusion that the availability of fetal care close to home is likely to have a positive impact on outcome disparities in maternal and infant health. Notably, fetal surgery can place a significant social burden on families (e.g., stressors associated with weeks of required maternal bed rest), and both lower socioeconomic status (SES) and longer distance to travel to a tertiary care center (the setting where fetal care is commonly provided) are associated with worse outcomes.
7	Research Article: Isaac EI, Meisman AR, Drucker K, Violante S, Behrhorst KL, Floyd A, Rohan JM. **The Relationship between Health Disparities, Psychosocial Functioning and Health Outcomes in Pediatric Hematology-Oncology and Stem Cell Transplant Populations: Recommendations for Clinical Care**. Int J Environ Res Public Health. 2020 Mar 26;17(7):2218. doi: 10.3390/ijerph17072218. PMID: 32224963; PMCID: PMC7178256. This article highlights outcome disparities specifically with respect to adolescent and young adult cancer patients and bone marrow transplant recipients, noting that racial and ethnic minorities and those living in high poverty areas experience substantially worse outcomes. The article attributes these outcomes to a complex interaction of psychosocial factors, however, lack of access to quality care in high poverty areas is cited as a notable factor impacting cancer survival rates.

8	Research Article: Houtrow AJ, Thom EA, Fletcher JM, Burrows PK, Adzick NS, Thomas NH, Brock JW 3rd, Cooper T, Lee H, Bilaniuk L, Glenn OA, Pruthi S, MacPherson C, Farmer DL, Johnson MP, Howell LJ, Gupta N, Walker WO. **Prenatal Repair of Myelomeningocele and School-age Functional Outcomes**. Pediatrics. 2020 Feb;145(2):e20191544. doi: 10.1542/peds.2019-1544. PMID: 31980545; PMCID: PMC6993457. Study shows long-term benefits of prenatal surgery included improved mobility and independent functioning and fewer surgeries for shunt placement and revision.
9	Research Article: Cheah IGS. **Economic assessment of neonatal intensive care**. *Transl Pediatr*. 2019;8(3):246-256. doi:10.21037/tp.2019.07.03. This study found neonatal intensive care to be very cost-effective.
10	Research Article: Sadatsafavi H, Niknejad B, Shepley M, Sadatsafavi M. **Probabilistic Return-on-Investment Analysis of Single-Family Versus Open-Bay Rooms in Neonatal Intensive Care Units-Synthesis and Evaluation of Early Evidence on Nosocomial Infections, Length of Stay, and Direct Cost of Care**. J Intensive Care Med. 2019 Feb;34(2):115-125. doi: 10.1177/0885066616689774. Epub 2017 Jan 25. PMID: 28118769. Cost savings associated with single family room units would justify additional construction and operation costs compared to open-bay units.
11	Research Article: Werner EF, Han CS, Burd I, Lipkind HS, Copel JA, Bahtiyar MO, Thung SF. **Evaluating the cost-effectiveness of prenatal surgery for myelomeningocele: a decision analysis**. Ultrasound Obstet Gynecol. 2012 Aug;40(2):158-64. doi: 10.1002/uog.11176. Epub 2012 Jul 9. PMID: 22511529. Prenatal myelomeningocele repair is cost effective and frequently cost saving compared with postnatal myelomeningocele repair despite the increased likelihood of maternal and future pregnancy complications associated with prenatal surgery.
12	Publication: OECD (2021), *Health at a Glance 2021: OECD Indicators*, *Hospital beds and occupancy*. OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en. Discusses occupancy rates as an indicator of availability of adequate resources. Suggests that a rate of 85% is often considered a safe maximum to reduce the risk of bed shortages.

d. the “state, federal, national or industry-approved” protocols or Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of all relevant sections and describe how the applicant proposes to meet the protocols or guidelines; **SEE ATTACHMENTS 5d (1-3)**

The primary services that will be provided in the New Tower include neonatal intensive care services, advanced cellular and gene therapy services, fetal care services, and medical/surgical

services. For neonatal intensive care services and medical/surgical services, we will continue to the follow the Standards of Practice that we currently utilize for those services. Below is a list of the Standard of Practice Guidelines that we are following in further developing these services. Attached are relevant articles mentioned below. We do not have electronic access to some of these yet (e.g., FGI Guidelines (2022), ACOG Guidelines, and AWHON Guidelines), but are more than willing to submit them once we do.

- Neonatal Intensive Care – governed by the American Nurses Association (ANA) *Neonatal Nursing: Scope and Standards of Practice (3rd ed)*
    - We intend to provide private neonatal rooms in accordance with the studies that show the highly positive impact this has on neonates (and their long-term health) as well as the overall experience for their families. We will comply with all of the necessary building and inspection standards set forth in the FGI Guidelines when building such rooms. Since the provision of NICU services is not new for us, we will continue to follow the same standard of care protocols that are currently followed in all of our NICUs, including those set forth in the ANA Neonatal Nursing guidelines.

- Advanced Cellular and Gene Therapy – governed by the Association for the Advancement of Blood & Biotherapies (AABB) *Standards for Cellular Therapy Services (10th ed)*
    - The Advanced Cellular and Gene Therapy Unit will comply with all of the applicable standards set forth by the Association for the Advancement of Blood and Biotherapies. Specifically, the clinical program will (i) consist of an integrated medical team, (ii) use cell collection and processing facilities that meet FACT-JACIE Standards, (iii) have a designated transplant team, (iv) comply with all clinical unit specifications, (v) follow the clinical program director, attending physician, as well as all of the corresponding training requirements for such personnel, (vi) comply with all quality management requirements, (vii) consist of the necessary policies and standard operating procedures protocols, (viii) follow the donor and recipient care guidelines, (ix) comply with all necessary clinical research rules, and (x) implement data management and record maintenance protocols to ensure the proper storage of all applicable records.

- *Fetal Care* – governed by the (i) American College of Obstetricians and Gynecologists (ACOG) practice advisories and clinical guidelines and (ii) Association of Women's Health, Obstetric and Neonatal.
    - In light of the fact that Fetal Care will be a new service line for us, we are actively in the process of obtaining membership and gaining access to the various evidence-based journals that set forth the industry standard of care practices. A few of the prevalent sources from ACOG include (i) Compendium of Postpartum Care, (ii) Core Curriculum for Maternal and Newborn Nursing, (iii) Perinatal Nursing, (iv) Preparing for Clinical Emergencies in Obstetrics and Gynecology, (v) Patient Safety in Surgical Environments, and (vi) Patient Safety in Obstetrics and Gynecology. Patient safety is and will always be our number one priority. We will develop our internal policies and protocols based on the guidance set forth by the industry leaders.

- Medical/Surgical Beds – *Facility Guidelines Institute (version 2022)*
    - The medical/surgical beds will be built to comply with intensive care unit

standards while also meeting the requirements specifically established for medical/surgical beds. The rooms will be built to accommodate intensive care needs, including having head wall gasses installed in each room and access to increased emergency power. Intensive care standards require minimum dimension of length as well as finish standards for seamless construction. One of the key distinguishing factors in this type of room will be that each will have its own patient toilet which does not exist in standard ICU rooms.

e. 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.

- Neonatal Intensive Care Services and Medical/Surgical Services – none

- Advanced Cellular and Gene Therapy

    - *Service Agreement* – We will contract with a blood bank or American Red Cross for cell processing and potentially apheresis services.
        - *These services are not due to go live until the new tower has been built. As such, an Initial draft of this contract will not be completed until such date.*

- Fetal Care Center

    - *Maternal Fetal Medicine (MFM) Physician Services Agreement* – lease a portion of MFM time from Hartford HealthCare Medical Group to support the Fetal Care Center
        - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

    - *MFM Call Coverage Agreement* – on-call coverage in the evenings, weekends, and while MFMs are on PTO
        - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

    - *Transfer Agreement with Hartford Hospital* – transfer of mothers to Hartford Hospital in the event Connecticut Children's LDRP beds are full
        - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

    - *OB Nursing Leasing Agreement* – OB nurses at Women's Health of Connecticut to come to Connecticut Children's to support OB procedures
        - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

    - *OB Hospitalist Leasing Agreement* – OB hospitalist to be leased from Women's Health of Connecticut to provide bedside hour-to-hour management

of obstetrics patients under the supervision of the MFM or fetal surgeon
    - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

- *Anesthesia Physician Services Agreement* – leasing OB anesthesia services from Integrated Anesthesia Associates to provide coverage of unexpected/urgent deliveries for patients on the inpatient services that are being monitored. Leasing OB anesthesia services to be present for all open and exit procedures completed at Connecticut Children's.
    - *These services are currently being discussed with Hartford HealthCare. As such, an Initial draft of this contract has not been finalized.*

Public Need and Access to Care

§ *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy;" 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 Office of Health Strategy (OHS).

Connecticut Children's is proposing an increase of twenty-six (26) beds and thirty-three (33) bassinets on the current children's hospital license. As such, the proposal for the increase in bed capacity adheres to the Connecticut General Statutes Sec. 19a-638(12) that requires a Certificate of Need for "increase in the licensed bed capacity of a health care facility."

7. Describe how the proposed project aligns with the OHS Health Systems Planning's Statewide Health Care Facilities and Services Plan, available at HSP Publications Library.

    a) Certificate of Need Program (Page 6):

    The proposal aligns with the objective of the Certificate of Need program of being a "regulatory and planning tool designed to improve access to high-quality health services, minimize unnecessary duplication of services, facilitate health care market stability and help contain the cost of health care." Due to the increased need for Level IV neonatal intensive care services as well as a fetal care center in the region, Connecticut Children's proposal does not represent a duplication of services or affect the health care market stability. Instead, the proposal will provide a needed and currently limited service for the community.

8. With respect to the proposal, provide evidence and documentation that demonstrate clear public need. Include citations to referenced articles, peer-reviewed literature or other documentation that supports the application:

    a. identify the target patient population to be served;

The target populations to be served are as follows:

- Neonates requiring intensive care (Level IV neonatal intensive care bed increase);
- Fetuses with complications requiring surgery or other intervention (bed increase to add Fetal Care Center, which will require Labor & Delivery Beds);
- Patients between 0-17 years old requiring medical/surgical care (medical/surgical bed increase);
- Patients between 0-17 years old requiring advanced cellular and gene therapy, including without limitation bone marrow transplant (bed increase to add Advanced Cellular & Gene Therapy Unit)

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

Level IV NICU: Patients requiring neonatal intensive care are currently served in Connecticut Children's neonatal intensive care units within Hartford Hospital and UConn Health, or in other NICUs around the state. However, only two NICUs in the state (Connecticut Children's NICU at Hartford Hospital and the NICU at Yale-New Haven Hospital) are certified as Level IV NICUs, which provide the highest level of NICU care to the most medically complex infants. Connecticut Children's Level IV NICU is undersized relative to the growing patient population it serves, as shown by its occupancy rate, which has been at or above 96% for the past three fiscal years and currently stands at 106% for the current fiscal year. This is not optimal for patient safety and demonstrates that the target population is in need of additional bed space to accommodate their needs.

Medical/Surgical Beds: Connecticut Children's currently has 103 licensed medical-surgical beds in Hartford, including an 18-bed pediatric intensive care unit (PICU). Because Connecticut Children's is the only freestanding children's hospital in the state, there are limited other in-state options for pediatric patients to receive equivalent care when Connecticut Children's medical/surgical or PICU beds are at capacity. If the PICU is in surge, patients whose conditions are less acute may need to be transferred to a medical/surgical floor to make room in the intensive care unit. Further, there is no ideal space for those who may require an intermediate level of care between the PICU and a general medical/surgical unit. If the medical/surgical units are at capacity, playrooms need to be closed to make space to board patients, which is not an optimal solution for either the patient being boarded or other patients on the unit. Apart from the temporary reduction in fiscal year 2020 due to the COVID-19 pandemic, the medical/surgical units' occupancy rate has remained at or above 85%, showing that the units are running out of space and the target population is in need of additional bed space to adequately and safely serve their needs.

Advanced Cellular & Gene Therapy and Fetal Care Services: Connecticut Children's does not currently have the facilities, capacity, or staff needed to offer this care. The majority of Connecticut Children's patients requiring these services indicate that their preference would be to remain at Connecticut Children's for this care with the providers they know and trust. However, because they are currently unable to do so, patients generally choose to seek these services at Boston Children's Hospital for advanced cellular & gene therapy and Children's Hospital of Philadelphia for fetal surgery, which

are currently perceived as the best programs in the region for these specific types of care. For example, internal tracking from Connecticut Children's Division of Hematology/Oncology indicates that 52 out of 55 Connecticut Children's patients requiring bone marrow transplants between 2015 and 2021 chose to go to Boston Children's Hospital for that care. Other services offered as part of this new program, such as Metaiodobenzylguanidine (MIBG) therapy and many of the services planned as part of the Fetal Care program, are not currently available in the state at all. Patients who need these unique, niche services must travel out of state to receive them.

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

Level IV NICU: As described in Section 8(e) below, a variety of factors have led to a significant increase in the proportion of NICU patients with high-acuity, complex conditions requiring Level IV care. As a result, demand at Connecticut Children's Level IV neonatal intensive care unit frequently exceeds its current capacity, as demonstrated in Table 1(c)(i) of the Supplemental Application for Increase In Licensed Bed Capacity. The current occupancy rate of 106% means the unit is frequently in surge status. When surges occur, less acute patients in the Level IV neonatal intensive care unit may need to be transferred to surge space within Connecticut Children's main building (which is not designed to be the equivalent of a full-time NICU), transferred to Connecticut Children's NICU at John Dempsey Hospital (which is a Level III NICU), or occasionally transferred outside of Connecticut Children's altogether. It is never optimal care to transfer a fragile infant when the transfer is not otherwise medically indicated, and patient satisfaction surveys reflect that this is a stressful process for families that results in concerns about coordination and quality of care. **CCMC Table 1** below sets forth the annual volume of transfers due to high census. The numbers shown include both transfers from Hartford Hospital's Labor & Delivery Room directly to outside NICUs and transfers from Connecticut Children's Level IV neonatal intensive care unit to lower-level NICUs.

CCMC Table 1
NICU Transfers Due to Census

Fiscal Year	Number of Transfers
FY 20	46
FY 21	39
FY 22 (YTD)	18

Medical/Surgical Unit: Similarly, the additional medical/surgical beds are necessary to keep up with current demand. Throughout the year, Connecticut Children's pediatric medical/surgical units and pediatric intensive care unit are in surge status for approximately 20% of the year, leaving no space for new admissions. As the only licensed children's hospital in the state and one of only two PICUs in the state, this is extremely problematic as there are few, if any, other comparable options for these patients. The new unit will be built and staffed to accommodate the right patient population at the right time, with rooms that meet standards for both general medical-surgical units and intensive care units. This is important because Connecticut Children's patient data shows rising acuity, with average year-over-year growth of 3.5% over the past five years in patients classified as "critical care" patients who were treated outside

the PICU. The ability to flex these beds to meet PICU or general medical/surgical standards as required by the patient's current acuity will help Connecticut Children's to best meet the needs of patients in this intermediate "critical care" category. It will also reduce the need for internal transfers of such patients, which have a significant negative impact on the family and on continuity of care.

It is also important to note that the services to be provided in the new tower are just one component of Connecticut Children's larger strategic plan to best meet the community's needs. The additional medical/surgical beds will be crucial to maintain adequate bed capacity for medical patients when Connecticut Children's opens its planned inpatient medical/psychiatric unit. As described in extensive detail in Connecticut Children's Certificate of Need Application for that unit, there is an ongoing pediatric mental health crisis in the region and an extreme shortage of beds available to provide inpatient medical/psychiatric care for children who need it, particularly those who have complex medical needs as well as psychiatric needs. It is anticipated that the new medical/psychiatric unit will frequently be at full capacity. During such times, patients awaiting a medical/psychiatric bed may be temporarily boarded on Connecticut Children's existing medical/surgical floors. This will result in better care to both emergency patients and those awaiting long term placements. Patients will no longer need to board in Connecticut Children's Behavioral Health Emergency Department, which is not designed for long-term stays. It will also improve access and throughput for patients needing acute emergency behavioral health care by freeing up beds in the Emergency Department. At the same time, with the anticipated increase in boarders with psychiatric needs on the existing medical/surgical floors, Connecticut Children's will need additional beds to maintain sufficient capacity to care for those patients whose needs are purely medical. The beds in the new tower's medical/surgical unit, which will meet standards for both intensive care and general medical/surgical rooms, will serve that important purpose.

Advanced Cellular and Gene Therapy and Fetal Care: With respect to the proposed new advanced cellular and gene therapy services and fetal care services, as described above in the answer to Question 8(b), these services are currently not available at Connecticut Children's. Patients who need them have indicated that they would prefer to receive the services at Connecticut Children's, but without that option, they generally choose to travel out-of-state to receive them at other facilities that are perceived as the best in their respective fields. This is a large burden on families who are already experiencing the hardships of a high-risk pregnancy or a child with cancer, and is beyond reach for patients who do not have the resources to manage this kind of travel. These patients would be better served if we could offer their care close to home at Connecticut Children's, resulting in better coordination of care at the same facility and within the same provider network that the patients already know and trust.

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

The proposal is to expand the footprint of Connecticut Children's main hospital location located at 282 Washington Street in Hartford. The services planned for the new tower are new, high-acuity services requiring inpatient hospitalization and/or expansion of existing inpatient hospital services. The Hartford location is Connecticut Children's only inpatient hospital location. As such the proposal is simply to expand the existing hospital to accommodate the proposed new services and better meet existing demand at that location.

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

While fertility rates in the United States are relatively stable overall, there has been a significant shift in the age groupings of women having children. Census Bureau and National Center for Health Statistics data shows that from 1990 to 2019, fertility rates of women ages 20-24 declined by 43%, while those of women ages 35-39 increased by 67%. In Connecticut, this trend is even more pronounced. According to Census data, nationally in 2018-2020, 3.5% of births were to women over 40 and 47.9% were to women over 30, whereas in Connecticut these percentages were 4.7% and 60.1%, respectively. **See Attachment 8e (1).** The association between advancing maternal age and increased risk of perinatal complications has been demonstrated by a number of studies. **See, e.g., Attachment 8e (2).** Connecticut Children's own patient data shows that conditions falling within the diagnostic category of "Certain Conditions Arising in the Perinatal Period" are responsible for an increasing share of Connecticut Children's overall patient days. In 2018, this category resulted in under 1,500 patient days in the PICU, whereas in 2021 it was responsible for over 2,500. On the Med/Surg units, the number rose from approximately 2,200 to over 5,000.

Likewise, as described in the various articles in **Attachments 5c (1-12)** and Question 8(f) below, significant racial and ethnic disparities exist in infant and maternal health outcomes. For example, while Connecticut has a lower preterm birth rate than the United States as a whole, the infant mortality rate among Black women in Connecticut is 46% higher than the rate among all other women. **See Attachment 5c (1).** Racial and ethnic disparities in infant and maternal health have been targeted by the Department of Public Health as a priority in its State of Connecticut 2019 Health Assessment because infants born preterm and/or with low birthweight are at risk for serious health consequences, such as respiratory problems, intellectual and developmental disabilities, vision and hearing loss, and cerebral palsy. (**See Attachment 8e (3), pages 87-93**).

The disparities identified in infant outcomes persist throughout childhood. For example, the most recent Department of Public Health Community Needs Assessment notes that Black and Hispanic children experienced higher rates of preventable pediatric hospitalizations for most of the leading of such hospital services (**Attachment 8e (4), page 25**). Access to quality care has been identified as one of the key barriers driving these disparate outcomes (**see, e.g. Attachment 5c (5)**).

Connecticut Children's is located in Hartford, which has a considerably higher concentration of racial and ethnic minorities than the state as a whole (as discussed further in the answer to Question 8(f) below). Because of this, it is well positioned to help address the disparities set forth above by expanding the capacity of its existing Level IV neonatal intensive care unit and pediatric beds and introducing new high acuity, highly specialized fetal care services and Advanced Cellular & Gene Therapy into the service area.

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

The proposal will provide care to any child who requires services regardless of race, gender, income, insurance coverage, origin, or disability. As a nonprofit hospital,

Connecticut Children's has a non-discrimination policy and provides financial assistance and charity care to low-income individuals. Connecticut Children's Patient Financial Assistance Policy and Nondiscrimination Policy are included in **Attachments 19 and 8f (1)**, respectively. Further, as described in the answer to Question 8(e), the expanded Level IV neonatal intensive care unit capacity and availability of a new fetal surgery program in Hartford will help to address racial and ethnic disparities in infant mortality rates. Connecticut Children's is located in Hartford, where the poverty rate and percentage of Black residents is nearly triple that of the state as a whole, and the concentration of individuals of Hispanic origin is more than double that of the state as a whole. (**See Census data in Attachment 8f (2)**). Connecticut Children's also has a significant Medicaid population (see OHS Table 9 below), and the Department of Public Health has identified significant outcome disparities between individuals with commercial insurance and those on Medicaid. (**See, e.g. State of Connecticut Health Assessment, Attachment 8e (3), Figure 1.10**). Because of this, Connecticut Children's location is ideally placed to make this state-of-the-art care easily accessible to the underserved groups that need it most and that already comprise a significant portion of Connecticut Children's patient population. With the proposed services and expanded bed capacity in the new tower, underserved groups in Connecticut will benefit from Connecticut Children's having adequate capacity to serve all patients who need its services, and from having convenient access to innovative, specialized care close to home.

g. list any changes to the clinical services offered by the applicant(s) and explain why the change was necessary;

The Advanced Cellular & Gene Therapy Program was proposed to keep pace with the latest, most advanced treatments available in order to provide the best outcomes possible for Connecticut Children's childhood cancer patients. The vision for this program is to provide various types of advanced cellular and gene therapy, including bone marrow transplant, gene therapy, cellular therapy, chemotherapy, and specialty treatments for neuroblastoma including Metaiodobenzylguanidine (MIBG) therapy. All these patient types require specialty facility environments, resources, and specialized nursing care, and a dedicated unit is necessary to accommodate special room types required to safely provide the services in question. For example, MIBG patients require a lead-lined patient suite due to the nature of the treatment. Further, the nature of these treatments renders the patient susceptible to other infections, so it is important that they are isolated from the general patient population.

Similarly, the Fetal Care Center was identified as an opportunity to improve perinatal and neonatal outcomes using the most cutting-edge methodologies. The vision for this program is to provide comprehensive care for a healthy individual carrying a fetus with a birth defect with the goal of normalizing the birth experience and optimizing the neonatal care within Connecticut Children's. Fetal surgery necessarily involves performing surgery on the pregnant parent as well as the fetus. Additionally, in some cases, it may be necessary for the infant to be delivered at Connecticut Children's to facilitate the presence of Connecticut Children's expert specialty care providers and the performance of immediate surgery. This care delivery model requires the addition of dedicated labor and delivery beds.

The remainder of the request for increased beds and bassinets does not reflect a change in clinical services, but rather a need to meet increasing demand for existing

services by expanding capacity. As demonstrated in the Supplemental Application for Increase in Licensed Beds, Connecticut Children's occupancy rates for the NICU and medical/surgical units are already high and continue to rise, creating an unsustainable situation that leaves us unable to provide optimal care to the target populations and accommodate unexpected surges. Although there is no definite consensus on what constitutes a "safe" occupancy rate, a rate of about 85% is often considered a safe maximum to reduce the risk of bed shortages. **See Attachment 5(c)(12).** Connecticut Children's historical occupancy rates for NICU and medical/surgical beds are already well above that threshold, demonstrating a significant need for additional beds to continue to safely accommodate the growth in demand. Further, as described in the answer to Question 8(c), it is expected that the opening of Connecticut Children's planned medical/psychiatric unit will result in even more strain on its existing medical/surgical space as these units are likely to need to accommodate boarders awaiting medical/psychiatric beds in addition to their current patient population. For the foregoing reasons, the changes described in this proposal are critical to maintaining adequate pediatric hospital capacity in the state.

Finally, Connecticut Children's existing spaces are more than 25 years old and are not always adequate to support evolving evidence-based practices. For example, many studies have shown that neonates treated in private neonatal intensive care rooms experience better outcomes than those treated in open-bay units. Internally, patient surveys routinely indicate dissatisfaction with the open bay model's noise level and lack of privacy during a stressful and traumatic time for families. Connecticut Children's existing Level IV neonatal intensive care unit is an open-bay unit. The proposed new unit will be constructed as a private room unit to keep pace with the most current evidence-based practices and provide a safe, supportive, and private environment for the patient and family.

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

As described in the answer to question 8(c), access to care will be expanded as a result of the proposed bed increases. The bed increases will enable Connecticut Children's to both better meet demand for its existing services and provide state-of-the-art new services that are currently not available in the service area.

i. discuss any alternative proposals that were considered.

The need to expand Connecticut Children's main hospital location has been apparent for nearly a decade, and the proposed Project represents the culmination of years of planning. The primary driver of these discussions has long been Connecticut Children's existing Level IV NICU within Hartford Hospital, which is outdated and undersized. Patient experience scores typically highlight these challenges. In addition, many of our support spaces for the hospital and our support services such as the kitchen/dining area were built too small for the volume of patients and families Connecticut Children's has come to serve. Moreover, the ongoing COVID-19 pandemic brought a concurrent pediatric behavioral health crisis, which resulted in more patients boarding in the ED and on our medical/ surgical floors. Our Emergency Department and medical/surgical floors, especially medical/surgical floor 6, are consistently at maximum capacity due in large part to the ongoing behavioral health crisis. Boarding patients in hallways or playrooms until a bed becomes available has become a routine occurrence. The convergence of these factors caused Connecticut Children's to begin planning for expansion in early

2021.

Many options were considered before determining that the eight-floor tower including all of the services and beds discussed in this proposal would best serve the needs of the community. One proposal was to renovate the second floor of the existing hospital to serve as the new Level IV NICU. This was determined to be infeasible due to the significant disruptions it would cause to hospital operations and patient care. Firstly, the ambulatory services that currently occupy that floor would need to be relocated to another building in Hartford, which would requiring finding and buying or renting an appropriate space at additional cost. Secondly, the second floor space is not large enough to accommodate even the current number of licensed bassinets, which would only exacerbate the current capacity problems. Thirdly, the medical gas capacity, our air handlers, plumbing lines, electrical and IT infrastructure of the existing hospital could not support an additional unit. Finally, the timeline to completion would be longer than that for new construction due to the phasing and working within a hospital that is already operating and serving patients. As such, utilizing existing space was not a practical solution; we are simply already out of space and in need of room to grow as quickly as possibly to better serve the community.

Another option considered was to build a smaller tower consisting of five or six floors. A tower of this size would have primarily served to expand the Level IV NICU and support services (kitchen/cafeteria, etc.), while deprioritizing the Fetal Care Services and Advanced Cellular and Gene Therapy Services. However, this would be a disservice to our patients. As described elsewhere in this application, the research shows that these niche, state of the art services continue to show positive outcomes for patients and are expected to become the new standard of care in the future. Patients are currently choosing to leave the state to seek this cutting-edge care, and we have an opportunity to make it more widely accessible by bringing it to their local community. Finally, it was also felt that a six-floor tower would not allow sufficient room for growth, and would therefore result in recurrence of the current capacity issues in the near future.

Connecticut Children's aims to make the children of Connecticut the healthiest in the country by providing access to the very best care in an environment that is warm and welcoming for families. Constructing the new tower and increasing bed capacity as described in this proposal is the best way to accomplish that goal.

§ "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;" Conn.Gen.Stat. § 19a-639(a)(5).

9. Describe and provide specific details on how the proposal will improve the following (i.e., include citations to referenced articles, peer-reviewed literature or other documentation that supports the application):

    a. the quality of health care in the region;

    b. accessibility of health care in the region; and

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

d. health equity in the region

See Attachments 9a.

- **Level IV NICU Services** – The bassinets that will be located in the New Tower will be housed in single patient rooms (as opposed to community rooms) to provide a safe, supportive and private environment for the patient and family. There will be direct connections between some rooms to enable care for twins and triplets. Offering single patient rooms in the neonatal intensive care environment is consistent and supported by industry standard. Those standards are reflected in multiple forums such as the Journal of Perinatology (2013), the Recommended Standards for Newborn ICU Design as noted in the Report of the Ninth Consensus Conference on Newborn ICU Design (2019), and the article *Evidence-based Design for Neonatal Units: a systematic review*, Maternal Health, Neonatology, and Perinatology, O'Callaghan et al. (2019). Connecticut Children's Level IV neonatal intensive care unit located within Hartford Hospital is frequently operating at full capacity without any ability to transfer highly acute neonates to any other units. The addition of new bassinets in the New Tower will increase accessibility of these highly specialized services to those in need. Offering single patient rooms to these critically ill neonates and their families could easily increase cost effectiveness for families and the health care industry overall if such care potentially reduces the need for longer-term care. Moreover, providing additional Level IV NICU beds to the region will reduce the likelihood that lower acuity neonates will have to be transferred to units farther away from home and will allow their families to maintain closer access to their babies.

- **Fetal Care Services** – As the only fetal care center in the region, Connecticut Children's will provide comprehensive care for a person carrying a fetus with a birth defect or otherwise requiring invasive surgical care with the goal of normalizing the birthing experience for the patient and optimizing a healthy outcome for the fetus. The care delivery model will encompass the full continuum of care including outpatient diagnostics, evaluation, and treatment; inpatient and surgical services; and neonatal intensive care for the baby once it is born. Offering these services will eliminate the need for pregnant people to have to travel outside of Connecticut and the region for these services. Providing access to these services closer to home will have a positive impact on accessibility, cost effectiveness of care and health equity.

- **Advanced Cellular and Gene Therapy Unit Services** – When managing pediatric cancers, we need a way to target the cancer cells more precisely, to maximize the drugs' effectiveness and minimize their potential damage. The Advanced Cellular and Gene Therapy Services will offer MIBG treatment. This treatment is not currently offered anywhere in the state. MIBG aims to treat those with a high risk cancer such as neuroblastoma. It is in the clinical trial phase for newly diagnosed patients, but is a standard option in relapsed neuroblastoma. Patients with neuroblastoma will be able to receive therapy and treatment in one location. Without this care, patients will continue to receive care across multiple states. This is just one form of cell therapy, and cell therapy is just one part of the services that will be offered in the new Advanced Cellular and Gene Therapy

Unit. This unit will also work with gene therapy, in which a faulty gene in a patient's DNA can be altered or removed to eliminate a disease or defect. In addition to the cellular and gene treatments, this unit will include a facility for performing bone-marrow transplants. The transplant is a highly specialized procedure requiring equally specialized equipment and skilled clinicians. It is an essential tool for treating cancers like leukemia, repairing damage caused by radiation and chemotherapy, and addressing noncancerous diseases and conditions, including immune system dysfunctions. Children whose lives are threatened by these diseases have to go to hospitals in other states to have the procedures done. The Advanced Cellular and Gene Therapy Unit will allow children in Connecticut and the region to stay close to home and have this care integrated with all of their other care. This will have a positive impact on accessibility, cost effectiveness and health equity.

- **Medical/Surgical Beds –** The new medical/surgical beds will serve patients with a range of acuity levels. The unit will be designed to accommodate acute care and intensive care needs in accordance with Facility Guidelines Institute (FGI) guidelines. The unit will be a single room-based unit with rooms sized for intensive care use but also furnished with a toilet and shower for acute care use. Space dedicated for family/visitors will be accommodated in the patient's room. The additional medical/surgical beds will be crucial to maintain adequate bed capacity for medical patients when Connecticut Children's opens its planned inpatient medical/psychiatric unit. As described in extensive detail in Connecticut Children's Certificate of Need Application for that unit, there is an ongoing pediatric mental health crisis in the region and an extreme shortage of beds available to provide inpatient medical/psychiatric care for children who need it, particularly those who have complex medical needs as well as psychiatric needs. It is anticipated that the new psychiatric unit will frequently be at full capacity. During such times, patients awaiting beds in the medical/psychiatric unit will be boarded in Connecticut Children's existing medical/surgical floors. This will result in better care to both emergency patients and those awaiting long term placements. Patients will no longer need to board in Connecticut Children's Behavioral Health Emergency Department, which is not designed for long-term stays, and will improve access and throughput for patients needing acute emergency behavioral health care. At the same time, with the anticipated significant increase in boarders with psychiatric needs on the existing medical/surgical floors, Connecticut Children's will need additional beds to maintain sufficient capacity to care for those patients whose needs are purely medical. The beds in the new tower's intensive care unit, which will meet standards for both intensive care and general medical/surgical rooms, will serve that important purpose.

10. What specific steps will the applicant(s) take to ensure that future health care services provided will adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area? (More details can be found at National CLAS Standards).

Connecticut Children's remains committed to providing quality care and services equitably and to be respectful and responsive to patients' cultural and linguistic bases. We adhere to the National

Standards on CLAS by implementing the following:

a) An active recruitment and promotion program for diverse team members that support the cultural and linguistic characteristics of the target patient population.
b) Connecticut Children's *Pathways to Action*, which is part of our *Diversity, Equity, and Inclusion Framework*, is offered to team members with the purpose of training and informing them about anti-racism, discrimination, and bias, suggesting improvements in more equitable hiring practices.
c) Language assistance to patients served by specialists via in-person or virtual translators at no cost. Patients are constantly informed about the availability of translation services. This approach facilitates timely and quality access to care for patients and families who do not speak English.
d) Printed and multimedia materials in English and Spanish.
e) Use of demographic data identifying race, ethnicity, and language of patients to implement strategies that respond to the diversity of the patient population.

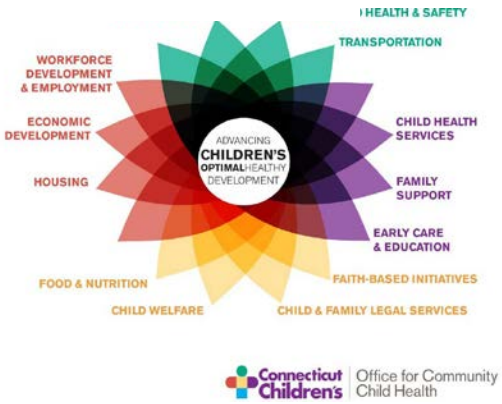
11. Describe how you are promoting health equity at your facility and/or in your programs.

Health equity has been defined as the equality of opportunity for all people to be as healthy as possible, and encompasses the removal of "obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Robert Wood Johnson Foundation, 2021). Connecticut Children's promotes health equity through a wide range of programs overseen by its Office of Community Child Health (OCCH). The OCCH addresses the interdisciplinary sectors that affect children's well-being and ensure they reach their full potential. OCCH develops, promotes, supports, evaluates, and disseminates innovative, effective community-oriented programs and services to address children's needs. OCCH key principles include:

- The promotion of healthy development for all children.
- The creation of integrated systems of care with strong linkages.
- The optimal use of existing resources.
- The advocacy for a child health services transformation.

OCCH supports health equity by a comprehensive approach characterized by "all sectors in" that considers the social and biomedical determinants of health to identify and address health inequities.

CCMC Figure 4. OCCH Flower Diagram



Comprised of 15 community-oriented programs, OCCH develops cost-effective and innovative strategies to promote health equity by closing the gaps between medical care and community services. The current scope of OCCH programs includes local, regional, national, and international programs.

Some examples of OCCH programs that promote health equity include:

a) Help Me Grow: The program is a local and national centralized directory that helps connect patients and families with community-based resources and services. At the local level, Help Me grow provides developmental screening, information and referral to services, support to address social determinants of health and unmet basic needs, coordination with primary care and other community-based providers, and parenting services. Numerous mental and behavioral health resources are available depending on the need of each child.

b) Center for Care Coordination: The Center facilitates comprehensive care to meet the medical, mental, and social needs of children and their families. The Center helps bridge the gap between families and services, links with programs and services in the community, connects patients with mental and behavioral health services, and ensures families understand how to navigate the health systems of care.

c) Injury Prevention Center: The Injury Prevention Center works in reducing unintentional injury and violence among Connecticut residents by engaging education, promotion, research, training, and public policy work to reduce preventable injuries among children. The Injury Prevention Center has a dedicated subprogram for Suicide Prevention aimed to provide training to college students, clinical and community agencies.

d) The Children's Center on Family Violence: Family violence is one of the determinants of children's mental health. The Center is a multidisciplinary, multiagency approach to respond and address the cases of children affected by family violence.

e) Co-Management: It is a care model that allows primary care providers to partner with subspecialists to design care protocols for diverse pediatric conditions, allowing children to receive specialty care as needed.

f) Kohl's Start Childhood Off Right: the goal is to prevent childhood obesity by working with 26 Hartford partners to develop wellness events, engage the community, and educate primary care providers and community works about nutrition and activity.

g) Healthy Homes: Provides support to improve living conditions for families, educates families on the importance of maintaining a healthy home, connects families to community resources, and advocates for all families to live in quality, stable, and affordable housing.

h) Center for Global Health: Builds the capacity to provide education and direct medical care in resource-limited settings, providing access to children and families worldwide and improving health through medical and holistic approaches.

In addition to the OCCH programs, Connecticut Children's advocates and works to end racism, discrimination, and bias, which affects access to care and aggravates disparities in education, housing, family, and employment, among other sectors. Therefore, Connecticut Children's

developed a Diversity, Equity, and Inclusion Declaration **(Attachment 11)** to strengthen a culture where patients, families, and team members are equally respected and served.

Additionally, Connecticut Children's Clinically Integrated Network (CIN) is comprised of more than 200 pediatric primary care providers located in different towns of Connecticut providing care to children close to home. Through efforts such as participating jointly in Accountable Care Organization (ACO) arrangements and developing co-management programs for common childhood conditions, the CIN supports community providers and ensures an integrated continuum of care.

12. Describe how your facility and/or programs will positively impact your community with special attention to the demographic data response in 8a (target patient population).

    Increasing access and availability to Level IV NICU beds and inpatient medical/surgical services will allow members of the community to receive care closer to home when necessary. Receiving care closer to home often increases the likelihood of a positive long-term outcome for the patient and families. Offering pregnant people whose fetuses require specialized or surgical services access to such services closer to home will prevent them from having to go out of state for such services. This will have a direct positive impact on these patients and families. Offering cutting edge cancer treatment to children with aggressive forms of cancer closer to home will allow these patients to continue receiving their care from the providers they have grown to love.

13. Connecticut has identified several health priorities in the state (i.e., addressing chronic conditions, access to substance use disorder treatment, childhood obesity, behavioral health treatment, lead screenings/prevention, addressing low birthweight racial gap, and emergency room use). Please click here to be taken to the Quality Council 2022 Core Measure Set. Identify if the proposal addresses any of the core measures outlined as health priorities for the state. If so, describe which core measure is addressed.

    While the fetal care services tangentially touch upon prenatal care, the services set forth in this proposal do not specifically address any of the core measures outlined as health priorities for the state.

14. Are you recognized as a Patient Centered Medical Home ("PCMH")? If not, are you working toward PCMH recognition?

    Connecticut Children's Medical Center itself is not eligible for PCMH recognition, however, the primary care division of its subsidiary medical foundation, Connecticut Children's Specialty Group, Inc. is recognized as a PCMH. Further, Connecticut Children's affiliated clinically integrated network, the Connecticut Children's Care Network, LLC (the "Care Network") includes 20 practices that are recognized as PCMHs and another is in the process of becoming a PCMH. Further, the Care Network participates in the PCMH+ model offered by the State.

15. Describe how your organization has tried to positively impact primary care in Connecticut. For example, explain your participation in primary care delivery models that incentivize value via alternative payment. If this application is for a mental health or substance use facility, explain any participation in models that integrate behavioral health care into primary care. If

this application relates to specialty care, explain how your proposal will integrate and coordinate with primary care.

Connecticut Children's Care Network is a clinically integrated network comprised of over 200 independent pediatric primary care providers and the specialists and primary care providers that are employed by Connecticut Children's. Through the Care Network, we are able to deliver integrated care to patients of our member practices. Connecticut Children's care coordinators work closely with patients, community pediatricians, specialists, and the medical center to manage chronic conditions and assist with access to care.

Through Connecticut Children's innovative Office for Community Child Health, described in detail in Question 11 above, Connecticut Children's also leads the way in addressing the social, environmental, and behavioral factors that keep children from being healthy and reaching their full potential.

The proposal in question relates to highly specialized care for the sickest and most vulnerable infants and children, and as such will not directly provide primary care. However, bringing this specialized care closer to home will result in improved coordination of care with patients' local primary care providers and specialists, including those affiliated with the Connecticut Children's Care Network.

16. Please provide a breakdown of the racial/ethnic composition for the service area and for the applicant's patient population.

Service Area – State of Connecticut
CCMC Table 2

Persons under 18 years old	**20.4%**
Race	
One Race	**93.1%**
White	66.6%
Black or African American	13.9%
Asian	4.8%
American Indian and Alaska Native	1.0%
Other	6.7%
Two or more races	6.9%
Ethnicity	
Hispanic or Latino (of any race)	25.5%
White alone	50.1%

Source: United States Census Bureau. 2019 ACS 1-Year Estimates. Connecticut, Children Demographics. TableID: S0901

Patient Population – Connecticut Children's Neonatal Intensive Care Units
CCMC Table 3

Race	
White/Caucasian	44.77%
Black or African American	10.89%
Asian	2.64%
Native Hawaiian or Other Pacific Islander	0.14%
American Indian and Alaska Native	0.11%
Other	19.79%

Two or more races	3.88%
Patient Refused/Unknown	17.8%
Ethnicity	
Not Hispanic or Latino	60.18%
Hispanic or Latino	24.43%
Patient Refused/Unknown	15.39%

Patient Population – Connecticut Children's Pediatric Admissions
CCMC Table 4

Race	
White/Caucasian	46.12%
Black or African American	15.12%
Asian	2.75%
Native Hawaiian or Other Pacific Islander	0.17%
American Indian and Alaska Native	0.15%
Other	24.95%
Two or more races	4.32%
Patient Refused/Unknown	6.43%
Ethnicity	
Not Hispanic or Latino	65.19%
Hispanic or Latino	29.49%
Patient Refused/Unknown	5.32%

17. Provide specific details describing how this proposal will help improve the coordination of patient care.

    The proposal is part of Connecticut's Children's broader plan to better serve the community and adapt to changing patient needs. As described above, including in the answer to question 8(c), Connecticut Children's proposed inpatient medical/psychiatric unit is expected to result in increased occupancy rates on its existing med-surg units due to boarders awaiting beds in the medical/psychiatric unit. As such, the bed increase in the new tower is one part of a coordinated plan to best address the pediatric mental health crisis.

    Secondly, the increased bed capacity will reduce transfers that would otherwise not be medically necessary. For example, as described above, the existing Level IV neonatal intensive care unit sometimes must transfer less acute patients out of the unit to make room for babies with more acute needs. No matter how carefully a transfer is done, each transfer has the potential for significant disruption to the baby and family as they adjust to a new care team, and provides the opportunity for potential gaps to arise. The new unit is expected to have sufficient beds that it will not be necessary to cohort patients by acuity or transfer patients to lower-level NICUs to address capacity issues. Similarly, the existing medical/surgical floors and PICU were frequently in surge status pre-pandemic. During these times, certain categories of patients (e.g. cardiac care patients) would be transferred from the PICU to the medical/surgical floors to make room for other patients requiring

intensive care. The additional medical/surgical beds, which will also meet standards for intensive care beds, will help avoid these otherwise unnecessary transfers and be adaptable to ensure that the patient has the right level of care at the right time. By alleviating space constraints and reducing the need for transfers due to capacity restrictions, the additional beds in the new tower will promote improved continuity of care within Connecticut Children's.

Further, the new beds in the Fetal Care Center and Advanced Cellular & Gene Therapy Program will promote coordination of care by providing access to niche services not previously available locally. This will, in turn, help patients requiring these services stay closer to home, within Connecticut Children's walls and their existing network of providers, promoting better continuity of care than when patients elect to travel out of state to seek these services. Additionally, the members of Connecticut Children's Care Network and many other local pediatric practices have access to Epic CareLink, Connecticut Children's integrated platform that permits sharing of Connecticut Children's patient records with other, outside members of the care team who don't use Connecticut Children's medical record system. As such, patients receiving the new specialty services will not only have concurrent, easier access to their other Connecticut Children's providers while receiving these treatments, but other members of their care team will also be able to quickly and easily access up-to-date information about their treatments.

18. Describe how this proposal will improve access to care for Medicaid recipients and indigent persons and, in addition, answer the following:

    a. Are you a current Medicaid provider? Yes. The majority of our patients are Medicaid beneficiaries.

    b. How will you assure that you will abide by the Medicaid Access standards?

    Medicaid recipients and indigent persons will not be negatively affected by the proposal. The proposed services will all be subject to Connecticut Children's charity care policy and sliding fee schedule so that care will still be accessible for these patient populations. Connecticut Children's will make all proposed services available in a timely fashion to individuals covered by Medicaid/Husky in accordance with state and federal Medicaid provider access requirements.

19. Provide a copy of the applicant's charity care policy and sliding fee scale applicable to the proposal.

    See Attachment 19

20. If charity care policies will be changed as a result of the proposal, list all changes and describe how the new policies will affect patients.

    There will be no changes in the charity care policies as a result of the proposal.

21. 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.

    The proposal does not reduce access to services by Medicaid recipients or indigents. More

than half of Connecticut Children's patients are Medicaid beneficiaries. As stated herein, the proposal will provide care to the children who need the proposed services, regardless of insurance coverage or income.

22. 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 and changes to health plan reimbursement for services.

    The proposal will not adversely affect patient health care costs. The neonatal intensive care services and medical/surgical bed services will be billed the same as they are now. The fetal care services and advanced cellular and gene therapy services will be new services provided by Connecticut Children's and therefore will not result in any changes.

23. Utilizing **OHS Table 3 and 4,** include both historical and projected cost data for self-pay patients and commercially insured patients as two separate tables.

    Note: If the COVID-19 pandemic affected the ability to report on FY2020 historical cost, please provide FY2019 cost data.

    The tables below reflect average reimbursement per patient for the entirety of FY2021. Costs include both facility and professional reimbursement per medical record number. Therefore, if a patient required many encounters throughout the year, those were totaled and included as part of the average with an n=1. The overall rates for self-pay patients were substantially lower than the commercial counterparts due to extreme discrepancies in services rendered. In other words, patients with the most costly treatment like neonatal and pediatric intensive care services are typically not self-pay.

    Based on historical data and prior experience, annual projected increases for self-pay patients were projected at 3% annually and annual projected increases for commercially insured were projected at 2% annually. There was insufficient data for self-pay patients in the intensive care units as those patients historically have either government or commercial coverage.

    Connecticut Children's has not provided fetal care or advanced cellular and gene therapy services before and, therefore, no historical cost data is available. In addition, we are unable to make meaningful projections as to the average cost per case for fetal surgery and advanced cellular and gene therapy services due to the variability in the services and fact that rates would need to be negotiated with commercial payers.

OHS TABLE 3

AVERAGE COST[1] OF CASE PER SELF-PAY PATIENT

	Historical	Projected			
Service	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
Overall	$203	$209	$215	$222	$228

[1] Cost is defined as the total dollar amount paid by the insurer plus patient out-of-pocket costs (e.g., deductibles, co-pays)

*Partial Year

Service	FY 2026	FY 2027	FY 2028
Overall	$235	$240	$245

OHS TABLE 4

AVERAGE COST[1] OF CASE PER COMMERCIALLY INSURED PATIENT

	Historical	Projected			
Service	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
Overall	$7,199	$7,343	$7,490	$7,640	$7,792
Neonatal intensive care services	$119,277	$121,663	$124,096	$126,578	$129,109
Pediatric intensive care services	$132,900	$135,558	$138,269	$141,035	$143,855
Medical/surgical unit services	$37,199	$37,943	$38,702	$39,476	$40,265

Service	**FY 2026**	**FY 2027**	**FY 2028**
Overall	$7,948	$8,107	$8,269
Neonatal intensive care services	$131,691	$134,325	$137,012
Pediatric intensive care services	$146,732	$149,667	$152,660
Medical/surgical unit services	$41,070	$41,891	$42,729

24. Explain whether this proposal will affect patient premiums or out of pocket costs for the commercially insured? If yes, please explain how. Click here for information on the CMS price transparency rule.

Connecticut Children's is not involved in setting premiums but does not anticipate the proposed project to have a significant impact on patient premiums or out of pocket costs for the commercially insured. The premium costs for Connecticut Children's patients are impacted by the total number of claims paid for all services provided to all of a commercial health plan's insureds in a given year. Commercially insured out of pocket costs are also defined in patients' individual policies and the timing of services within an insurance plan year (i.e. has a deductible been met) and plan changes happen often and are outside of Connecticut Children's control.

Connecticut Children's rates and charges are set independent of any capital expenditure. Therefore, the project will not have any impact on the costs and charges for healthcare services. All existing services will be billed the same as they are now.

The new services lines (i.e. advanced cellular gene therapies and fetal care) proposed by Connecticut Children's in this application may already covered in patient health plans and most of these services are already provided in the state (albeit outside of Connecticut Children's primary service area). Despite this, many patients currently seeking these services travel out of state. These other facilities may have a higher or lower cost negotiated with the insurers for the proposed service lines. If the services are covered regardless of where the patient receives those services, then there should not be increased costs to commercial payers. As such, Connecticut Children's best estimate is that there would not be an increase in premiums or out of pocket costs for the commercially insured resulting from this proposal. In fact, reducing family travel expenses by providing advanced cellular & gene

therapy and fetal care services closer to home should result in an overall reduction in family out of pocket costs.

25. Explain whether this proposal will affect costs to the uninsured.

    The proposal will not affect costs to the uninsured since services provided to those patients would be covered under the existing charity care policy. The institution provides services to children regardless of their insurance coverage.

26. Will the proposal result in increased costs to any State of Connecticut program (e.g., Medicaid, State employee plan)?

    The proposal will not result in increased costs to any State of Connecticut program beneficiaries. To the extent a Medicaid beneficiary required fetal care services or advanced cellular and gene therapy services, those beneficiaries would have to go out of state to receive those services. If receiving those services in a different state results in less cost to the State of Connecticut, then it is possible that receiving those services within Connecticut could result in increased costs. However, if the services are covered regardless of where the patient receives those services, then there should not be increased costs to the state.

27. Are you currently participating in any accountable care organization (ACO) arrangements or value-based payment arrangements? If yes, please describe in detail and describe whether and how the proposal will be incorporated into such arrangements.

    The Care Network participates in four value-based payment arrangements, described in more detail below. The services contemplated by this proposal will enhance Connecticut Children's ability to meet demand and provide high quality services, specialty expertise, and state-of-the-art services at the level needed by the community and the patients served through its ACO arrangements. Although the shared savings metrics involved in these arrangements do not directly measure these niche specialty services, access to such services is likely to have an indirect downstream impact on measures such as preventable hospitalizations by improving outcomes from the start.

    a. **Aetna commercial**: providers are paid at a negotiated fee schedule for services rendered to patients. The Network's performance on pediatric-focused quality measures is evaluated compared to agreed-upon improvement targets. Under the current arrangement, if the Care Network is able to manage medical cost trend better than the peer network, on a risk-adjusted basis, the Network is able to participate in a percentage of the savings. The quality performance score determines the percentage of savings available to the Network. This ensures that quality remains the highest priority under the value-based arrangement.
    b. **Anthem commercial**: providers are paid at the Anthem market fee schedule for services rendered to patients. The value-based metrics include both quality and total medical cost. Quality metrics cover the range of preventive, acute and chronic, utilization and pharmacy categories of care. The Network baseline cost is established and reported on a quarterly basis. Anthem establishes a medical cost target, based on market trend, and evaluates the group's actual medical cost performance compared to the target. If the Network's annual cost performance comes in below the target, the Network may share in a percentage of those savings. The percentage is then determined by the Network's total quality score. If the quality score does not meet the threshold, any savings

generated by the group are forfeited.

c. **ConnectiCare commercial**: each provider is reimbursed for services rendered in accordance with the relevant fee schedule. The ConnectiCare arrangement enables separate payment for quality and cost, but the quality score also determines the percentage of any savings in which the group may participate. Quality metrics. The Network must achieve 6 out of 8 quality targets in order to be eligible to participate in any savings. ConnectiCare establishes the Network's baseline medical cost and establishes a target based on projected medical trends. Performance is reported on a quarterly basis and reviewed with the health plan in joint operating committee meetings. In 2020, the Network met 8 out of 8 quality metric targets which qualified the Network to share in 50% of any savings, defined as actual cost vs. the projected target cost.
d. **PCMH+ Medicaid**: All Care Network practices that have earned PCMH+ recognition participate in the Care Network's PCMH+ agreement. The model is very similar to the commercial arrangements described above. The State's model includes both scoring and challenge metrics. The measures cover utilization, prevention and screening, acute and chronic conditions and "other." The Care Network joined the PCMH+ program in 2020 and results for that performance year remain outstanding, with quality and cost reports expected in December 2022. Under the model, a participating practice is considered an "Advanced Practice." The financial model compares the Network's prior-year and performance-year cost, which are risk adjusted. The Network's actual performance year target is the risk-adjusted performance year cost multiplied by the statewide trend. This is defined as "expected" performance. Savings are defined by Expected Performance minus Actual Performance. There is a minimum savings rate of 2% applied to determine the MSR-adjusted savings. There is also a cap on savings. The Advanced Network is eligible to participate in up to 50% of savings, with savings adjusted for minimum and maximum savings percentages. The savings pool is then adjusted based on the Network's aggregate quality score.

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 applicant;" Conn.Gen.Stat. § 19a-639(a)(4).

28. Provide the applicant's fiscal year: start date (10/01) and end date (09/30).

29. Describe how this proposal will help ensure the stability of the state's health care system or demonstrate that the proposal is financially feasible for the applicant(s).

    Foregoing care can often lead to worse health outcomes and increased treatment costs. Additionally, providing comprehensive care can help increase prevention and aid in cost containment. Connecticut's health care system currently does not have optimal inpatient services for the treatment of fetal conditions, conditions requiring advanced cellular and gene therapy services, or the rising acuity and medical complexities seen in neonates. As a result, patients who are not able to travel to seek such specialty care lack access to the needed services. Further, medically complex and critically ill patients, if admitted, experience longer hospital stays. Due to the limited capacity to treat this population, patients are often transferred to other institutions within or outside the state, increasing costs. This proposal will benefit patients and ensure the stability of Connecticut's health care system by providing greater continuity of care and better health outcomes, which will in turn help to offset the up-front costs of this specialized care and control costs of the State's health care system.

30. Provide a detailed explanation for all capital expenditure/costs associated with the proposal and list the dollar amount in **OHS Table 5.**

OHS TABLE 5
TOTAL PROPOSAL CAPITAL EXPENDITURE

Category	Cost
Equipment (specify the type)*	$45,348,169
Design & Engineering & Consultants	$31,912,114
Construction Manager	$169,755,830
Other Owner Construction	$2,704,250
Insurance	$660,000
Permits	$5,793,601
Furniture/Furnishings/Art	$5,558,501
Move In Expenses	$400,000
Internal Project Support	$1,697,558
Owner Contingency	$12,277,016
Total Capital Expenditure	$276,107,039

*Equipment costs include fixed equipment, movable equipment, instruments, information technology infrastructure, and security systems as required for advanced cellular gene therapy services, a fetal care unit, a level IV neonatal intensive care unit, medical/surgical unit, and a pediatric intensive care unit. Connecticut Children's derived the estimated cost based on an analysis performed for Connecticut Children's by Blue Cottage of CannonDesign medical equipment planning consultants.

31. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as: interest rate; term; letter of interest or approval from a lending institution.

    The proposal will be funded with a combination of debt (approximately $100m), operating capital (approximately $76m) and philanthropic funds (approximately $100m). Connecticut Children's is in the process of exploring opportunities for debt financing with various lending institutions that it has worked with in the past. Please see **Attachment 31(1)** for additional details on the philanthropic funding. Please see **Attachment 31(2)** for additional details on debt financing.

32. 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, statement of cash flow, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current; and

       Connecticut Children's most recent audited financial statements are on file with OHS.

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available at OHS 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 statements previously submitted or referenced. In addition, please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the utilization and payer mix tables (OHS Tables 8 and 9**).

33. Fully identify the basis for the projections and explain all calculations reported in the Financial Worksheet. In providing these detailed assumptions, please include the following:

    a. Identify general assumptions for projected amounts that are estimated to be the same, both with or without this proposed project (i.e., project-neutral increases or decreases that occur between years). Explain significant variances (+/- 25% variances) that occur between years for the project neutral changes;

       Without the proposed project, net patient revenue is assumed to grow on an approximately 4.04% annual basis due to changes in government and non-government reimbursement and volume. Case rates are assumed to grow by service line, averaging 4% annually. Assumptions also include $20 million in annual releases of restricted assets from operations, which comes from philanthropic sources. Interest expenses are calculated based on existing debt schedules ($25 million paid down from FY 2022-28).

       Both with and without the proposal, an overall inflation factor of 4.6% was used for salaries and 4.4% for purchased services and supplies. Fringe benefits were estimated to inflate at an annual rate of 4.6%. Malpractice expenses were assumed to inflate at 4.4% per year. There is also an assumption of (non-project) capital expenditures of 75% of depreciation and amortization, which assumes a 20-year useful life for future capital.

Assumptions also include an overall 3% return on cash and investment balances, which is reflected in non-operating revenue.

Other Operating Revenue is anticipated to increase 3% annually, with no incremental Other Operating Revenue from the proposed project.

- Non-Operating Revenue – non-operating revenue increased from $2,859,497 in FY2021 to $3,822,611 in FY2022 based on existing debt schedules, with an assumption that $25m of debt is paid down through FY2028.
- Hospital Non-Operating Margin – non-operating margin increased from 0.6% in FY2021 to 0.8% in FY2022 because in FY2021 Connecticut Children's experienced a one-time lease termination settlement that drove $2.9 million in non-operating costs.

b. Identify specific assumptions for all projected amounts that are estimated to change as a result of implementation of the proposed project (i.e., project-specific increases or decreases). Address projected changes in revenue, payer mix, expense categories and FTEs. In addition, connect any service, volume (utilization) or payer mix change described elsewhere in the CON application narrative or tables with these financial assumptions; and

Revenue calculations for FY2022 and beyond are based on Connecticut Children's historical utilization for previous years, extrapolated forward based on anticipated payer mix. See OHS Table 8 for projected inpatient incremental days for new and existing service lines. The payer mix assumptions for each of these service lines are based on historical utilization and the patient mix in Connecticut Children's primary service area.

- Level IV Neonatal intensive care services – 50% commercial, >48% Medicaid/Husky, <2% self-pay/other
- Fetal Care – 40% commercial, >58% Medicaid/Husky, <2% self-pay/other
- Advanced Cellular & Gene Therapy – 37.5% commercial, >60.5% Medicaid/Husky, <2% self-pay/other
- Pediatric intensive care services – 50% commercial, >48% Medicaid/Husky, <2% self-pay/other
- Medical/surgical unit services – 40% commercial, >58% Medicaid/Husky, <2% self-pay/other

Incremental increases in Principal Payments and Interest Expense anticipated beginning FY2023 resulting from loans to finance project, with interest expense calculated based upon debt schedules of $100M being paid down over 30-year Period at 5% interest.

Incremental increases in Net Assets Released from Restrictions anticipated beginning FY2022 with the project resulting from project-specific philanthropy campaign.

The following incremental changes in the Operating Expense Categories of the Worksheet are outlined below:

- Salaries and wages – incremental salaries are based on the addition of hired to support proposed project and included inflation of 4.6% each year. Increases in clinical and non-clinical full-time equivalents (FTEs) are estimated to be 158 FTEs in FY26, 166 FTEs in FY27 and 178 FTEs in FY28.
- Fringe Benefits – fringe benefit expenses expected to increase 4.6% each year

and expected additional incremental increases from additions of FTEs.

- Supplies and drugs - Growth of fetal surgery and NICU volumes beginning with project completion in FY26 drives incremental supply and drug expenses with assumption of inflation.
- Depreciation & Amortization - Depreciation and amortization expenses have been projected based on additions to property plant and equipment based on additions to property plant and equipment less retirements. Depreciation has also been updated to reflect the construction, equipment, and furniture based on total project costs. A half year of depreciation is expected in the first year of project completion, FY26.
- Malpractice Insurance Cost - malpractice expenses expected to increase 4.4% each year and expected additional incremental increases from additions of 17 physician full-time equivalents to staff the new beds.
- Other Operating Expenses – **See Attachment 33b** for Top Expense Categories
- Other Operating Expenses (incremental)
  - EVS – Linen, Medical, General Supplies - $413,242
  - Food Services – patient, pantry, boxed lunches, retail, smallwares - $246,589
  - Marketing - $300,000
  - Physician Relations - $106,090
  - IT Implementation Activity - $89,000
  - Collection Manager (equipment/software) - $50,000
  - CMEs - $108,000
  - Dues - $58,500
- Provision for bad debts is expected to increase as a function of incremental revenue associated with the proposed project.
- Incremental increases in patient discharges driven by anticipated volume growth in neonatal, medical/surgical and fetal care services. Please see OHS Table 8 for additional details.

c. If the applicant does not project any specific increases or decreases with the project in the Financial Worksheet, explain why.

N/A

34. Describe any projected incremental losses from operations resulting from the implementation of the CON proposal. If losses will result, provide an estimate of the timeframe needed to achieve incremental operational gains.

Taking net assets released from restrictions into account, no incremental losses from operations are anticipated from the implementation of this proposal. However, if net assets released from restrictions are excluded, the interest expenses resulting from the project's debt offering would result in an incremental loss until FY2028 due to no offsetting clinical services in place until the project is completed in FY2026. These losses reflect the initial costs necessary for building the space to accommodate the new beds discussed in this proposal.

35. Describe how your proposal will aid in controlling the cost of health care (to patients and to the overall health care system). Please support your answer with historical cost data and comparisons (i.e., cost to patient and impact on cost to the CT health care system).

Note: All applications will have some sort of impact whether that includes additional fees, higher copays, fewer required visits, etc.

The proposal will aid in controlling the cost of health care by improving access to specialized services and reducing unnecessary downstream costs due to lack of services. For example, as described in the response to question 8(b), a number of patients currently travel out of state to receive services Connecticut Children's is proposing in this application. This out of state travel results in additional costs to families, in addition to lack of care coordination closer to home. The proposed project will offer more space for the growing demand for patient services and will include state of the art technology designed to reduce length of stay, reduce admissions, and reduce patient transfers. In addition, proposed service lines like fetal care and certain advanced cellular gene therapy treatments are only available at one other hospital in the state, and not at all within Connecticut Children's primary service area. Connecticut Children's offering of these services will drive competition and allow payers to negotiate lower rates with the service providers, which in turn would result in a net decrease in patient premiums. The proposal does not involved local provider consolidation and does not duplicate cost-effective services in Connecticut Children's primary service area.

The cost to the Connecticut health care system as a whole would also be minimal. Of the $11.95 billion in Connecticut statewide net patient revenue in 2020, Connecticut Children's accounted for $387 million, or approximately 3.2% of all net patient revenue.1 The incremental net patient revenue from this proposal is estimated to be 12% of Connecticut Children's total net patient revenue by FY27 (the second year after the project is completed). As such, in FY27, and assuming a conservative 7% annual increase in total state net patient revenue, the incremental increase in the state's total short term acute care hospital revenue from the proposed project would be only 0.3%.

As noted above in OHS Tables 3 and 4, Connecticut Children's does not anticipate the project will result in incremental increases in costs to patients or payers. Intensive care services, medical/surgery services and average cost for all services are expected to increase at an approximate rate of 2% for commercial payers and 3% for self-pay patients.

And unlike many adult health care services, pediatric care has the general benefit of offering a high return on investment by eliminating future health care costs associated with chronic conditions. Due to the relative newness of fetal surgery and advanced cellular gene therapy services, Connecticut Children's cannot conclusively say that the long-term savings will be realized from the initial costs associated with these services. However, the fact that these procedures typically result in children being significantly less disabled as they go through life supports estimates of compelling lifetime savings potentials and fewer required hospital visits.

For additional information on the cost-effectiveness of these services, please refer to the studies in Section 5(c), particularly those numbered 8-11.

36. Complete the table below (i.e., provide all information appropriate for your facility or service) with data from the most recently completed three fiscal years. Please use the formulas in the table below.

1 OHS Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2020.

OHS TABLE 6
HISTORICAL FINANCIAL INDICATORS AND MISCELLANEOUS DATA

	Comments	Formula	FY 2019	FY2020	FY2021
A. Operating Performance					
Operating Margin	The total of net patient revenue from reimbursement of patient services by government and non-government payers plus other operating revenue.	Gains / (Loss) from Operations / Revenue from Operations	7.15%	6.79%	11.44%
B. Liquidity					
Days Cash on Hand	The average number of days of cash available to pay for expenses that is maintained in cash accounts. A higher number is favorable, since it indicates a greater ability to meet outstanding obligations.	Cash + Short Term Investments / (Total Expenses less depreciation) / 365	116.44	142.77	218.66
C. Leverage and Capital Structure					
Long-term Debt to Capitalization	The measure of the proportion of Long-Term Debt in a capital structure. A lower proportion or percentage is desirable because it allows for obtaining of more favorable terms (i.e., lower interest rates) when borrowing.	LTD / (LTD + Net Assets)	21.38%	22.56%	15.74%
D. Additional Statistics					
Income from Operations	The difference between total operating revenue and total operating expenses that results in a financial gain or loss from operating activities.	Total Operating Revenue less Total Operating Expenses	$27,408,739	$27,097,817	$50,535,325
Available bed occupancy	A measure of the volume and utilization of inpatient hospital services.	(Patient Days x 100) / (Available beds x 365)	77	74	76
Annual operating revenue growth rate	The difference between total operating revenue in the current year compared with total operating revenue in the prior year.	(Current year amount less prior year amount) / prior year amount. (*Amount added to source file*.)	6.62%	4.08%	10.72%
Annual expense growth rate	The difference between total operating expenses in the current year compared with total operating expense in the prior year.	(Current year amount less prior year amount) / prior year amount.	6.71%	4.48%	5.20%

Community Benefit amount (total by fiscal year) – IRS 990	Services and activities provided by nonprofit hospitals that address and impact the health related needs of the community the hospital serves.	Amount provided by the hospital in their annual IRS 990 submission. (Financial Assist and other Comm Benefits - Schedule H - Part I, Line 7, Col E, line K total) & (Comm. Bldg activities - Schedule H, Part II, Col E, line 10 total)	$95,384,407	$87,866,460	$87,866,460*
Charity Care expenses/recipients	The difference between the hospital's published charges and the amount of reimbursement received for services provided to patients from whom reimbursement was not expected.	No formula. Amounts for expenses and recipients are provided by the hospital.	$3,548,093 / 1739	$2,842,270 / 1387	$2,318,994 / 1500
30 day readmission penalties & rates	Under the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program, CMS assesses penalties on and reduces Medicare payments to hospitals with excess 30 day readmissions of Medicare patients to improve health care by linking payments to quality of care.	Hospital Readmission Penalty Trends (MCR Worksheet E, Part A, Line 70.94)	N/A	N/A	N/A
E. Capacity and Utilization					
Average Daily Census	The average number of patients per day in a hospital over a given period of time.	Total patient days / 365	122.9	116.5	120.3
Case Mix Index	The average relative Diagnostic Related Group (DRG) weight of a hospital's inpatient discharges. The CMI reflects the diversity, clinical complexity, and resource needs of all the patients in the hospital.	[Sum (DRG weight x # of discharges)] / total discharges FY 2020 Final Rule and Correction Notice Tables | CMS	1.72	1.22	1.47

*Connecticut Children's does not yet have the final community benefit amount for FY2021, though we anticipate it to be greater than or equal to the FY2020 community benefit amount, which saw a reduction due to the COVID-19 pandemic.

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).

37. Complete **OHS Table 7** and **OHS Table 8** 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. In completing these tables, please adhere to the following:

    a) Identify each service type and add lines as necessary. Provide the number of visits or discharges as appropriate for each service type and **label** what the **volumes represent** (e.g., visits) and the **fiscal year** reflected in the table.
    b) For CFY periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months covered.
    c) For OHS Table 8, if the first year of the proposal is only a partial year, provide the partial year utilization and indicate the months included in a footnote. In addition, provide projections for the first three complete FYs.

Note: Please make sure that the fiscal years reported on OHS Table 8 match the fiscal years reported in the Financial Worksheet and payer mix (OHS Table 9) projections.

OHS TABLE 7
HISTORICAL UTILIZATION BY SERVICE

Service	Actual Volume (discharges) (Last 3 Completed FYs)			CFY Volume*
	FY 19	FY 20	FY 21	FY 22
Pediatric	11,536	9,937	10,257	6,814
Total	11,536	9,937	10,257	6,814

*****CFY months include October 2021 – April 2022
* Includes observation as well as inpatient volume, as patients in observation status are occupying beds and contributing to census

OHS TABLE 8a
PROJECTED UTILIZATION BY SERVICE

Service	Projected Volume (incremental **discharges**)		
	FY 2026	**FY 2027**	**FY 2028**
Maternity (Fetal Care Labor & Delivery Beds)	23	36	46
Pediatric (Incremental from Bed Increases/New Services)	1,406	1,825	2,093
Total	1,429	1,861	2,139

*****Projections begin in FY 2026 based on anticipated construction timeline. Please note that this table shows expected incremental increases in discharges as a result of the new services and beds being proposed (not total projected utilization). A full breakdown by individual service in incremental patient days, which provides a fuller picture of bed utilization for the requested new beds, is below.

OHS TABLE 8b
PROJECTED UTILIZATION BY SERVICE

Service	Projected Volume (incremental patient **days**)		
	FY _2026*__	**FY _2027_**	**FY _2028_**
Level IV Neonatal Intensive Care Unit	7,023	9,458	11,397
Fetal Care	268	408	436
Advanced Cellular & Gene Therapy	573	599	626
Pediatric – Hartford New Tower Medical/Surgical Beds	2,920	2,993	3,030

38. Provide a detailed explanation and justification of all assumptions used in the derivation/calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHS Tables 7 and 8.

OHS Table 7 represents the total patient discharges each year (including inpatient and observation). The decrease in FY20 was a result of the COVID-19 pandemic, with patients opting to delay non-critical services and forego hospital care as well as the decline in respiratory care volumes due to masking and distancing mandates. However, FY22 is projected to end with an increase over FY19's pre-pandemic volume and shows that the need for Connecticut Children's services continues to grow. Respiratory care volumes are anticipated to return, in keeping with national trends, as masking and distancing decrease.

Connecticut Children's footprint is also growing regionally, and demand for inpatient admission is keeping pace with this expanding reach. In the past three years, Connecticut Children's physician group has added several office locations across the state, including in Farmington, Danbury and Westport, and added additional providers to provide sufficient staffing to these new locations. The Connecticut Children's Care Network was also established in 2018, further expanding Connecticut Children's network of affiliated providers. Connecticut Children's partnerships with both Nuvance Health and Hartford Healthcare have also resulted in Connecticut Children's neonatologists caring for babies in Nuvance and Hartford Healthcare NICUs, nurseries, and pediatric floors around the state. In FY 2021, 117,551 patients were treated by Connecticut Children's providers, an increase of 20% over 5 years. This expansion of preventive and ambulatory services is, in turn, impacting inpatient demand. Additional demand will also be created by the proposed new services given their unique nature and limited availability.

For OHS Table 8, projected incremental volumes were based on historical length of stay, average daily census, occupancy rates, and unmet demand. With respect to the new services (Advanced Cellular & Gene Therapy and Fetal Care), benchmarking was completed against other children's hospitals offering similar services, and adjusted for the size of the Connecticut market and proposed number of beds. Although total incremental volume is provided in discharges to align with the instructions and Table 7, we have also provided a breakdown of incremental patient days by service to provide better context surrounding expected bed utilization.

For the Labor & Delivery Beds, while utilization appears relatively low during this initial three-year period, it is important to note that these beds are not intended to serve the general labor & delivery population. Rather, they are an integral part of the fetal care program to serve a niche population of extremely high risk pregnancies. It would not be possible to have a fetal care program without labor & delivery beds to deliver these infants. As such, the utilization rates are not reflective of the importance of the need.

39. Provide the current and projected patient population mix **by individual service location(s)** for the proposal using **OHS Table 9,** provide the number and percentage of patients by payer, all assumptions and label what the volume represents (e.g., discharges).

Note: payer mix should be calculated from patient volumes, not patient revenues. Also, current year should be the most recently <u>completed</u> fiscal year. Projected years should match OHS Table 8 and the Financial Worksheet.

OHS TABLE 9
APPLICANT'S CURRENT & PROJECTED PAYER MIX
CONNECTICUT CHILDREN'S MEDICAL CENTER, 282 WASHINGTON STREET, HARTFORD , CT

Payer	Most Recently Completed FY _21__		Projected					
			FY _26___		FY __27__		FY _28___	
	Volume: (discharges)	%	Volume: (discharges)	%	Volume: (discharges)	%	Volume: (discharges)	%
• Medicare	49	1		1		1		1
• Medicaid	5,864	57		57		57		57
• TRICARE	115	1		1		1		1
Total Government	6,028	59		59		59		59
• Commercial Insurers	4,163	40		40		40		40
• Uninsured and Self-Pay	66	1		1		1		1
• Workers Compensation	0	0		0		0		0
Total Non-Government	4,229	41		41		41		41
Total Payer Mix	10,257	100		100		100		100

The proposal is not expected to meaningfully alter Connecticut Children's payer mix. As reflected in OHS Table 2, the service area consists of the entire state and is not projected to change as a result of the proposed bed increases. The intended patient population remains children across the state of Connecticut. With no changes to the service area or patient population, it is not anticipated that the payor mix would change as a result of the construction of the new tower. Although it is expected that the new cutting-edge, niche services offered may attract an increased number of patients from across state borders, this number is not expected to be significant enough to materially alter the payer mix.

§ "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).

40. Describe the population (as identified in question 8(a)) by gender, race/ethnicity, 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 and Connecticut State Data Center) in a format consistent with the standards established in compliance with** Public Act 21-35**, and document the source.**

    As identified in Question 8(a), the target populations to be served are as follows:

    - Neonates requiring intensive care (Level IV neonatal intensive care unit bed increase);
    - Fetuses with complications requiring surgery or other intervention (bed increase to add Fetal Care Center, including Labor & Delivery Beds)
    - Patients between 0 – 17 years old requiring intensive care (medical/surgical bed increase)
    - Patients between 0-17 years old requiring advanced cellular and gene therapy, including without limitation bone marrow transplant (bed increase to add Advanced Cellular & Gene Therapy Unit)

CCMC Table 5 below shows demographic data from the United States Census Bureau of children in Connecticut. **Attachment 8f (2)** compares the statewide data to that in the city of Hartford, and demonstrates that Hartford has a significantly higher share of people of color and individuals living below the poverty line. As such, expanding Connecticut Children's Hartford campus by increasing bed capacity and adding new cutting-edge services in specialties where there are demonstrated disparities in both access and outcomes will help to promote health equity in the region.

CCMC Table 5
Connecticut Census Data (Children)

	Connecticut
Children under 18 years in households	**20.4%**
Age	
Under 6 years	32.0%
6-11 years	33.4%
12-17 years	34.6%
Race	
One Race	**93.1%**
White	66.6%
Black or African American	13.9%
Asian	4.8%
American Indian and Alaska Native	1.0%
Other	6.7%
Two or more races	**6.9%**
Hispanic or Latino (of any race)	25.5%
White alone	50.1%
Income	

Below poverty level	16.7%
Above poverty level	83.3%

Source: United States Census Bureau. 2019 ACS 1-Year Estimates. Connecticut, Children Demographics. TableID: S0901

As described in Questions 8(e) and 8(f), a wealth of scholarly articles, census data, internal Connecticut Children's data and other data sources support the need to expand Connecticut Children's capacity to best support the community and address disparities in care. The proposed Project will bring state-of-the art specialty care closer to home for medically underserved populations that are disproportionately likely to experience poor outcomes and may lack the ability to travel to seek such care. It will also improve access by ensuring that Connecticut Children's has sufficient capacity to treat all who need its services Finally, it will bring the Level IV NICU current with the newest evidence-based design practices, removing another potential source of care disparities. Studies have shown that underserved populations are more likely to receive care in outdated, quality-challenged facilities, and that single-family room NICUs are associated with positive outcomes such as higher Bayley III cognitive and language scores and higher rates of breastfeeding. (**See Attachment 5c (3)**). The proposal will therefore bring resources to the community that will assist in lessening well-documented care disparities and achieving the Department of Public Health's identified health improvement goals in the sphere of Maternal, Infant, and Child Health.

41. Using **OHS Table 10**, provide a breakdown of utilization by town (i.e., use **ONLY** official town names) for the **most recently completed fiscal year**. Indicate the fiscal year and the type of volume being reported: number of persons, visits, scans or other appropriate unit. Provide the source of data.

OHS TABLE 10 UTILIZATION BY TOWN FY 2021	
Official Connecticut Town	**Volume of inpatient/ observation discharges**
Andover	10
Ansonia	6
Ashford	8
Avon	86
Barkhamsted	15
Beacon Falls	5
Berlin	47
Bethany	1
Bethel	35
Bethlehem	10
Bloomfield	97
Bolton	15
Bozrah	5
Branford	2
Bridgeport	13
Bristol	273
Brookfield	17
Brooklyn	17
Burlington	35
Canaan	7
Canterbury	6
Canton	19
Chaplin	3
Cheshire	30
Chester	1
Clinton	7
Colchester	54
Colebrook	6
Collinsville	8
Columbia	11
Cornwall Bridge	1
Coventry	36
Cromwell	52
Danbury	117
Deep River	5
Derby	4
Durham	26
East Granby	24

East Haddam	17
East Hampton	40
East Hartford	332
East Haven	1
East Lyme	8
East Windsor	49
Eastford	4
Ellington	58
Enfield	149
Essex	1
Fairfield	4
Farmington	95
Franklin	5
Glastonbury	135
Goshen	8
Granby	41
Greenwich	1
Griswold	40
Groton	17
Guilford	3
Haddam	21
Hamden	3
Hampton	4
Hartford	1152
Hartland	9
Harwinton	9
Hebron	38
Kent	6
Killingly	52
Killingworth	5
Lebanon	19
Ledyard	12
Lisbon	11
Litchfield	12
Lyme	2
Madison	1
Manchester	366
Mansfield	34
Marlborough	17
Meriden	214
Middlebury	15

MIiddlefield	9
Middletown	135
Milford	15
Monroe	2
Montville	45
Morris	2
Naugatuck	97
New Britain	441
New Canaan	7
New Fairfield	26
New Hartford	18
New Haven	19
New London	8
New Milford	55
Newington	149
Newtown	25
Norfolk	3
North Canaan	2
North Haven	2
North Stonington	3
Norwalk	13
Norwich	138
Old Saybrook	2
Orange	4
Oxford	16
Plainfield	66
Plainville	77
Plymouth	42
Pomfret	7
Portland	37
Preston	8
Prospect	13
Putnam	23
Redding	4
Ridgefield	15
Rocky Hill	71
Roxbury	1
Salem	9
Salisbury	4
Scotland	4
Seymour	3

Sharon	3
Shelton	4
Sherman	2
Simsbury	118
Somers	27
South Windsor	94
Southbury	27
Southington	142
Sprague	8
Stafford	26
Stamford	7
Sterling	3
Stonington	5
Stratford	6
Suffield	39
Thomaston	19
Thompson	7
Tolland	84
Torrington	136
Trumbull	2
Vernon	134
Voluntown	9
Wallingford	37
Warren	2
Washington	3
Waterbury	561
Waterford	8
Watertown	49
West Granby	6
West Hartford	289
West Haven	3
Westbrook	1
Weston	3
Westport	3
Wethersfield	85
Willington	11
Winchester	37
Windham	120
Windsor	144
Windsor Locks	80
Wolcott	42

Woodbury	14
Woodstock	12

Source: Connecticut Children's discharge records

§ "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).

42. Using **OHS Table 11**, identify all existing providers in the service area and, as available, list the services provided, population served, days/hours of operation and current utilization. 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.

OHS TABLE 11
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Facility's Provider Name, Street Address and Town	Program or Service	Population Served	Days/Hours of Operation	Current Utilization
Yale-New Haven Hospital 20 York Street New Haven, CT	Level IV Neonatal Intensive Care Unit	Neonatal patients,	24/7	82.01% occupancy rate in 2020
Yale-New Haven Hospital 20 York Street New Haven, CT	Pediatric medical/surgical unit	Hospitalized pediatric patients	24/7	69.26% occupancy rate in 2020
Yale-New Haven Hospital 20 York Street New Haven, CT	Fetal surgery	Fetuses requiring surgical intervention	Unknown	Unknown (not separately reported)
Yale-New Haven Hospital	Bone marrow transplant (subset of advanced cellular & gene therapy)	Patients requiring bone marrow transplant	Unknown	Unknown (not separately reported)

Sources: Yale New Haven Hospital, OHS Report 400, 2020;
OHS Statewide Health Care Facilities and Services Inventory – 2020, Table 3: Acute Care and Children's Hospital Service Lines

Note: Although other hospitals in the state have pediatric units, these units are generally only able to treat a small number of patients for a limited range of relatively low acuity conditions and have limited or no availability of pediatric-specific equipment or pediatric subspecialists on site. As such, they have been excluded from this chart as they are not comparable to the services provided at Connecticut Children's.

43. Will this proposal shift volume away from existing providers in the area? If not, explain in detail why the proposal will have no impact on existing provider volumes. Please justify the utilization figured provided.

The proposal is not expected to shift significant volume away from existing providers in

the area, as none of the services proposed for the new tower are available elsewhere in the primary service area, and few are even available elsewhere in the state. Connecticut Children's Hartford NICU is the one of only two Level IV neonatal intensive care units in the state. The other is located a significant distance away at Yale-New Haven Hospital. Further, NICU admissions are generally unplanned and determined by the location where the mother delivers. As such, the increase in NICU beds is not expected to shift volume away from existing providers, but rather to expand Connecticut Children's capacity to better meet the service area's demonstrated demand for neonates requiring Level IV care. It will also provide sufficient capacity for neonates born at Hartford Hospital and requiring intensive care, who are generally referred to the Connecticut Children's NICU, to remain at the Connecticut Children's NICU for the duration of the time they require intensive care. Currently, bed shortages in the Connecticut Children's NICU result in transfers that would otherwise not be medically necessary.

Likewise, Connecticut Children's is the only freestanding children's hospital in the state, offering access to specialists in over 30 specialties, and has only one of two pediatric intensive care units in the state. As such, there are limited other hospitals offering a comparable range of services to those available at Connecticut Children's, and there is no other referral option within the primary service area. The expanded bed capacity provided by the medical/surgical bed increase will help to ensure adequate capacity to meet the needs of existing patients, and ensure that such patients can receive care close to home and to their referring provider.

With respect to the proposed Advanced Cellular and Gene Therapy services and Fetal Care services, Connecticut Children's also does not anticipate that the introduction of these services at Connecticut Children's will meaningfully shift volume away from existing providers in the state. Yale-New Haven Hospital does offer bone marrow transplant services, however, as described above in Question 8(b), most Connecticut Children's pediatric patients who need these services are currently choosing to leave the state to seek them at Boston Children's Hospital, which is perceived by them as the best in the region and therefore the preferred alternative if they cannot remain at Connecticut Children's with their existing care team. Likewise, many of the services offered at Connecticut Children's Fetal Care Center will be unique in the state. The selection of Dr. Timothy Cromblehome, a leading expert in this field, to head the development of the unit will bring to the state a range of cutting-edge treatments not currently available in the State of Connecticut.

44. Describe what effect the proposal will have on existing physician referral patterns in the service area.

Existing referral patterns for services that currently exist in the state are likely to continue given Connecticut Children's position as the only freestanding children's hospital in the state. Providers who already refer to Connecticut Children's will now be able to refer to Connecticut Children's for new services that were not previously available within Connecticut Children's primary service area, enabling their patients to receive the high-quality specialized care that they need closer to home. The services planned for the new tower will offer Connecticut physicians a trusted in-state option when their patients are diagnosed with conditions requiring the cutting-edge treatments involved in advanced

cellular and gene therapy or fetal surgery. Additionally, given the unique nature of the Fetal Care and Advanced Cellular & Gene Therapy programs, it is expected that Connecticut Children's will become a destination for patients from across the state and the broader region for these specific services.

With respect to the neonatal intensive care unit and pediatric intensive care unit, Connecticut Children's is home to one of the only two PICUs and two Level IV NICUs in the state. As such, there are limited referral options and current patterns are not expected to significantly change. Further, NICU admissions for neonatal intensive care are generally unplanned, and the choice of NICU is dictated by level of acuity and the location of the baby's delivery as opposed to referrals. By building the new medical tower, Connecticut Children's will help ensure that Connecticut has adequate capacity for these critical services and that babies in need of Level IV care who are delivered at Hartford Hospital and other surrounding hospitals are able to receive that care closer to home.

45. Describe how this proposal will affect the overall health care system/market concentration. Include how the proposal will impact other providers, referral patterns, regional impact, rates, and any other applicable factors.

The proposal will fill a need that the health care system and market have demonstrated to exist. As such, market concentration or oversaturation is not an applicable concern for this project. The proposal will strengthen Connecticut Children's existing relationships and create connections with other institutions since the proposed services will be unique, complex, state-of-the-art services that are either entirely new to the state or one of only very few options in the state and/or region. At the same time, the project will have significant positive outcomes for the health care delivery system in Connecticut.

Connecticut Children's existing provider network is well aware of the quality of pediatric services offered and are enthusiastic about having the ability to refer their patients to closer-to-home options for state-of-the art services such as fetal care and advanced cellular and gene therapy, as described above in questions 43 and 44. Due to the limited options for these services in the region and the proximity to several other states, out-of-state patients may seek this care at Connecticut Children's as well. Connecticut Children's market share of children with complex needs for fetal, perinatal, and neonatal care is likely to expand with the opening of the Fetal Care Center and expansion of the Level IV NICU.

46. Will the proposal result in additional providers added to your staff? If yes, provide the number, location, provider types, and justification to be added.

The chart below details anticipated staffing needs for licensed independent practitioners in the initial three (3) years following completion of the new tower. Please note that for existing programs that will be expanded in the new tower, the numbers represent the incremental increase needed to staff the additional beds, and not the total number of staff in the unit.

CCMC Table 6
Anticipated Staffing for New Tower

Provider Type	Year 1 FTE	Year 2 FTE	Year 3 FTE	Program/Justification

Fetal Surgeon	1.00	1.00	2.00	Fetal Surgery (new program)
Maternal-Fetal Medicine Physician	0	0	1.00	Fetal Surgery (new program)
Physician	1.50	1.50	1.50	Advanced Cellular & Gene Therapy (new program)
Advanced Practice Providers (APP)	1.00	1.00	1.00	Advanced Cellular & Gene Therapy (new program)
Neonatologists	2.85	5.7	5.7	NICU (staff needed to care for increased patient capacity)
NICU APPs	9.2	9.2	9.2	NICU (staff needed to care for increased patient capacity)
Pediatric Intensivists and Hospitalists	5.20	5.20	5.20	Medical/Surgical Beds (staff needed to care for increased patient capacity)

47. If applicable, describe how the proposal will help advance the applicant's ability to participate in alternative payment arrangements for health care delivery and reimbursement (e.g., shared savings arrangements).

    Connecticut Children's Care Network already participates in four value-based payment arrangements, as described in Question 27. The services contemplated by this proposal will enhance Connecticut Children's ability to meet demand and provide high quality services, specialty expertise, and state-of-the-art services at the level needed by the community and the patients served through its ACO arrangements. Although the shared savings metrics involved in these arrangements do not directly measure these niche specialty services, access to such services is likely to have an indirect downstream impact on measures such as preventable hospitalizations by improving outcomes from the start.

48. Considering the proposed transaction as a whole, describe any potential constraints or limitations that will impact the applicant's ability to participate in the Connecticut Health Information Alliance d/b/a Connie. Health Information Alliance (ct.gov)

    Connecticut Children's already participates in the Health Information Exchange (HIE) through CTHealth Link. The health system as well as the Connecticut Children's Care Network participate in the HIE.

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

    The proposal will not result in duplication of unnecessary services. The increase in bed capacity for the neonatal intensive care services and critical care bed services is a direct result of high demand and low supply in the current market. Moreover, the fetal care services and a few of the key advanced cellular and gene therapy services are services that are not currently offered in Connecticut or the region. Patients are currently required to go out of state to receive these services. As such, the addition of these services within the state will not result in any duplication.

50. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The proposal will positively impact the diversity of health care providers by becoming a destination for neonatologists, fetal care surgeons, pediatric intensivists, as well as pediatric hematology oncologists. As specialized niche services, clinicians with these corresponding skillsets will likely seek out Connecticut Children's when looking for employment. It is important to note that multidisciplinary care will be provided to patients receiving all of these services and therefore diverse health care providers will be engaged.

The proposal will also have a positive impact on patient choice. Currently, patients have limited options for neonatal intensive care and medical/surgical bed services. And, for fetal care and key advanced cellular and gene therapy services, Connecticut Children's will be the only pediatric hospital in the region that offers these services. In light of the foregoing, the proposal will allow Connecticut Children's to serve more pediatric patients who require specialized and integrated care.

Supplemental CON Application Form

Increase in Licensed Bed Capacity

Conn. Gen. Stat. § 638(a)(12)

Applicant: Connecticut Children's Medical Center

Project Name: Increased Bed Capacity – New Medical Tower

Affidavit

Applicant: Connecticut Children's Medical Center

Project Title: Increased Bed Capacity – New Medical Tower

I, James E. Shmerling, President and Chief Executive Officer of Connecticut Children's Medical Center in Hartford, CT being duly sworn, depose and state that Connecticut Children's Medical Center complies with the appropriate and applicable criteria as set forth in Sections 19a-630, 19a-637, 19a-638, 19a-639 of the Connecticut General Statutes, and that all facts contained in the submitted Certificate of Need application are true and correct to the best of my knowledge.

Signature

06/08/2022
Date

Subscribed and sworn to before me on 08 June 2022.

Notary Public/Commissioner of Superior Court

B. Mojos Vargas
Juris No 427621

~~My commission expires:~~ _____

1. Project Description: Increase in Licensed Bed Capacity

a. Provide information the existing/proposed allocation of beds for each unit/location involved in this proposal. In completing Table A and Table B below, please adhere to the following:

i. The licensed bed column should represent the number of licensed beds and newborn bassinets listed on the hospital's Connecticut Department of Public Health (DPH) license on the last day of the fiscal year;

ii. available beds should represent the number of beds in service in nursing units that could be occupied by patients during the fiscal year; and

iii. staffed beds should represent the number of beds with sufficient staff occupied by patients during the fiscal year.

TABLE A
EXISTING BEDS

Unit/Location	Licensed	Available	Staffed
Pediatric, Connecticut Children's Hartford (Med/Surg and ICU)	103	101	98
Bassinets, Connecticut Children's Level IV NICU at Hartford Hospital	32	32	32
Bassinets, Connecticut Children's Level III NICU at UConn Health	40	40	40
Pediatric, St. Mary's Waterbury	12	12	12

TABLE B
PROPOSED ADDITIONAL BEDS

Unit/Location	Licensed	Available	Staffed
Pediatric Beds, Connecticut Children's Hartford (Med/Surg and ICU)	14	14	14
Labor & Delivery Beds, Fetal Care Center, Connecticut Children's Hartford	6	6	6
Level IV NICU – Connecticut Children's Hartford*	33	33	33
Advanced Cellular & Gene Therapy Unit	6	6	6

*Level IV NICU in the proposed new tower will consist of a 50-bed unit. 15 bassinets will remain at Hartford Hospital to support their labor & delivery service and provide transitional care.

b. **Explain the specific rationale for the increase in beds at each unit/location, including:**

i. the calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;

The proposed Level IV NICU in the new medical tower will accommodate 50 patients. 15 existing bassinets will remain at Hartford Hospital to support their labor & delivery service and provide transitional care.

Together, the additional Level IV NICU bassinets, additional medical/surgical beds, Advanced Cellular & Gene Therapy Unit ,and Fetal Care Center add a total of 59 beds, divided as follows:

- 33 new bassinets (bringing the total licensed bassinets in Hartford to 65, of which 50 will be located in the Level IV NICU in the new tower and 15 will remain at Hartford Hospital to provide transitional care);
- 14 additional medical/surgical beds in a unit constructed to meet standards for both intensive care units and general medical/surgical units;
- A 6-bed unit for advanced cellular & gene therapy services; and
- A 6-bed labor/delivery/recovery/postpartum unit for high-risk deliveries as part of the Fetal Care Center.

The proposed increases were based on projected volumes as determined by historical average daily census and length of stay as well as current trends. Projected volumes are illustrated in OHS Table 8, Table F, and Table G. Detailed explanations of the research and assumptions supporting the need for additional beds follows below.

Advanced Cellular & Gene Therapy

A thorough market analysis was conducted, estimating 14-15 transplants/year and 4 MIBG patients/year. These estimates were based on benchmarking completed with the Center for International Blood & Marrow Transplant Research (CIBMTR) regarding bed counts at hospitals with dedicated units for these types of therapies and annual transplant volumes of a similar size. This effort projected a volume of 11-20 transplants/year and suggested a bed count range between 4 and 11 beds. Connecticut Children's projected a need of 15 transplants/year with 3 transplants per bed for a total of 6 dedicated patient beds (rounded up from 5).

Fetal Care Center

A thorough market analysis was conducted to assess the market need and feasibility. With the recruitment of Dr. Timothy Cromblehome, a leading expert in the development of fetal surgery programs, Connecticut Children's was able to tailor its analysis specifically to Dr. Cromblehome's current visit volumes, adjusted for the relative size of the market in Connecticut. The requested bed count is based on these projected needs.

Level IV NICU

Projections for continued increase in demand are based on historical volume, average daily census, length of stay, and the proposed bed capacity, noting trends towards increasing acuity and complexity and increasing patient days. Current growth patterns are expected to continue. Projections also assume that the Fetal Care Center is approved, as the babies treated by that program will represent the sickest and most medically fragile infants, and as such, the Level IV NICU is expected to be the destination for the majority of babies treated through this program once delivered at Connecticut Children's.

Medical/Surgical Beds

Projections were based on historical volume, average daily census and length of stay in Connecticut Children's existing Pediatric Intensive Care Unit and Medical/Surgical Units,

as well as the proposed bed capacity, noting trends towards increasing acuity and complexity and increasing patient days. Current growth patterns are expected to continue, requiring additional beds to meet growing demand. It is also expected that the development of Connecticut Children's inpatient medical/psychiatric unit (addressed in a separate Certificate of Need Application) will have a downstream effect on other services and lead to increased occupancy rates. The new medical/psychiatric unit is expected to be at full capacity on a routine basis given the ongoing pediatric behavioral health crisis and insufficient medical/psychiatric unit beds across the state. Because of this, psychiatric patients may need to board on the existing medical/surgical units while awaiting a placement in the medical/psychiatric unit. This will in turn drive up the census on the existing medical/surgical floors. The proposed size of the new unit assumes that the new psychiatric unit will also be approved and that the space in the new tower will be needed to ensure that Connecticut Children's continues to have adequate capacity for patients with medical/surgical needs.

ii. the patient population that will be served; and

The target populations to be served are as follows:

- Neonates requiring intensive care (Level IV Neonatal Intensive Care Services);
- Fetuses with complications requiring surgery or other intervention (Fetal Care Center including Labor & Delivery beds);
- Patients between 0 – 17 years old requiring general inpatient hospitalization (medical/surgical beds);
- Patients between 0-17 years old requiring advanced cellular and gene therapy, including without limitation bone marrow transplant (Advanced Cellular & Gene Therapy Services).

iii. the benefits of each proposed increase.

As detailed in the main application, the increase in beds is needed to provide specialized and integrated care for the treatment of fetal conditions and for the most critically ill, complex medical patients, including medical/surgical and Level IV NICU patients, patients of the Fetal Care Center, and patients requiring advanced cellular and gene therapy. T

The bed increases requested for the Level IV NICU and Medical/Surgical capacity are necessary to continue to have adequate capacity to serve the target population and provide optimal care. High historical occupancy rates in these units show a desperate need for additional capacity. Having increased capacity in these units will promote continuity of care by minimizing the need for internal and external transfers due to high census. It will also help alleviate expected downstream capacity issues resulting from the opening of Connecticut Children's proposed medical/psychiatric unit.

With respect to the beds requested for the Fetal Care Center and Advanced Cellular and Gene Therapy Services, the additional beds will allow for improved access to high quality, cutting-edge care. These units will serve small, niche populations, and as such may not have consistently high census in the initial years as the program is established and gains recognition across the state and region. Nonetheless, it is necessary to have dedicated

beds for each of these programs, and utilization is expected to continue to grow. To operate a successful Fetal Care Center, it is necessary to have facilities in which the program's high risk patients can be delivered in-house and immediately treated by our specialists. Connecticut Children's does not currently have labor and delivery beds and as such is not equipped to provide this care without adding these beds. Likewise, the therapies involved in the Advanced Cellular and Gene Therapy program require specialized facilities such as a lead-lined patient room. The patients in this program also must be segregated from the general population due to the effects of these treatments on their immune systems. As such, the additional beds are necessary to operate these cutting-edge programs, the benefits of which are described in depth throughout the main application form.

c. For the last three complete FYs, the current FY-to-date, and the first three full years of the proposal, provide the following by service (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric) as relevant to the proposal:

i. **Occupancy rate**;

CCMC Table 1
Occupancy Rate

Occupancy Rate	FY19	FY20	FY21	FYTD22 (Oct-Feb)	FY26	FY27	FY28
Pediatric Intensive Care Unit (Existing)	78%	71%	69%	68%	79.4%	81.1%	82.8%
Pediatric – All Other Hartford Inpatient Units (Existing)	85%	79%	85%	90%	94.6%	96.0%	97.5%
Level IV NICU	96%	98%	104%	106%	84.0%	90.5%	96.9%
Pediatric – Hartford New Tower Medical/Surgical Beds	N/A	N/A	N/A	N/A	57.1%	58.3%	59.4%
Fetal Care (Labor & Delivery Beds)	N/A	N/A	N/A	N/A	12.2%	18.6%	19.9%
Advanced Cellular & Gene Therapy	N/A	N/A	N/A	N/A	26.2%	27.4%	28.6%

*Projections for existing medical/surgical units assume psychiatric boarders may be placed in these beds while awaiting a bed in the proposed medical/psychiatric unit.

ii. **Average daily census;** and

CCMC Table 2
Average Daily Census

Average Daily Census	FY19	FY20	FY21	FYTD22 (Oct-Feb)	FY26	FY27	FY28
Pediatric - All Other Hartford Inpatient Units (Existing)	72.4	67.4	72.5	76.4	78.5	79.7	80.9

Pediatric Intensive Care Unit (Existing)	14	12.7	12.5	12.3	14.3	14.6	14.9
Level IV NICU	30.5	31.3	33.4	33.9	54.6	58.8	63.0
Pediatric - Hartford New Tower Medical/Surgical Beds	N/A	N/A	N/A	N/A	8.0	8.2	8.3
Fetal Care (Labor & Delivery Beds)	N/A	N/A	N/A	N/A	0.73	1.11	1.19
Advanced Cellular & Gene Therapy	N/A	N/A	N/A	N/A	1.57	1.64	1.72

*Projections for existing medical/surgical units assume psychiatric boarders may be placed in these beds while awaiting a bed in the proposed medical/psychiatric unit.

iii. Variability in census including peak census.

CCMC Table 3
Peak Daily Census

Peak Daily Census	FY19	FY20	FY21	FYTD22 (Oct-Feb)	FY26	FY27	FY28
Pediatric Hartford (Total) - All Existing Inpatient Units	102	99	96	96	98	98	98
Pediatric Intensive Care Unit (Existing)	18	18	18	18	18	18	18
Level IV NICU	36	37	38	39	65	65	65
Pediatric - Hartford New Tower Medical/Surgical Beds	N/A	N/A	N/A	N/A	14	14	14
Fetal Care (Labor & Delivery Beds)	N/A	N/A	N/A	N/A	6	6	6
Advanced Cellular & Gene Therapy	N/A	N/A	N/A	N/A	6	6	6

*Projections for existing medical/surgical units assume psychiatric boarders may be placed in these beds while awaiting a bed in the proposed medical/psychiatric unit.

CCMC Table 4
Minimum Daily Census

Minimum Daily Census	FY19	FY20	FY21	FYTD22 (Oct-Feb)	FY26	FY27	FY28

Pediatric Hartford (Total) - All Existing Inpatient Units	49	39	47	54	47	47	47
Pediatric Intensive Care Unit (Existing)	6	5	3	6	5	5	5
Level IV NICU	24	18	22	23	26	26	26
Pediatric - Hartford New Tower Medical/Surgical Beds	N/A	N/A	N/A	N/A	0	0	0
Fetal Care (Labor & Delivery Beds)	N/A	N/A	N/A	N/A	0	0	0
Advanced Cellular & Gene Therapy	N/A	N/A	N/A	N/A	0	0	1

*Projections for existing medical/surgical units assume psychiatric boarders may be placed in these beds while awaiting a bed in the proposed medical/psychiatric unit.

2. Historical & Projected Volume

b. Provide the number of discharges by town for the most recently **completed** fiscal year. In completing the Table C below, please adhere to the following:

i. Label and identify the period covered and define the Applicant's FY (e.g., July 1-June 30, calendar year, etc.); and

ii. Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric);

iii. List the official name of town (i.e., use **ONLY** official town names); do not use village or borough names; and

iv. Table totals should match OHS Tables 4 and 7 from the CON Main form.

TABLE C
DISCHARGES BY SERVICE AND TOWN

Official Town Name	FY21 OCT 1 2020-SEPT 30 2021					
	Medical/Surgical	**Maternity**	**Psychiatric**	**Rehabilitation**	**Pediatric**	**Total**
Andover					11	
Ansonia					7	
Ashford					9	
Avon					101	
Barkhamsted					17	
Beacon Falls					4	
Berlin					64	
Bethany					2	
Bethel					42	

Bethlehem					12	
Bloomfield					116	
Bolton					16	
Bozrah					6	
Branford					1	
Bridgeport					16	
Bridgewater					0	
Bristol					342	
Brookfield					23	
Brooklyn					21	
Burlington					37	
Canaan					13	
Canterbury					8	
Canton					36	
Chaplin					6	
Cheshire					34	
Chester					3	
Clinton					10	
Colchester					76	
Colebrook					5	
Columbia					15	
Cornwall					5	
Coventry					47	
Cromwell					80	
Danbury					170	
Darien					0	
Deep River					3	
Derby					3	
Durham					30	
E Granby					32	
E Haddam					21	
E Hampton					51	
East Hartford					406	
East Haven					6	
East Lyme					9	
E Windsor					56	
Eastford					4	
Easton					0	
Ellington					74	
Enfield					178	
Essex					1	
Fairfield					8	
Farmington					129	
Franklin					7	
Glastonbury					157	
Goshen					7	
Granby					50	
Greenwich					0	
Griswold					60	

Groton					28	
Guilford					1	
Haddam					24	
Hamden					4	
Hampton					6	
Hartford					1322	
Hartland					12	
Harwinton					16	
Hebron					50	
Kent					7	
Killingly					63	
Killingworth					6	
Lebanon					26	
Ledyard					11	
Lisbon					0	
Litchfield					12	
Lyme					0	
Madison					2	
Manchester					391	
Mansfield					43	
Marlborough					22	
Meriden					256	
Middlebury					20	
Middlefield					12	
Middletown					164	
Milford					14	
Monroe					2	
Montville					49	
Morris					3	
Naugatuck					115	
New Britain					516	
New Canaan					7	
New Fairfield					28	
New Hartford					19	
New Haven					10	
New London					10	
New Milford					76	
Newington					175	
Newtown					39	
Norfolk					3	
N Branford					1	
N Canaan					1	
North Haven					5	
N Stonington					3	
Norwalk					11	
Norwich					164	
Old Lyme					4	
O Saybrook					2	
Orange					3	

Oxford					16	
Plainfield					74	
Plainville					106	
Plymouth					50	
Pomfret					6	
Portland					41	
Preston					13	
Prospect					18	
Putnam					35	
Redding					5	
Ridgefield					22	
Rocky Hill					73	
Roxbury					4	
Salem					13	
Salisbury					11	
Scotland					5	
Seymour					1	
Sharon					3	
Shelton					4	
Sherman					2	
Simsbury					135	
Somers					35	
S Windsor					107	
Southbury					34	
Southington					173	
Sprague					10	
Stafford					35	
Stamford					9	
Sterling					5	
Stonington					9	
Stratford					6	
Suffield					41	
Thomaston					26	
Thompson					11	
Tolland					95	
Torrington					167	
Trumbull					3	
Union					0	
Vernon					165	
Voluntown					12	
Wallingford					43	
Warren					0	
Washington					6	
Waterbury					659	
Waterford					12	
Watertown					64	
W Hartford					367	
West Haven					1	
Westbrook					3	

Weston					3	
Westport					2	
Wethersfield					115	
Willington					17	
Wilton					0	
Winchester					44	
Windham					136	
Windsor					165	
Wind Locks					102	
Wolcott					55	
Woodbridge					0	
Woodbury					21	
Woodstock					13	
Out of State					444	
Total					10,257	

c. Provide historical volumes (three **full** fiscal years and the current year-to-date) for the number of discharges and patient days by service. In completing Table D and Table E below, please adhere to the following:

i. Provide the number of discharges/patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation and Pediatric);

ii. Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.);

iii. 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.

TABLE D
HISTORICAL AND CURRENT **DISCHARGES**

Service	**Actual Volume (Last 3 Completed FYs)**			
	FY 19__	**FY 20__**	**FY 21__**	**CFY 22 Oct-April***
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric	11,536	9,937	10,257	6,814
Total	11,536	9,937	10,257	6,814

*Applicant's fiscal year runs from October 1 – September 30. Months for current fiscal year (CFY) include October 2021 – April 2022.

*Includes observation as well as inpatient volume, as patients in observation status are occupying beds and contributing to census.

TABLE E
HISTORICAL AND CURRENT **PATIENT DAYS**

Service	Actual Volume (Last 3 Completed FYs)			
	FY 19__	**FY 20__**	**FY 21__**	**CFY 22 Oct-April***
Medical/Surgical				
Maternity				
Psychiatric				
Rehabilitation				
Pediatric	51,271	47,240	51,952	32,327
Total	51,271	47,240	51,952	32,327

*****Applicant's fiscal year runs from October 1 – September 3-. Months for CFY include October 2021 – April 2022.

d. Explain any increases and/or decreases in volume seen in Tables D and E, above.

Like other hospitals nationwide, Connecticut Children's volumes decreased in FY2020 during the COVID-19 pandemic, which resulted in postponement of elective surgeries, patient-initiated deferment of care, and the temporary decline in cases of other respiratory conditions due to masking and distancing mandates. Masking and social distancing prevented the typical patterns of respiratory infections and therefore reduced demand for PICU services among the respiratory care population, which represented one of the largest groups of patients requiring PICU services pre-pandemic. However, it is anticipated that Connecticut Children's, like other children's hospitals around the country, will experience a return to pre-pandemic norms as masking and distancing requirements ease, with an initial rebound involving a higher than usual incidence of respiratory cases. Based on current trends, FY22 is projected to end with an increase in discharges over FY19's pre-pandemic volume.

e. **Complete Table F and Table G for the first three full fiscal years ("FY"), for the projected number of discharges and patient days by service (if the first year is a partial year, include that as well).**

TABLE F
PROJECTED DISCHARGES BY SERVICE

Service*	Projected Volume (incremental patient discharges)		
	FY _2026_	FY _2027_	FY _2028_
Medical/Surgical	-	-	-
Maternity	23	36	46
Psychiatric	-	-	-
Rehabilitation	-	-	-
Pediatric	1,406	1,825	2,093
Total	1,429	1,861	2,139

TABLE G
PROJECTED PATIENT DAYS BY SERVICE

Service*	Projected Volume (incremental patient days)		
	FY _2026_	FY _2027_	FY _2028__
Medical/Surgical	-	-	-
Maternity	268	408	436
Psychiatric	-	-	-
Rehabilitation	-	-	-
Pediatric	10,516	13,050	15,053
Total	10,784	13,458	15,489

f. **Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service/patient day volume; explain any increases and/or decreases in volume reported in OHS Tables F and G.**

For the existing services (medical/surgical and neonatal intensive care services), projected volumes were based on historical utilization, with incremental patient volumes based on historical average length of stay, average daily census, occupancy rates, and unmet demand.

It is also assumed that the development of Connecticut Children's inpatient medical/psychiatric unit (addressed in a separate Certificate of Need Application) will have a downstream effect on other services and lead to increased occupancy rates across the hospital as a whole.

For the new services (Fetal Care and Advanced Cellular & Gene Therapy), projections were based on volume data from comparable programs at other institutions, adjusted for the relative size of the market in Connecticut. Due to continued health equity gaps and the limited number of providers available in Connecticut and the broader region for the proposed new services, demand for these services is expected to be high and no decreases are projected.

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State of Connecticut

May 21, 2022

County of Hartford

Order No: 7213258
$369.64

I, Robin Collar, do solemnly swear that I am a representative of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notices was inserted in the regular edition.

On Dates as Follows:

May 18, 2022; May 19, 2022; May 20, 2022

Robin Collar, Representative,

Subscribed and sworn before me on May 21, 2022

Notary Public

DENISE I CARR
NOTARY PUBLIC, STATE OF CONNECTICUT
MY COMMISSION EXPIRES MAY 31, 2023

Name of Notary, Typed, Printed, or Stamped

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Statutory Reference: Conn. Gen. Statutes §19a-638
Applicant: Connecticut Children's Medical Center
Proposal: The Applicant intends to file a Certificate of Need Application with the State of Connecticut Office of Health Strategy to increase its licensed bed capacity by 26 beds and 28 bassinets in connection with the construction of a new medical tower adjacent to its current campus. The increases are requested to (i) expand the capacity of certain existing services, notably the Hartford Neonatal Intensive Care Unit, (ii) establish a dedicated unit for bone marrow transplant services, and (iii) establish a labor, delivery, recovery & postpartum unit as part of a new Fetal Care Center, all of which will be located in the new tower.
Project Address: 282 Washington Street, Hartford, CT 06106
Capital Expenditure: $286,000,000
5/18, 5/19, 5/20/2022 7213258

Order # - 7213258

NON-PROFIT

Applicant: Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics

Financial Worksheet (A) without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY21 Actual	(2) FY22 Projected	(3) FY22 Projected	(4) FY22 Projected	(5) FY23 Projected	(6) FY23 Projected	(7) FY23 Projected	(8) FY24 Projected	(9) FY24 Projected	(10) FY24 Projected	(11) FY25 Projected	(12) FY25 Projected	(13) FY25 Projected
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$948,081,046	$986,383,173	$0	$986,383,173	$1,026,234,098	$0	$1,026,234,098	$1,067,692,901	$0	$1,067,692,901	$1,110,827,106	$0	$1,110,827,106
2	Less: Allowances	$555,138,704	$577,566,105	$0	$577,566,105	$600,900,386	$0	$600,900,386	$625,176,145	$0	$625,176,145	$650,432,917	$0	$650,432,917
3	Less: Charity Care	$2,318,994	$2,412,681	$0	$2,412,681	$2,510,155	$0	$2,510,155	$2,611,563	$0	$2,611,563	$2,717,069	$0	$2,717,069
4	Less: Other Deductions	$3,525,341	$3,667,763	$0	$3,667,763	$3,815,945	$0	$3,815,945	$3,970,105	$0	$3,970,105	$4,130,495	$0	$4,130,495
	Net Patient Service Revenue	**$387,098,007**	**$402,736,625**	**$0**	**$402,736,625**	**$419,007,611**	**$0**	**$419,007,611**	**$435,935,088**	**$0**	**$435,935,088**	**$453,546,625**	**$0**	**$453,546,625**
5	Medicare	$1,262,948	$1,313,971	$0	$1,313,971	$1,367,056	$0	$1,367,056	$1,422,284	$0	$1,422,284	$1,479,744	$0	$1,479,744
6	Medicaid	$144,891,615	$150,745,183	$0	$150,745,183	$156,835,448	$0	$156,835,448	$163,171,439	$0	$163,171,439	$169,763,475	$0	$169,763,475
7	CHAMPUS & TriCare	$3,419,846	$3,558,007	$0	$3,558,007	$3,701,754	$0	$3,701,754	$3,851,301	$0	$3,851,301	$4,006,891	$0	$4,006,891
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$149,574,409**	**$155,617,160**	**$0**	**$155,617,160**	**$161,904,258**	**$0**	**$161,904,258**	**$168,445,024**	**$0**	**$168,445,024**	**$175,250,110**	**$0**	**$175,250,110**
9	Commercial Insurers	$235,094,415	$244,592,143	$0	$244,592,143	$254,473,925	$0	$254,473,925	$264,754,410	$0	$264,754,410	$275,450,342	$0	$275,450,342
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$2,429,183	$2,527,321	$0	$2,527,321	$2,629,428	$0	$2,629,428	$2,735,654	$0	$2,735,654	$2,846,173	$0	$2,846,173
12	Workers Compensation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$237,523,598**	**$247,119,464**	**$0**	**$247,119,464**	**$257,103,352**	**$0**	**$257,103,352**	**$267,490,064**	**$0**	**$267,490,064**	**$278,296,515**	**$0**	**$278,296,515**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$387,098,007**	**$402,736,625**	**$0**	**$402,736,625**	**$419,007,611**	**$0**	**$419,007,611**	**$435,935,088**	**$0**	**$435,935,088**	**$453,546,625**	**$0**	**$453,546,625**
14	Less: Provision for Bad Debts	$2,774,460	$2,886,547	$0	**$2,886,547**	$3,003,167	$0	**$3,003,167**	$3,124,492	$0	**$3,124,492**	$3,250,719	$0	**$3,250,719**
	Net Patient Service Revenue less provision for bad debts	**$384,323,547**	**$399,850,078**	**$0**	**$399,850,078**	**$416,004,444**	**$0**	**$416,004,444**	**$432,810,596**	**$0**	**$432,810,596**	**$450,295,906**	**$0**	**$450,295,906**
15	Other Operating Revenue	$31,358,559	$28,124,066	$0	**$28,124,066**	$28,968,239	$0	**$28,968,239**	$29,837,118	$0	**$29,837,118**	$30,732,509	$0	**$30,732,509**
17	Net Assets Released from Restrictions	$26,150,652	$20,000,000	$6,000,000	**$26,000,000**	$20,000,000	$16,000,000	**$36,000,000**	$20,000,000	$22,000,000	**$42,000,000**	$20,000,000	$25,000,000	**$45,000,000**
	TOTAL OPERATING REVENUE	**$441,832,758**	**$447,974,143**	**$6,000,000**	**$453,974,143**	**$464,972,683**	**$16,000,000**	**$480,972,683**	**$482,647,714**	**$22,000,000**	**$504,647,714**	**$501,028,414**	**$25,000,000**	**$526,028,414**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$163,767,746	$171,211,183	$0	$171,211,183	$179,005,315	$0	$179,005,315	$187,168,337	$0	$187,168,337	$195,717,344	$0	$195,717,344
2	Fringe Benefits	$34,369,513	$35,931,648	$0	$35,931,648	$37,567,382	$0	$37,567,382	$39,280,535	$0	$39,280,535	$41,074,693	$0	$41,074,693
3	Physicians Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
4	Supplies and Drugs	$45,910,744	$47,902,868	$0	$47,902,868	$49,985,792	$0	$49,985,792	$52,163,891	$0	$52,163,891	$54,441,542	$0	$54,441,542
5	Depreciation and Amortization	$15,378,745	$15,295,984	$0	$15,295,984	$15,789,789	$0	$15,789,789	$16,861,078	$0	$16,861,078	$18,531,921	$0	$18,531,921
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$1,737,213	$1,130,865	$0	$1,130,865	$1,068,751	$5,000,000	$6,068,751	$1,004,665	$4,924,743	$5,929,408	$938,608	$4,845,723	$5,784,330
8	Malpractice Insurance Cost	$3,577,806	$3,733,051	$0	$3,733,051	$3,895,373	$0	$3,895,373	$4,065,111	$0	$4,065,111	$4,242,608	$0	$4,242,608
9	Lease Expense	$10,993,786	$11,470,820	$0	$11,470,820	$11,969,597	$0	$11,969,597	$12,491,164	$0	$12,491,164	$13,036,570	$0	$13,036,570
10	Other Operating Expenses	$115,561,879	$120,576,252	$0	$120,576,252	$125,819,177	$0	$125,819,177	$131,301,668	$0	$131,301,668	$137,034,740	$0	$137,034,740
	TOTAL OPERATING EXPENSES	**$391,297,432**	**$407,252,671**	**$0**	**$407,252,671**	**$425,101,174**	**$5,000,000**	**$430,101,174**	**$444,336,449**	**$4,924,743**	**$449,261,192**	**$465,018,025**	**$4,845,723**	**$469,863,748**
	INCOME/(LOSS) FROM OPERATIONS	**$50,535,326**	**$40,721,472**	**$6,000,000**	**$46,721,472**	**$39,871,509**	**$11,000,000**	**$50,871,509**	**$38,311,265**	**$17,075,257**	**$55,386,522**	**$36,010,389**	**$20,154,277**	**$56,164,667**
	NON-OPERATING REVENUE	**$2,859,497**	**$3,858,344**	**$0**	**$3,858,344**	**$3,917,975**	**$0**	**$3,917,975**	**$3,978,104**	**$0**	**$3,978,104**	**$4,035,859**	**$0**	**$4,035,859**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$53,394,823**	**$44,579,816**	**$6,000,000**	**$50,579,816**	**$43,789,485**	**$11,000,000**	**$54,789,485**	**$42,289,370**	**$17,075,257**	**$59,364,627**	**$40,046,248**	**$20,154,277**	**$60,200,525**
	Principal Payments	**$2,201,592**	$2,223,608	$0	**$2,223,608**	$2,245,844	$1,505,144	**$3,750,988**	$2,268,302	$1,580,401	**$3,848,703**	$2,290,985	$1,659,421	**$3,950,406**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**11.4%**	**9.0%**	**100.0%**	**10.2%**	**8.5%**	**68.8%**	**10.5%**	**7.9%**	**77.6%**	**10.9%**	**7.1%**	**80.6%**	**10.6%**
2	Hospital Non Operating Margin	**0.6%**	**0.9%**	**0.0%**	**0.8%**	**0.8%**	**0.0%**	**0.8%**	**0.8%**	**0.0%**	**0.8%**	**0.8%**	**0.0%**	**0.8%**
3	Hospital Total Margin	**12.0%**	**9.9%**	**100.0%**	**11.0%**	**9.3%**	**68.8%**	**11.3%**	**8.7%**	**77.6%**	**11.7%**	**7.9%**	**80.6%**	**11.4%**
D.	**FTEs**	**1,626**	1,643	0	**1,643**	1,660	0	**1,660**	1,677	0	**1,677**	1,695	0	**1,695**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	5,624	5,682	0	**5,682**	5,741	0	**5,741**	5,801	0	**5,801**	5,861	0	**5,861**

NON-PROFIT

Applicant: Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics

Financial Worksheet (A) without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY21**	**FY22**	**FY22**	**FY22**	**FY23**	**FY23**	**FY23**	**FY24**	**FY24**	**FY24**	**FY25**	**FY25**	**FY25**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	Advanced Cellular & Gene Therapy													
	Medical/Surgical Unit													
	Fetal Surgery (includes Fetal NICU Cases)													
	Neonatal Intensive Care Unit													
2	Outpatient Visits	213,444	215,664	0	**215,664**	217,907	0	**217,907**	220,173	0	**220,173**	222,463	0	**222,463**
	TOTAL VOLUME	**219,068**	**221,346**	**0**	221,346	**223,648**	**0**	223,648	**225,974**	**0**	225,974	**228,324**	**0**	228,324

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

CONNECTICUT CHILDREN'S MEDICAL CENTER
CERTIFICATE OF NEED APPLICATION
ATTACHMENTS