STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Agreed Settlement

Applicants:	**Yale-New Haven Hospital** **Saint Raphael Healthcare System, Inc. &** **Hospital of Saint Raphael, Inc.**
Docket Number:	**12-31747-CON**
Project Title:	**Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.**

Project Description: Yale-New Haven Hospital ("YNHH") proposes to acquire certain assets of the Saint Raphael Healthcare System, Inc. ("SRHS"), including The Hospital of Saint Raphael ("HSR"). Following the acquisition, YNHH would be the sole acute care hospital in New Haveu, Connecticut with two inpatient campuses and multiple ambulatory satellites.

Procedural History: On February 1, 2012, the Department of Public Health's Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from YNHH, SRHS and HSR (collectively, the "Applicants") for the above-referenced project. A notice to the public concerning Applicants intent to file the CON application was published on January 9, 10 and 11, 2012 in the *New Haven Register*.

A public hearing regarding the CON application was held on June 5, 2012. On May 14, 2012, the Applicants were notified of the date, time and place of the hearing. On May 21, 2012, a notice to the public announcing the hearing was published in the *New Haven Register*.

Commissioner Jewel Mullen designated Joanne V. Yandow, Esq. as the hearing officer in this matter on May 22, 2012.

The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-639a of the Connecticut General Statutes. On June 6, 2012, OHCA received certain updated financial statements from Applicants that were requested as late filed submissions at the June 5, 2012 public hearing and, by letter dated June 7, 2012, Applicants were informed that the public hearing was closed.

OHCA's authority to review and approve, modify or deny this proposal is established by Sections 19a-638 and 19a-639a of the Connecticut General Statutes. These provisions, as well as the principles and guidelines set forth in Section 19a-639 of the Statutes, were fully considered by OHCA in its review.

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph

FINDINGS OF FACT

1. YNHH is an acute care general hospital located at 20 York Street in New Haven, Connecticut that includes the Yale-New Haven Children's Hospital, the Yale-New Haven Psychiatric Hospital and the Smilow Cancer Hospital. YNHH's total licensed bed capacity of 1,008 licensed beds and bassinets includes 916 general hospital beds and 92 bassinets.[1] Ex. A, pp. 17, 22, 226-227.

2. YNHHS is a Connecticut non-stock 501(c)(3) corporation located at 20 York Street in New Haven, Connecticut and is the parent company of YNHH. Ex. A, pp. 76, 111, 223.

3. HSR is an acute care general hospital located at 1450 Chapel Street in New Haven, Connecticut. HSR's total licensed bed capacity of 533 licensed beds and bassinets includes 511 general hospital beds and 22 bassinets. Ex. A, pp. 20, 43, 111, 229.

4. SRHS is a Connecticut non-stock 501(c)(3) corporation located at 1450 Chapel Street in New Haven, Connecticut. SRHS is the parent company of HSR, Saint Raphael Healthcare System Affiliated Physicians, Inc., DePaul Health Services Corporation, Inc., Saint Raphael Foundation, Inc. and Saint Regis Health Center, Inc. d/b/a Sister Anne Virginie Grimes Health Center (the "Grimes Center"). Ex. A, pp. 78, 111.

5. On September 26, 2011, YNHH and YNHHS entered into an Asset Purchase Agreement with SRHS, HSR and the other above-listed SRHS subsidiaries for YNHH to acquire, among other assets, HSR, the Grimes Center, a 120-bed short-term rehabilitation and long-term care facility, and SRHS's ownership interest in three joint ventures: Saint Raphael Magnetic Resonance Center,[2] Connecticut CK Leasing, LLC, a business engaged in stereotactic radiosurgery in which HSR has a 49.1% interest, and Saint Raphael Dialysis Center Partnership, a business engaged in the provision of outpatient kidney dialysis services and managing HSR's inpatient kidney dialysis service in which DePaul Health Services holds a 49.1% interest.[3] Ex. A, pp. 20, 80-159; Ex. F, pp. 105-106.

6. The result of the proposed acquisition will be a single, acute care hospital in New Haven, Connecticut with two inpatient campuses and multiple ambulatory satellites. Ex. A, p. 20.

7. The Applicants based the need for the transaction on the following:

---

[1] Of these 1,008 total licensed beds, 874 general hospital beds and 92 bassinets are located in New Haven, and 42 dedicated pediatric beds are located on the campus of Bridgeport Hospital. See OHCA Docket No. 11-31714-CON (approving the addition of the 42 pediatric beds at Bridgeport Hospital to YNHH's license).

[2] Saint Raphael Magnetic Resonance Center ("SRMRC") operates two MRI scanners at 330 Orchard Street in New Haven, Connecticut and is a joint venture entity formed between DePaul Health Services Corporation, Inc. and Medical Imaging Associates, P.C., a subsidiary of New Haven Radiology Associates, P.C. YNHH's acquisition of DePaul's 50% interest in SRMRC is the subject of a separate CON Application under OHCA Docket No. 12-31759-CON.

[3] Certificates of need are not required for the acquisitions of Connecticut CK Leasing, LLC and Saint Raphael Dialysis Center Partnership. *See*, General Statutes § 19a-638.

a. HSR's significant financial losses in recent years, which have required reductions in operating expenses, including limiting employee benefits and delaying capital investments; and

b. Increased demand for inpatient bed capacity at YNHH.

Ex. A, pp. 26-27, 34-35.

8. HSR's service area includes the following 22 towns/cities: East Haven, New Haven, North Haven, West Haven, Hamden, Ansonia, Bethany, Branford, Cheshire, Clinton, Derby, Guilford, Madison, Meriden, Milford, North Branford, Orange, Oxford, Seymour, Shelton, Wallingford and Woodbridge. Ex. A, p. 38.

9. In fiscal year ("FY") 2011, HSR accounted for 5.43 % of Connecticut's acute care discharges. The cities and towns with the largest number of discharges that collectively made up 75% of HSR's total discharges were as follows:

Town	Discharges	Percent of Total	Cumulative Percent
New Haven	5,823	25.2	25.2
Hamden	3,381	14.6	39.8
West Haven	2,693	11.6	51.4
East Haven	1,888	8.2	59.6
North Haven	1,310	5.7	65.2
Branford	1,032	4.5	69.7
Wallingford	832	3.6	73.3
Milford	649	2.8	76.1

(Source: OHCA Hospital Inpatient Discharge Database)

10. In FY 2011, YNHH accounted for 13.55% of Connecticut's acute care discharges. The cities and towns with the largest number of discharges that collectively made up 75% of YNHH's total discharges were as follows:

Town	Discharge	Percent of Total	Cumulative Percent
New Haven	14,260	24.7	24.7
West Haven	4,318	7.5	32.2
Hamden	3,989	6.9	39.1
East Haven	2,932	5.1	44.2
Branford	2,694	4.7	48.8
Guilford	1,562	2.7	51.5
Milford	1,525	2.6	54.2
North Haven	1,465	2.5	56.7
Bridgeport	1,341	2.3	59
Wallingford	1,304	2.3	61.3
Madison	1,137	2	63.2
North Branford	1,055	1.8	65.1
Waterbury	874	1.5	66.6
Meriden	816	1.4	68
Cheshire	721	1.2	69.3
Clinton	665	1.2	70.4
New York	649	1.1	71.5
Other State/Cntry	643	1.1	72.6
Orange	612	1.1	73.7
Groton	571	1	74.7
Shelton	560	1	75.7

(Source: OHCA Hospital Inpatient Discharge Database)

11. In FY 2011, utilization of Connecticut hospitals by the residents of the locations identified in the tables in Findings of Fact ("FF") 9 and 10 was as follows:

FY 2011
Discharges

Town	Yale-New Haven Hospital	Hospital of Saint Raphael	Saint Vincent's Medical Center	Bridgeport Hospital	MidState Medical Center
Bridgeport	7%	0%	47%	41%	0%
Branford	70%	27%	1%	0%	0%
East Haven	59%	38%	1%	0%	0%
Guilford	71%	20%	0%	0%	0%
Hamden	51%	43%	1%	1%	1%
Madison	63%	17%	0%	0%	0%
Meriden	10%	4%	1%	0%	65%
Milford	25%	10%	10%	11%	0%
New Haven	69%	28%	0%	1%	0%
North Branford	61%	31%	0%	0%	2%
North Haven	48%	43%	0%	1%	4%
Orange	40%	34%	4%	3%	0%
Shelton	12%	3%	24%	24%	0%
Wallingford	25%	16%	0%	0%	47%
West Haven	54%	34%	1%	1%	0%
Clinton	48%	9%	0%	0%	0%
Groton	11%	0%	0%	0%	0%
Cheshire	28%	13%	1%	0%	28%
Waterbury	6%	1%	1%	0%	1%
New York	6%	0%	1%	1%	0%
Oth State or Ctry	21%	3%	4%	3%	2%
% of Total*	**31%**	**15%**	**9%**	**8%**	**6%**

* The remaining 31% of discharges for residents of the above locations were spread among the following hospitals: New Milford Hospital, Charlotte Hungerford Hospital, John Dempsey Hospital, Day Kimball Hospital, Windham Community Memorial Hospital, Griffin Hospital, William W. Backus Hospital, Milford Hospital, St. Mary's Hospital, St. Francis Hospital, Lawrence and Memorial Hospital, Bristol Hospital, Norwalk Hospital, Middlesex Memorial Hospital, Sharon Hospital, Waterbury Hospital, Greenwich Hospital, New Britain General Hospital, Rockville General Hospital, Johnson Memorial Hospital, Stamford Hospital, Manchester Memorial Hospital, Hartford Hospital, Danbury Hospital, Connecticut Children's Medical Center.

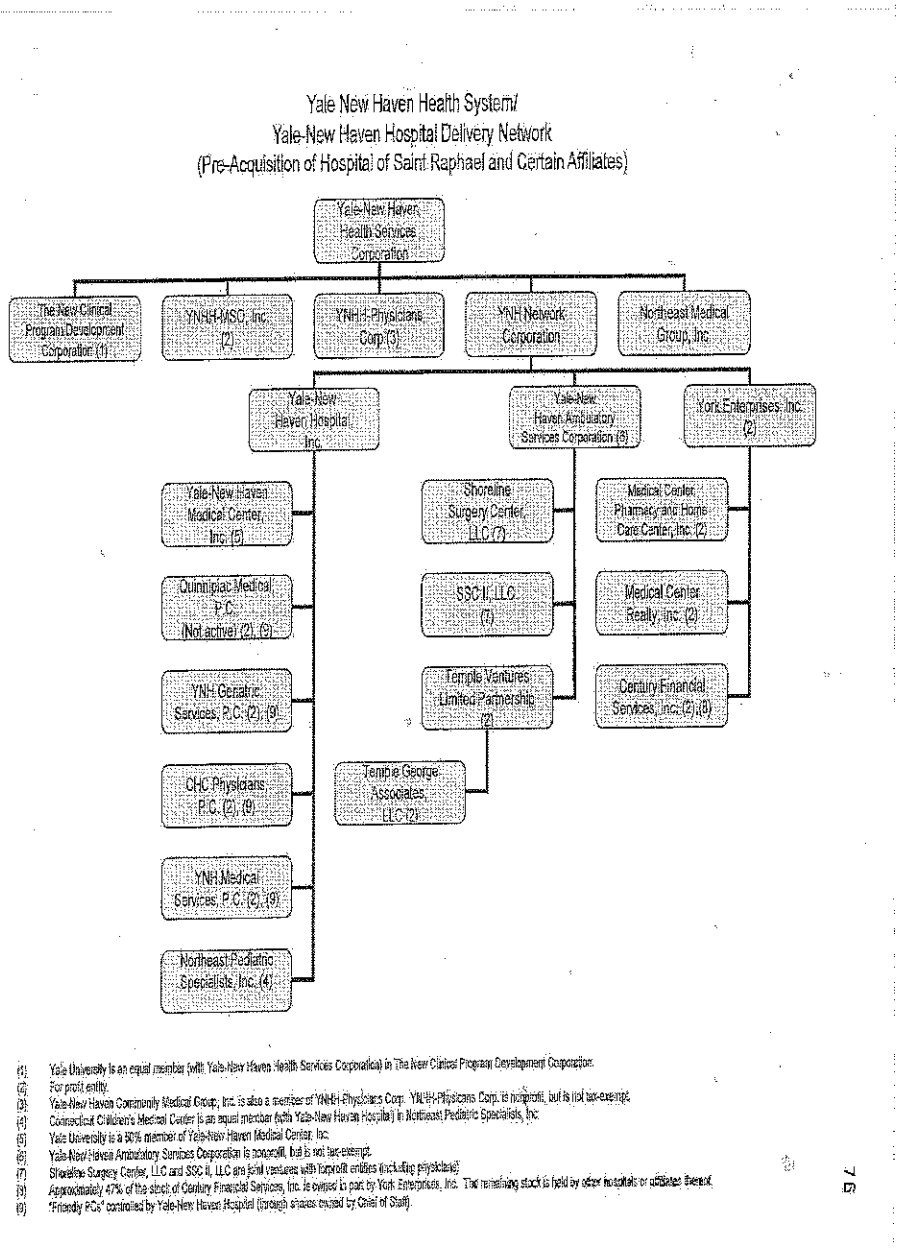
(Source: OHCA Hospital Inpatient Discharge Database)

12. With respect to the proposed transaction, Applicants provided the following general timeline:

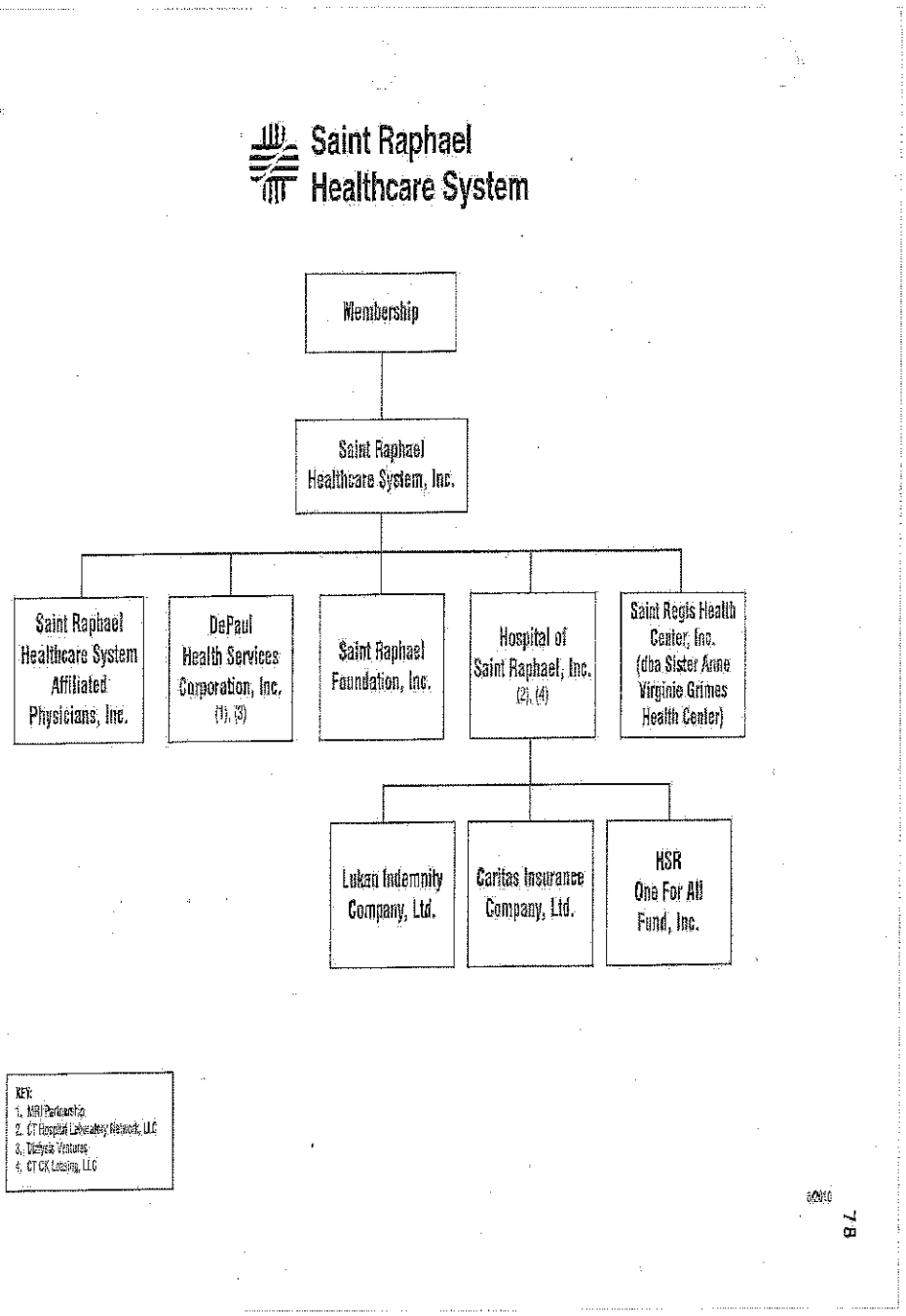
    a. Early 2010 – HSR approached YNHH to discuss how the organizations could work together;
    b. March 2011 - Applicants signed a letter of intent;
    c. In the months following March 2011 – Applicants engaged in the due diligence process; and
    d. September 2011 – Applicants executed Asset Purchase Agreement.

Ex. A, p. 36.

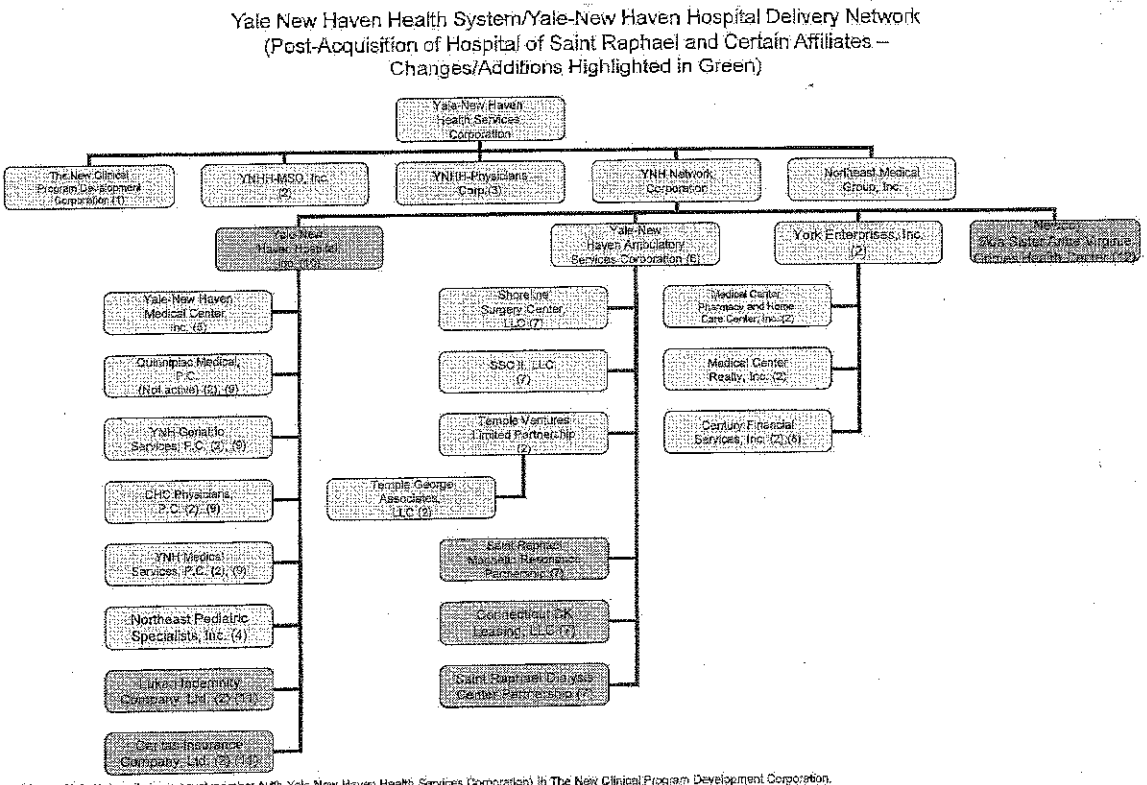
13. Applicants supplied an organizational chart of YNHHS prior to the proposed transaction that depicts the organization as follows: Ex. A, p. 76



14. Applicants supplied an organizational chart of SRHS prior to the proposed transaction that depicts the organization as follows: Ex. A, p. 78.



15. The Applicants provided an organizational chart of YNHHS following the proposed transaction that depicted the organization as follows:



Ex. A, pg. 77.

16. HSR had significant operating losses for FYs 2005 through 2009 and it cannot survive long-term as a standalone entity without outside assistance and investment. Ex. A, pp. 26-27; Transcript of June 5, 2012 Public Hearing ("Tr."), Testimony of Christopher O'Connor, President and Chief Executive Officer of HSR and SRHS, pp. 34-39.

17. Due to its financial situation, HSR has initiated cost-cutting measures, including negotiations with managed care organizations to improve reimbursement rates, productivity enhancements, supply chain cost reductions, fringe benefit eliminations, and cancellation and deferment of equipment, renovations, information technology ("IT") investments and other capital projects. Ex. A, p.26; Ex. F, pp. 110, 132-133.

18. Although it is licensed for 511 beds, HSR is currently operating 423 beds and has a current maximum physical plant capacity of 484 beds. Two units – Verdi 4N (30 beds)

and SLA (31 beds) – have been closed by HSR and an additional 27 beds have been removed as a result of renovations that occurred over the past few years. Ex. F, p. 118.

19. The following table depicts the inpatient hospital utilization for each of YNHH and HSR, as well as the two hospitals combined, for FYs 2009-2011:

	Discharges			Patient Days						
Yale-New Haven Hospital	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	4,644	4,494	4,596	26,189	26,401	24,465	-3%	2%	1%	-7%
Maternity	5,141	5,034	5,247	16,927	16,522	17,100	-2%	4%	-2%	3%
Psychiatric	3,189	3,300	3,077	30,470	30,453	32,083	3%	-7%	0%	5%
Rehabilitation	-	-	-	-	-	-				
Pediatric	5,492	5,643	5,599	21,249	20,833	19,822	3%	-1%	-2%	-5%
Medical or Surgical	35,956	38,291	39,232	184,531	190,458	206,503	6%	2%	3%	8%
Total	**54,422**	**56,762**	**57,751**	**279,366**	**284,667**	**299,973**	4%	2%	2%	5%
	Discharges			Patient Days						
Hospital of Saint Raphael	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	1,270	1,183	1,211	4,213	3,773	4,305	-7%	2%	-10%	14%
Maternity	1,403	1,286	1,292	4,026	3,661	3,888	-8%	0%	-9%	6%
Psychiatric	1,163	1,235	1,189	13,813	13,941	13,605	6%	-4%	1%	-2%
Rehabilitation	443	393	411	4,388	3,761	4,005	-11%	5%	-14%	6%
Pediatric	88	78	39	203	149	85	-11%	-50%	-27%	-43%
Medical or Surgical	20,601	20,335	18,998	105,242	99,828	96,742	-1%	-7%	-5%	-3%
Total	**24,968**	**24,510**	**23,140**	**131,885**	**125,113**	**122,630**	-2%	-6%	-5%	-2%
	Discharges			Patient Days						
YNHH/HOSR Combined	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	5,914	5,677	5,807	30,402	30,174	28,770	-4%	2%	-1%	-5%
Maternity	6,544	6,320	6,539	20,953	20,183	20,988	-3%	3%	-4%	4%
Psychiatric	4,352	4,535	4,266	44,283	44,394	45,688	4%	-6%	0%	3%
Rehabilitation	443	393	411	4,388	3,761	4,005	-11%	5%	-14%	6%
Pediatric	5,580	5,721	5,638	21,452	20,982	19,907	3%	-1%	-2%	-5%
Medical or Surgical	56,557	58,626	58,230	289,773	290,286	303,245	4%	-1%	0%	4%
Total	**79,390**	**81,272**	**80,891**	**411,251**	**409,780**	**422,603**	2%	0%	0%	3%

(Source: OHCA Hospital Inpatient Discharge Database)

20. HSR's volume is down approximately 8% in the current year and cannot remain a viable standalone provider of hospital services due, in part, to the following:

    a. It has received a "going-concern" qualification in each auditor's report accompanying its audited financial statements since FY 2008. This qualification relates to its inadequate financial performance which has resulted in its inability to achieve financial covenant requirements of its long-term debt and insufficient current assets available to satisfy current liabilities if the credit-enhancers to its long term debt were to declare an event of default.

    b. Its employee and benefit matters have diminished the ability to attract and retain a robust workforce. It ceased all post-retirement pension benefit accruals for all employees effective during FY 2010 and its projections indicate that available resources will be inadequate to reinstitute these pension programs.

    c. Its unmet capital needs. Limitations on capital acquisitions over the last several years due to the lack of available funds continue to result in competitive disadvantages.

    d. It has experienced significant volume declines over the last several years.

    e. Payment rates from Medicare and Medicaid (approximately 70% of HSR net revenues) are expected to decline, and commercial payment rate increases will be more difficult to negotiate due to current economic conditions.

    f. As of April 30, 2012, HSR had only 23.5 days cash on hand. Existing loan agreement covenants require minimum days cash on hand of 40 days through 2013 and 45 days thereafter.

    g. As of February 29, 2012, HSR had a negative fund balance of $23.4 million, largely due to the underfunded position of the defined benefit pension plan. Existing loan agreement covenants include a minimum fund balance requirement of $54 million.

Ex. F, pp. 111-113; Ex. M, Pre-file Testimony of Christopher O'Connor, pg. 344-345; Tr., Testimony of Christopher O'Connor, p. 34-38.

21. HSR had the following liquidity, solvency and utilization measures as noted in the table below, for the last three FYs ending September 30, 2011:

Selected Liquidity and Solvency Measures for HSR

	FY 2009	FY 2010	FY 2011
Days Cash on Hand	16.5	11.2	21.0
Long Term Debt to Capital	(11.6)	(23.1)	(1.4)
Average Age of Plant	19.0	23.3	26.1

Source: OHCA Hospital Reporting System ("HRS") Twelve Months Filings Report 185 for Fiscal Year's 2009, 2010, and 2011

22. HSR's unmet capital needs have caused the age of its hospital physical plant to double in five years and become the oldest in the state at 26.2 years. HSR has deferred, postponed or cancelled capital needs as a result of the financial challenges it has faced in recent years that totals over $132 million. Ex. F, pp. 110-111, 139, 159, 232-243.

23. HSR's inability to fund capital expenditures has been especially noteworthy in two areas: medical equipment and IT. HSR's FY 2010 Capital Budget showed that although medical departments requested $34.8 million in medical equipment, HSR was able to commit only $3.8 million in that fiscal year, or just over 10% of requests. HSR was able to provide only $3.8 million in IT investment over the same period. A larger sum, estimated to be as high as $60 million, would be required to adopt the Epic electronic medical records ("EMR") system on a standalone basis.[4] Ex. F, p. 139.

24. In recognition of HSR's inability to achieve financial stability, the SRHS Board of Trustees and the sponsoring Sisters of Charity of Saint Elizabeth concluded that integrating with a stronger hospital or system was necessary to meet their mission of serving the poor, elderly and underserved. The SRHS Board's Ad Hoc Strategy Committee began a formal process in early 2010 to explore and evaluate its options. Ex. A, p. 26.

25. SRHS examined Catholic and secular, not-for-profit and for-profit, and national, Connecticut and local systems and determined that integrating with YNHH was in the best interest of SRHS, its staff, patients, physicians and community for the following reasons:

    a. The integration has the ability to transform and improve the way care is delivered in terms of quality, effectiveness, efficiency and access.

[4] Epic makes electronic medical record software for mid-size and large medical groups, hospitals and integrated healthcare organizations. An electronic medical record is a collection of electronic health information about individual patients or populations and is contained in a digital format that is capable of being shared across health care settings.

b. It will enable clinical service growth on the HSR campus.

c. It will provide financial stability for HSR, especially by eliminating long-term debt, significantly contributing to church pension plan obligations and providing much needed capital.

d. It will keep health care decisions local.

Ex. A, pp. 27-28; Ex. F, pp. 140-142.

26. Integrating with YNHH would provide the following benefits to HSR:

a. The organizations share a history of being part of the greater New Haven community.

b. YNHH would address HSR's financial challenges.

c. YNHH would employ the majority of HSR staffs.

d. YNHH would combine the medical staff of both hospitals.

e. YNHH would recognize the Teamsters as the bargaining unit for certain HSR employee groups.

f. YNHH would provide representation for HSR physicians on the YNHH Medical Board and its committees.

g. YNHH would enable HSR's campus to be the site of key centers of excellence.

h. YNHH would provide continuity and enhancement of patient care and stability through its investment in program development, infrastructure improvement and technology investments.

i. YNHH agrees to respect HSR's Catholic tradition by:

i. Continuing to provide care on the HSR campus according to the Ethical and Religious Directives (ERDs) for Catholic Health Care Services;

ii. Allowing the Sisters of Charity of Saint Elizabeth to have a role at YNHH through the selection of a senior leader to oversee matters pertaining to Catholic tradition, helping to select representatives for a committee to ensure clinical services are consistent with ERDs and serving on YNHH's Board of Trustees; and

iii. Honoring HSR's Catholic heritage on the HSR campus through signage, the continued presence of chapel, religious statuary and other symbols.

Ex. A, pp. 27-28.

27. HSR's long term-debt was $67.7 million as of February 29, 2012. All of this long-term debt will be extinguished as part of the acquisition transaction from a combination of HSR's cash on hand and a portion of the $160 million purchase price. Ex. F, p. 117.

28. HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011 and included in the agreed upon purchase price of $160 million was the approximately $86 million shortfall. HSR's estimated Church plan pension shortfall on a termination basis as of December 31, 2011 was estimated to be approximately $135 million. The sources of funds to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price. Ex. F, p. 117.

29. YNHH developed the Y Access Line, a single-source phone center exclusively for physicians who are interested in transferring a patient to YNHH, which opened in August 2010. Inpatient cases transferred to YNHH totaled 2,996 the year before the Y Access Line was initiated and increased to 3,990 during the first year of its operation. This represents a 33% increase in volume, and it is projected that more than 4,500 patients will be transferred via the Y Access Line this year. Ex. A, pp. 30-31; Ex. M, Pre-file Testimony of Marna Borgstrom, Chief Executive Officer, YNHH, p. 325; Tr., Testimony of Peter Herbert, M.D., Chief of Staff and Senior Vice President for Medical Affairs of YNHH, pp. 20-21.

30. Patients referred through the Y Access Line are high acuity and in FY 2011 had an average length of stay of 10.81 days, more than double that of the average length of stay of 5.24 days for all YNHH inpatients. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 331.

31. In FY 2011, 73% of YNHH's admissions were categorized as emergent, and the figure increases to 76% if one excludes maternity, pediatrics and psychiatry. YNHH estimates that approximately three quarters of its admissions arrive with little or no advance notice. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 332.

32. YNHH has considered constructing a 5th bed tower to meet growing demand for bed capacity. Ex. A, p. 24.

33. As a result of its bed capacity constraints, YNHH periodically places patients on units not typically intended for their primary diagnosis, overflow areas have been developed to hold patients until they can be admitted to a bed, double rooms have been converted to triples and emergency department patients may wait in the ED for an extended period of time until an acute care or ICU bed becomes available. Ex. A, p. 31; Tr., Testimony of Peter Herbert, M.D., pp. 20-22.

34. YNHH has managed patient length of stay in the hospital through numerous initiatives and although length of stay reductions are projected (YNHH has projected average length of stay for FY 2012 at 5.10 days, reducing to 4.89 days by 2016), continued length of stay reduction will be challenging given the treatment of higher acuity patients via the Y Access Line and the aging of the population. Ex. A, pp. 33-34; Tr., Testimony of Peter Herbert, M.D., pp. 20-22.

35. If YNHH were to construct a 5th bed tower in order to meet projected inpatient demand, it estimates cost at approximately $537 million (and up to $622 million when the full cost of parking facilities and a new chiller plant are factored in). The only available site on the YNHH campus prohibits the new bed tower from being tied to YNHH's existing central medical complex and therefore would require construction of duplicate facilities to service the new tower. The bed tower would not be available until late 2016. The average occupancy rate for YNHH is projected to climb to 93% by 2016 without the ability to expand bed capacity. Ex. A, pp. 34-35; Ex. F, pp. 113, 149; Tr., Testimony of Marna Borgstrom, pp. 12-13.

36. As the cost and time required to build a 5th bed tower is a less than ideal solution, YNHH determined that the acquisition of HSR presents a much more cost effective and timely option for increasing its acute care bed capacity. Ex. A, p. 35.

37. After the closing of YNHH's acquisition of HSR, the two closed units on the HSR campus would be reopened, providing 484 operational beds in FY 2012. Renovation and staffing plans are also being made to bring 15 more beds into operation in FY 2013 for a total of 499 operational beds at HSR. The following table summarizes HSR's bed capacity between FY 2012 and FY 2015:

HSR Planned Bed Capacity				
	FY 2012	FY 2013	FY 2014	FY 2015
Beds	484	499	499	499
Bassinets	22	22	22	22
TOTAL	**506**	**521**	**521**	**521**

Ex. F, p. 120.

38. If the acquisition is approved, YNHH's projected total bed utilization would be 79%, 79%, 80%, 81% and 83% in FYs 2012 through 2016, respectively. Ex. H, pp. 294-298.

39. YNHH plans to spend a total of $129.5 million in capital expenditures on the HSR campus during the first five years after closing. A total of $85 million of this amount is earmarked for infrastructure (mechanical, electrical and plumbing) and architecturally related facility and appearance improvements (including operationalizing, by FY 2013, 15 of the 27 beds that have been removed from HSR in recent years). Another $25 million will be spent for routine capital needs, and $5.1 million will be spent for IT integration, including upgrades to the local area network, wireless network and computing equipment on the HSR campus. Lastly, $14.4 million will be spent to implement the Epic EMR system on the HSR campus. The Epic system is scheduled to be installed at YNHH on February 1, 2013. If the acquisition is approved, it is estimated that the installation of Epic on the HSR campus will be implemented in the summer of 2013. Ex. F, pp. 114-117, 144; Tr., Testimony of Vincent Tammaro, Vice President of Finance of YNHHS, pp. 64-65.

40. Prioritization of the capital improvements projects on the HSR campus will be determined by YNHH's senior leadership and based on a variety of factors, including regulatory requirements, updated facility assessments, patient volumes and annual budget amounts. YNHH is currently undertaking a budgeting process to identify planned capital expenditures for the HSR campus in FY 2013. Ex. F, p. 117; Tr., Testimony of Vincent Tammaro, pp. 65-66.

41. The following tables represent the patient population mixes for YNHH if the CON proposal is approved and for HSR currently. The projected payer mix for YNHH is based on the combination of YNHH volume and HSR volume by payer category, and projected volumes for FY 2013-2015 include holding current HSR volume flat and increasing YNHH volume 3% per year for inpatient admissions and 5% per year for outpatient encounters.

Patient Population Mix- YNHH – Inpatient (2013 – 2015 assumes HSR acquisition)

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	31%	38%	38%	38%
Medicaid*	29%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**60%**	**63%**	**63%**	**64%**
Commercial Insurers*	38%	35%	35%	34%
Uninsured (Self Pay)	2%	2%	2%	2%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**40%**	**37%**	**37%**	**36%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Current includes only YNHH.

Patient Population Mix- YNHH – Outpatient (2013 – 2015 assumes HSR acquisition)

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	21%	25%	25%	24%
Medicaid*	27%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**48%**	**50%**	**50%**	**50%**
Commercial Insurers*	45%	44%	44%	44%
Uninsured (Self Pay)	7%	6%	6%	6%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**52%**	**50%**	**50%**	**50%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Current includes only YNHH.

Patient Population Mix- HSR Inpatient

	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	55%	N/A	N/A	N/A
Medicaid*	14%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**69%**	N/A	N/A	N/A
Commercial Insurers*	29%	N/A	N/A	N/A
Uninsured	2%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**31%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

Patient Population Mix- HSR Outpatient (Discharge Equivalent)

	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	36%	N/A	N/A	N/A
Medicaid*	20%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**56%**	N/A	N/A	N/A
Commercial Insurers*	40%	N/A	N/A	N/A
Uninsured	4%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**44%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

Ex. A, pp. 47-49.

42. Applicants are preparing a transition plan and, during the next six months, will develop an operating plan which will identify the timing and process to integrate clinical services, clinical support, non-clinical support and infrastructure services over a three year period following the closing of the transaction. The plan is to ensure a smooth transition from two hospitals to one hospital with two campuses and an integrated ambulatory network. All services currently provided will remain and new services will be offered over time. Ex. A, p. 39.

43. As part of the transition plan, Applicants will integrate the medical staffs of the two hospitals to ensure coverage at both campuses at closing. They have almost completed the process of credentialing the HSR physicians who did not already have privileges at YNHH. More than 400 doctors, physician assistants and APRNs/midwives are being added to the YNHH medical staff and virtually every vital caregiver at HSR will be privileged by the closing date. Ex. H, p. 292; Tr., Testimony of Peter Herbert, M.D., pp. 46-47.

44. YNHH states that virtually all employed physicians at HSR have agreed to employment with the YNHHS, including emergency medicine physicians, intensivists, traumatologists and hospitalists. YNHH has agreed to accept assignment of the contracts of physicians and physician groups providing service in the primary care and specialty clinics at HSR. Site medical directors have been identified for all clinical services, and the hospital-based service providers (radiology, pathology, therapeutic radiology and anesthesiology) have agreed to assign their contracts to YNHH. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 334.

45. As part of the transition plan, YNHH will integrate HSR's teaching and residency programs into its own teaching and residency programs, and existing residents and fellows will be able to continue their training under YNHH. Substantially all of the teaching staff at HSR will continue their teaching duties. Ex. F, p. 130.

46. As part of the transition plan, YNHH will expand the research and clinical trials conducted as a result of the transaction, and, after the closing, patients at both hospitals will have access to trials conducted at YNHH and YNHH will continue all of the trials that were ongoing at HSR prior to the closing of the transaction. Ex. F, p. 131.

47. Applicants have financial assistance policies to support patients with limited financial means, and, after the transaction, the financial policies of YNHH will be used for services provided on both campuses. YNHH financial assistance policies are broader and offer financial assistance to a wider range of patients at or around the poverty level than existing HSR financial assistance policies. With the exception of differences where YNHH policies provide additional assistance, all other financial assistance processes and collection practices of the hospitals are the same. Ex. F, p. 131; Ex. H, 299-321.

48. YNHH will bill for the proposed services. It indicates that new provider contracts will be negotiated based on the relative mix and volume of services in the combined institution and that the intent will be to establish melded, budget neutral agreements that will not result in an adverse impact to managed care payers or the self-funded employers. YNHH does not have any plans to raise charges as a result of the HSR acquisition. Ex. A, pp. 50-51; Tr., Testimony of William Gedge, Senior Vice President of Payer Relations for YNHHS, pp. 51-52.

49. The transaction-related investigations conducted by the state Attorney General and the Federal Trade Commission have been completed, and on June 1, 2012, these authorities indicated to Applicants that they will not oppose the transaction. The parties plan to formally close the transaction effective July 29, 2012, and they indicate that this date is important for many reasons, including the following: further delay is likely to cause HSR to lose additional key personnel and financial deterioration of HSR might force HSR to lay off more employees. Ex. F, p. 150; Tr., Testimony of Marna Borgstrom, p. 11.

50. The expected value of HSR's donor restricted funds at closing will be approximately $26 million. Applicants state that any charitable funds that cannot be transferred to YNHH or a YNHH affiliate will be used by HSR at or for the benefit of the HSR campus and consistent with donor intent. In the event that some charitable funds cannot be used for the benefit of HSR or consistent with donor intent, donors will be asked by HSR to consent to a transfer to YNHH or a revised charitable purpose, or the parties will seek court intervention to modify the donation in a manner that such funds may be used by YNHH or used to fund activities that benefit the delivery of health care services in the greater New Haven area consistent with the ERD Services. Ex. F, p. 144; Tr., James Rude, Assistant Vice President of Finance and acting interim Chief Financial Officer of HSR, pp. 69-72.

51. HSR currently provides the following community-based programs and each is expected to continue following the closing of the transaction: Father Michael J. McGivney Cancer Center in Hamden, Occupational Health Program, Blood Draw Centers in Amity/New Haven and Hamden, Midwifery Services in Shelton, Geriatric Assessment Centers in Branford and Hamden; ElderCare Geriatric Clinics; Project Mothercare; Smiles to Go! Dental Van, School-based health clinics, CareCard, Lifeline, Parish Nurse, WIC, Nurturing Families Network, New Haven Healthy Start, Project Brotherhood, Sister to Sister Program, Off Campus Classroom, H.O.P.E., AIDS/HIV Services, Bereavement Support Programs and the Family-Based Recovery Program. Ex. F, pp. 106-109.

52. It is expected that both campuses will continue to provide general medical/surgical, cardiology, vascular surgery, urology, psychiatric, low-risk obstetrical, gynecological, dentistry and non-trauma emergency services. Certain subspecialties will be consolidated on one campus. Ex. F, pp. 151-152.

53. The establishment of a musculoskeletal institute, including orthopedics, pain management, spine, rehabilitation, podiatry, and possibly a bariatric surgery program, is being planned for the HSR campus. Ex. F, p. 152.

54. Cardiac surgery, pediatrics, high risk obstetrics, trauma and medical, thoracic, gynecologic, surgical and breast oncology will likely be located on the YNHH campus. With regard to cardiac surgery, YNHH has made significant investments in its cardiac surgery program and can accommodate volume for both campuses. With regard to trauma, YNHH offers a Level I adult and pediatric trauma center, while HSR has a Level II trauma center. Following the acquisition, a single location for trauma will be established at YNHH. This is expected to simplify transport from the field. With regard to pediatrics, inpatient pediatric care is highly specialized, and HSR currently transfers almost all pediatric patients to YNHH. With regard to high risk obstetrics, HSR currently refers most of its high risk obstetrical cases to YNHH. In addition, Applicants state that high-risk obstetrics should be located in the same building as a Level III nursery, which YNHH currently has. Finally, with regard to oncology services, the Smilow Cancer Hospital's infrastructure along with Yale University Medical School's designation as a NCI-Comprehensive Cancer Center, make the YNHH campus the preferred campus for cancer treatment. Ex. F, pp. 151-152.

55. YNHH currently has two designated adult trauma bays and will have four following its current emergency department renovation which is scheduled to be completed in December, 2013. Based on FY 2011 trauma cases, HSR's trauma volume represents an additional 2.3 trauma cases per day to YNHH, and Applicants indicate that HSR's volume can be accommodated on the YNHH main campus. Ex. H, pg. 292; Tr., Testimony of Peter Herbert, M.D., pp. 74-75.

56. The acquisition will result in expanded facilities for ambulatory services such as outpatient clinics, community based practices and programs, radiation therapy and imaging services and will also improve access to healthcare services for YNHH patients. The acquisition will also create greater economies of scale and efficiencies and will eliminate duplication of investments and maximize capacity while also allowing it to focus on primary care development. As part of its clinical integration activities, YNHH will convert the internal medicine training programs for both YNHH and HSR into a primary care medicine program to expand the availability of such physicians in the community. Ex. A, p. 35; Tr., Testimony of Peter Herbert, M.D., pp. 44-45.

57. A major benefit of the proposed acquisition is the opportunity to expand the use of Epic to the YNHH and HSR campuses, outpatient services areas and physicians. The benefit of such a system is the ability to access consistent, clinical information across the health care continuum, reducing the need for duplicate tests and procedures and providing patients access to their clinical records. Such a system improves patient safety by providing a list of the patient's current medications, allergies, medical conditions and medical/surgical history and inserting such data directly into the patient's medical record without the time and potential errors of having a clinician write, then type, the information. Applicants estimate that the installation of the Epic system at HSR will cost approximately $30 million less if done as part the overall YNHH installation as opposed to being done by HSR on a standalone basis. Ex. A, p. 52; Ex. M, Pre-file Testimony of Alan Kliger, M.D., Senior Vice President, Chief Medical & Quality Officer of SRHS, pp. 340-341.

58. YNHH expects that it will initially secure short-term financing to raise the $160 million being paid for purchase of the assets and will secure long-term financing for this amount approximately two months after closing. YNHH's lead underwriter on the transaction (Barclays Capital) has done debt capacity evaluations and projections of special interest to rating agencies and, from this work, YNHH has concluded that the hospital has the ability to obtain necessary funding for the transaction. Ex. A, p. 46; Ex. F, p. 154; Tr., Testimony of Vincent Tammaro, p. 65.

59. HSR projects that, without approval of the CON proposal, it will incur a deficit of approximately $4.1 million in FY 2012 followed by deficits of approximately $8 million, $15 million and $17 million in FYs 2013 through 2015, respectively. Ex. A, p. 234.

60. SRHS projects that, without approval of the CON proposal, it will incur a deficit of approximately $6.1 million in FY 2012 followed by deficits of approximately $10.5 million, $18 million and $21 million in FYs 2013 through 2015, respectively. For the seven months ending April 30, 2012, SRHS provided financial statements reporting a net operating loss of $3.5 million. Ex. A, p. 233; Ex. P, p. 362.

61. YNHH projects that, if the CON proposal is approved, it will incur a deficit incremental to the CON of approximately $11.9 million in FY 2012 due to one-time acquisition costs associated with the transaction, thereby reducing its total projected surplus of $82.9 million to $71 million for the fiscal year. Thereafter, YNHH projects a total surplus incremental to the CON of $12.3 million, $16.5 million and $24.4 million in fiscal years 2013 through 2015, respectively. For the seven month ending April 2012, YNHH provided financial statements reporting a net gain of $45.7 million. Ex. A, p. 231; Ex. P, p. 355.

62. Applicants engaged a consultant (Deloitte) to help identify cost savings that could be achieved through the acquisition. The combined hospital will be able to achieve a cost savings of approximately $700 million, derived from capital cost avoidance savings of almost $400 million and operational cost savings of approximately $300 million, over the first five years. The capital cost avoidance savings is largely the result of avoiding the need to construct a fifth bed tower and not replacing certain capital equipment (DaVinci robot, PET, CT), and the operational cost savings is largely the result of labor cost savings and savings in contractual obligations resulting from the integration of various business functions and medical specialties. The operational costs savings were separated into two parts: infrastructure (non-clinical) cost savings and clinical cost savings. The infrastructure cost savings are expected to result from the integration of various business functions (including, but not limited to, finance, human resources, information technology, marketing, strategic planning and legal) across the two campuses. On the clinical side, Applicants indicate that the cost savings over the first five years after closing are expected to be almost $26 million. In addition, because estimates for the cost of the 5th bed tower have increased over time, the Applicants expect that total cost savings from the acquisition appear likely to exceed the amount calculated durmg the Deloitte engagement. Ex. F, pp. 127-128.

DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes and the Applicant bears the burden of proof in this matter by a preponderance of the evidence. Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008); Steadman v. SEC, 450 U.S. 91, 101 S.Ct. 999, reh'g den., 451 U.S. 933 (1981); Bender v. Clark, 744 F.2d 1424 (10th Cir. 1984); Sea Island Broadcasting Corp. v. FCC, 627 F.2d 240, 243 (D.C. Cir. 1980).

SRHS is the parent company of HSR and YNHHS is the parent company of YNHH. FF 2, 4. HSR and YNHH are both acute care general hospitals located in New Haven, Connecticut. FF 1, 3. The two hospitals are integral parts of the health delivery system in the region. FF 19. Pursuant to Applicants' proposal, YNHH would acquire certain assets of SRHS, including HSR, with the result being YNHH operating a single, acute care hospital with two inpatient campuses and multiple outpatient satellites. FF 5, 6. Applicants base the need for their proposal on HSR's significant financial losses in recent years, which have required reductions in operating expenses, including limiting employee benefits and delaying capital investments, and increased demand for inpatient bed capacity at YNHH. FF 7.

HSR has experienced a decrease in its annual patient days in all service areas, including medical/surgical, since FY 2009. FF 19. In addition, HSR has received a "going concern" qualification in each auditor's report accompanying its audited financial statements since FY 2008, ceased all post-retirement pension benefit accruals for all employees effective during FY 2010 without being able to reinstitute them, and reported low liquidity and solvency measures in terms of long term debt to capital and days cash on hand since FY 2008. FF 20. HSR also reported that the average age of its physical plant rose to 26.1 years in FY 2011 and provided a list of capital needs totaling over $132 million that have been deferred, postponed or cancelled due to its deteriorating financial condition. FF 22, 23. SRHS' financial statements for the month ending April 2012 also show a year-to-date operating loss of over $3.5 million and the Chief Executive Officer of HSR testified that HSR's current operation as an independent hospital is unsustainable. FF 16, 60.

YNHH has experienced increased demand for inpatient beds in recent years that it attributes to growth of its specialty care services and increased referrals of high acuity patients from health care providers both inside and outside Connecticut. FF 29-31. YNHH described its efforts to manage length of stay, but nonetheless indicated that continued length of stay reduction will be challenging due to the high acuity of its Y Access Line patients. FF 35. To create more inpatient capacity, YNHH has contemplated the construction of a 5th bed tower on its main campus at an estimated capital cost of $622 million. FF 35. YNHH claims it has pursued the acquisition of HSR because it presents a more cost effective and timely option for increasing acute care bed capacity than constructing the new bed tower. FF 36. Applicants have projected the bed utilization for YNHH after the acquisition of HSR to be 79%, 79%, 80%, 81% and 83% in FYs 2012 through 2016, respectively. FF 38.

Portions of the $160 million purchase price for SRHS' assets will be used to extinguish HSR's long-term debt and to fund the shortfall in its pension plan. FF 27, 28. In addition, during the first

five years after closing, YNHH plans to spend $129.5 million on capital expenditures at the HSR campus to address infrastructure improvements and routine capital needs as well as provide technology integration and implementation of the Epic electronic medical record system. FF 39. Given the challenges faced by HSR, this acquisition will help ensure continued access for Connecticut residents to hospital services on its campus while also allowing for enhancements in patient care through infrastructure improvement and technology investments at that location. FF 26. The acquisition of HSR will also provide YNHH with additional bed capacity without the capital expenditure and delay associated with new construction. FF 36.

OHCA expects that a single hospital provider with two campuses will create greater economies of scale and efficiencies and will eliminate duplication of investments and maximize capacity at both locations. FF 56. However, OHCA will monitor this process further due to Applicants' inability to submit a transition/operating plan identifying the timing and process to integrate clinical, support and infrastructure services for the combined hospital.

It is anticipated that both campuses will continue to provide general medical/surgical, cardiology, vascular surgery, urology, psychiatric, low-risk obstetrical, gynecological, dentistry and emergency services. FF 52. With respect to hospital services that may be consolidated in one location, it is expected that the HSR campus will house a new musculoskeletal institute, including orthopedics, pain management, spine, rehabilitation, podiatry, and possibly a bariatric surgery program. FF 53. On the other hand, cardiac surgery, pediatrics, high-risk obstetrics and trauma services as well as medical, thoracic, gynecologic, surgical and breast oncology services are expected to be consolidated on the existing YNHH campus. FF 54. YNHH affirmed its ability to handle the trauma cases shifted from HSR in its Emergency Department, which is presently being renovated, and it is further expected that the acquisition will result in expanded facilities for outpatient clinics, community based practices and programs, as well as radiation therapy and imaging services. FF 55, 56. In addition, YNHH plans to adopt financial assistance policies that are broader than HSR's on its new campus, and each of the numerous community-based programs currently operated by HSR is expected to continue following the closing of the transaction. FF 47, 51. Accordingly, OHCA finds that access to quality health care in the region will be maintained and improved by this proposal.

OHCA also finds that the Applicants' projected cost savings of approximately $700 million over the first five years following the closing appear reasonable and achievable. However, OHCA will monitor this process further to determine if such savings are actually realized. The projected cost savings are broken down into capital cost avoidance savings of almost $400 million and operational cost savings of approximately $300 million. The capital cost avoidance savings are expected to result from avoiding new construction for bed capacity and not replacing certain capital equipment (DaVinci robot, PET, CT), and the operational cost savings are expected to result from labor cost savings and savings in contractual obligations resulting from the integration of various business functions and medical specialties. FF 62. YNHH also plans to enter into budget neutral payer agreements that will not cause managed care companies or self-funded employers to be adversely affected by the HSR acquisition and stated that it has no plans to raise charges as a result of this transaction. FF 48. Accordingly, this proposal should achieve savings that will improve the cost effectiveness and efficiency of the health care delivery system in the region and make it more efficient.

In summary, OHCA finds that the Applicants have demonstrated a clear public need for the proposed transaction and, by avoiding further financial losses and possible insolvency for HSR, the acquisition of SRHS's assets by YNHH will positively impact the financial strength of the state's health care system. As Applicants have represented that specific service integration and cost savings will occur as a result of the acquisition, OHCA, as set forth in the Order, herein, establishes conditions to monitor the transition.

ORDER

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access, and Yale-New Haven Hospital ("YNHH"), the Saint Raphael Healthcare System ("SRHS") and Hospital of Saint Raphael, Inc. ("HSR") hereby stipulate and agree to the terms of settlement with respect to the acquisition of certain assets of SRHS, including HSR, as follows:

1. Within five (5) calendar days of the closing of YNHH's acquisition of certain assets of SRHS, including HSR, YNHH agrees to report to the Office of Health Care Access ("OHCA") the date of such and, upon surrender of HSR's acute care hospital license to the Department of Public Health, YNHH shall be authorized to increase its licensed bed capacity from the present 916 licensed hospital beds and 92 bassinets to 1,427 licensed hospital beds and 114 bassinets.

2. The Applicants agree that within sixty (60) calendar days of the closing date, YNHH shall provide OHCA with an unredacted copy of the Asset Purchase Agreement that was provided as Attachment III to the CON Application (Ex. A). The unredacted copy will be entered as part of the permanent record in this proceeding.

3. YNHH agrees to submit to OHCA, no later than January 31, 2013, a detailed and comprehensive document showing the three-year plan ("the plan") to integrate the operations of both hospitals and attain the cost savings stated within the CON Application. At a minimum, the submission shall address the planned location of services and beds, anticipated cost savings, staffing and quality improvements, and merger-related revenue enhancements. Subsequent to the submission of the plan, YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the Order, semi-annual periods are October 1 – March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31, 2013, November 30, 2013, May 31, 2014, November 30, 2014, May 31, 2015, and November 30, 2015. YNHH shall submit the following on a semi-annual basis:

    a. YNHH agrees to file narrative updates on the progress of the implementation of the plan. This would include integration of all affected clinical services including primary care initiatives in the community.

    b. YNHH agrees to report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or

successor report. YNHH will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. YNHH agrees to file a completed Balance Sheet and Statement of Operations for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. YNHH agrees to file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

4. Applicants agree to comply with all state and federal statutes and regulations applicable to all licenses and certificates issued by the Department of Public Health.

5. DPH and YNHH, SRHS, and HSR agree that this Agreed Settlement represents a final agreement between OHCA and YNHH, SRHS, and HSR with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes, which may have been raised by the Applicants with regard to Docket Number 12-31747-CON.

6. This Agreed Settlement is an order of the Department of Public Health Office of Health Care Access with all the rights and obligations attendant thereto, and the Department of Public Health may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Signed by Marna P. Borgstrom Chief Exec. Officer
(Print name) (Title)

6/27/12
Date

Marna P. Borgstrom
Duly Authorized Agent for
The Yale-New Haven Hospital

Signed by JAMES R. RUDE, AVP-FINANCE
(Print name) (Title)

6/27/12
Date

James R. Rude
Duly Authorized Agent for
The Hospital of Saint Raphael

Signed by JAMES F RYDL, AVP-FINANCE
(Print name) (Title)

6/27/12
Date

James F. Rydl
Duly Authorized Agent for
Saint Raphael Health Services

As the designated Hearing Officer in this matter, I respectfully recommend to Deputy Commissioner Lisa A. Davis that she accept and approve the terms of this Agreed Settlement.

6/27/12
Date

Joanne V. Yandow, Esq.
Hearing Officer

The above Agreed Settlement is hereby accepted and so ordered by the Department of Public Health Office of Health Care Access on June 27, 2012.

6/27/2012
Date

Lisa A. Davis MBA, BSN, RN
Deputy Commissioner