State of Connecticut
Office of Health Care Access
Letter of Intent/ Waiver Form (2030)

All applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of OHCA's Regulations. Applicants should submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	The Manchester Memorial Hospital	
DBA (Doing Business As)		
Name of Parent Corporation	Eastern Connecticut Health Network, Inc	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	Eastern Connecticut Health Network, Inc 71 Haynes Street Manchester, CT 06040	
Applicant type (e.g., profit/ non-profit)	Non-profit	
Contact person, including title or position	Dennis McConville V.P. Strategic & Operational Planning	
Contact person's street mailing address	Eastern Connecticut Health Network, Inc 71 Haynes Street Manchester, CT 06040	
Contact person's phone #, fax # and e-mail address	860-533-3429 dmcconvill@echn.org	

SECTION II. GENERAL APPLICATION INFORMATION

Proposal/Project Title:

Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.

☐	New (F, S, Fnc)	☒	Replacement	☐	Additional (F, S, Fnc)
☐	Expansion (F, S, Fnc)	☐	Relocation	☐	Service Termination
☐	Bed Addition	☐	Bed Reduction	☐	Change in Ownership or Control

☒ Capital Expenditure pursuant to Section 19a-639, C.G.S.
- ☒ Project cost greater than $ 1,000,000
- ☐ Equipment Acquisition greater than $ 400,000
  - ☐ New ☐ Replacement ☐ Major Medical
  - ☐ Imaging ☐ Linear Accelerator
- ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

Location of proposal (Town including street address): 71 Haynes Street, Manchester, CT 06040

List all the municipalities this project is intended to serve: Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford/Union, Tolland, Vernon, Willington

Estimated starting date for the project: September 2006

Type of Entity: (Please check E for Existing and P for Proposed in all boxes that apply)

E	P		E	P		E	P	
☒	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Other (specify): (E)_____			(P)_____			

Type of project: 19 **(Fill in the appropriate number(s) from page 4 of this form)**

Number of Beds (to be completed if changes are proposed)

This project does not propose any licensed bed changes

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Capital Expenditure: $ 8,958,167

Please provide the following breakdown as appropriate:

Renovations	$ 7,141,467
New Construction	$
Fixed Equipment	$ 1,500,000
Movable Equipment	$
Fair Market Value of Leased Space	$
Fair Market Value of Leased Equipment	$
Other : Contingency, Legal	$ 316,700

Note: The aggregate of all categories should equal the estimated total capital expenditure.
"Other" includes any category not listed above, (e.g., land acquisition, service agreement, fees, etc.)

Major Medical equipment acquisition: N/A

Unit Type	Model	Name	Number of Units	Cost

Type of financing or funding source (more than one can be checked):

☒ Applicant's Equity
☒ Charitable Contributions
☐ Other (specify): _____
☐ Lease Financing
☐ CHEFA
☐ Conventional Loan
☐ Grant Funding

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following:

1. What are the anticipated payer sources?
2. Identify any unmet need and how this project will fulfill that need.
3. What is the effect of this project on the health care delivery system in the State of Connecticut?
4. Are there any similar existing providers in the proposed geographic area?
5. Why should this project be approved?
6. Who will be responsible for providing the service?
7. Who is the target population?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER INFORMATION

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment
- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____
- ☐ The cost of the equipment is not to exceed $2,000,000
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit.

For Office Use Only:

Action taken:

☐ Waiver Approved
☐ Appropriate Forms Sent
☐ Waiver Denied
List of the forms sent: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Critical Care Unit
3. Hospice
4. Maternity
5. Med/ Surg.
6. Pediatrics
7. Rehabilitation Services
8. Transplants - Bone Marrow
9. Transplants - Organ
10. Trauma Centers
19. Other Inpatient

Outpatient

20. Ambulatory Surgery Center
21. Birthing Centers
22. Imaging Services
23. Lithotripsy
24. Mobile Services
25. Oncology Services
26. Outpatient Rehabilitation Services
27. Paramedics Services
28. Primary Care Clinics
29. Urgent Care Units
39. Other Outpatient

Behavioral Health

40. Detox - Inpatient
41. Detox - Outpatient
42. Psych. Only - Inpatient
43. Psych Only - Outpatient
44. Psych Only - Partial Hospital Program
45. Substance Abuse Only - Inpatient
46. Substance Abuse Only - Outpatient
47. Psych. and Substance Abuse - Inpatient
48. Psych. and Substance Abuse - Outpatient
49. Psych. and Substance Abuse - Partial Hospital Program
59. Other Behavioral Health

Non-Clinical

60. Facility Development
61. Non-Medical Equipment
62. Organizational Structure
63. Renovations
71. Other Non-Clinical

Manchester Memorial Hospital
Intensive Care Unit Replacement
Proposal Summary

The existing Intensive Care Unit at Manchester Memorial Hospital was built in 1969, and is in need of replacement to meet current standards for the environment of care, as well as to improve patient care and comfort. This proposal seeks to replace the existing unit with 12 ICU beds and 10 step down beds, while creating a healing environment that supports both patient privacy and patient and family empowerment. The new design will also allow for flexibility and facilitate transition between intensive care and step down patient areas. The design will improve way-finding and ease of access to the unit for patients and families as well as hospital staff and physicians, will provide improved comfort, and will result in more accessible supportive services.

The current unit was designed under a set of assumptions about patient care and clinical practice which are dated. Physician practice patterns have changed, technology has changed and improved, acuity levels are higher, and staffing patterns have changed. The need for various pieces of technical equipment (e.g., PACS stations) as well as computers for documenting care electronically was not taken into account in the current configuration of space. These deficiencies will be addressed, and the new space will be created with future requirements in mind. The new design will be more flexible and adaptable to the changing needs of our patients as well as our providers.

The payer sources for the patient population to be served by this replacement unit are not expected to change, as the target population to be served is the same population currently served. The providers of care will not change, and the competitive providers in area hospitals will remain the same.

This proposal should be approved to positively impact the health care delivery system of Connecticut by ensuring the availability of state of the art intensive care inpatient services to the communities served by Manchester Memorial Hospital and Eastern Connecticut Health Network.