150 YEARS
1854-2004

29 December 2004

The Honorable Cristine Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Letter of Intent.

Dear Commissioner Vogel:

I have enclosed a completed Letter of Intent for a forthcoming Certificate-of-Need application for our proposal for capital expenditures associated with the replacement of CT scanning equipment. We look forward to submitting our project application to you; and we request from your office the necessary application forms.

Please feel free to contact me if you have any questions about this matter. Thank you.

Sincerely,

J. Bryan Simmons
Vice President for Planning
and Facilities Development

JBS/km

HARTFORD HOSPITAL
80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037 (860) 545-5000 www.harthosp.org
A member of Hartford Healthcare Corporation

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
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-643-79 of OHCA's Regulations. Please 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 there are 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	Hartford Hospital	
Doing Business As		
Name of Parent Corporation	Hartford Health Care Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	J. Bryan Simmons, Vice President for Planning and Facilities Development	
Contact person's street mailing address	80 Seymour Street Hartford, CT 06102-5037	
Contact person's phone #, fax # and e-mail address	860 / 545-2232 phone 860 / 545-3600 fax bsimmon@harthosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of Computed Tomography Scanner.

b. 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/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost 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

c. Location of proposal (Town including street address):
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

d. List all the municipalities this project is intended to serve.

Response: This project is will not change the municipalities, primarily within the Hospital's primary and secondary service areas, served by the Hospital's existing CT Scanning services: The municipalities within these primary and secondary service areas include the following:

Primary Service Area:

Avon	Hartford	Simsbury
Bloomfield	Manchester	South Windsor
Bolton	New Britain	West Hartford
East Hartford	Newington	Wethersfield
Farmington	Rocky Hill	Windsor
Glastonbury		

Secondary Service Area:

Andover	Enfield	Portland
Barkhamsted	Franklin	Preston
Berlin	Granby	Salem
Bozrah	Haddam	Somers
Bristol	Hartland	Southington
Burlington	Harwinton	Stafford
Canton	Hebron	Suffield
Colchester	Lebanon	Tolland
Columbia	Mansfield	Torrington
Coventry	Marlborough	Union
Cromwell	Meriden	Vernon
East Granby	Middlefield	Wallingford
East Haddam	Middletown	Winchester
East Hampton	New Hartford	Windham
East Windsor	Norwich	Windsor Locks
Ellington	Plainville	

e. Estimated starting date for the project: 1 June 2005.

f. Type of project: 10, 20 **(Fill in the appropriate number(s) from page 7 of this form)**

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

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ 2,750,400

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$ 152,400
Medical Equipment (Purchase)	$ 410,000
Imaging Equipment (Purchase)	$2,200,000
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$2,762,400**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$2,762,400**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CT Scanner	TBD	TBD	1	$2,200,000

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.
Response: Because the exact model has not yet been selected and purchased, a copy of the contract is not yet available. We would be happy to furnish it when the contract has been signed.

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

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☒ Funded Depreciation ☐ Other (specify): _____

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 (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

3. Who is the current population served and who is the target population to be served?

4. Identify any unmet need and how this project will fulfill that need.

5. Are there any similar existing service providers in the proposed geographic area?

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

7. Who will be responsible for providing the service?

8. Who are the payers of this service?

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

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

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 Section V only.

Project Description:

This is a proposal to replace an existing computed tomography (CT) scanner with a new scanner and to complete minimal facilities changes to accommodate the replacement equipment. The existing scanner is approximately eight years old, fully depreciated and technically limited. Recognizing the technical and clinical advances in computed tomography imaging, the proposed replacement scanner will feature "multi-slice" and fluoroscopic capabilities that will permit the performance of the entire array of CT imaging procedures with enhanced speed and resolution. This will include enhanced imaging of vascular structures, including the heart, coronary arteries and other anatomy, thus providing diagnostic detail not previously possible.

With regard to specific questions within the Letter of Intent form, the following information is provided:

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

   Response: Hartford Hospital currently provides routine and emergency CT scanning services 24 hours a day, seven days a week. The proposed replacement unit is expected to be available during these hours, but expected primarily to operate from 7:00 a.m. to 11:00 p.m. daily. The actual schedule will be dictated by patient care needs. This proposal will not affect the Hartford Hospital license issued by the Department of Public Health.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

   Response: This proposal involves the continuation of existing CT scanning services with replacement equipment. However, given the evolution of CT scanning and imaging capabilities, it is anticipated that services will be broadened to include cardiovascular imaging applications that the existing scanner is unable to perform. The replacement scanner will provide functional and anatomical images of the heart. These may include the quantification of coronary calcifications and vascular lesions as well as cardiac ventricular functional analysis. No changes in the Hospital's existing DPH license will be sought.

3. Who is the current population served and who is the target population to be served?

   Response: The current population served generally resides in the municipalities within the Hospital's primary and secondary service areas (listed above within the response to question II. d), although patients arrive at Hartford Hospital for care from throughout New England and beyond. The target population would remain unchanged by this proposed project.

4. Identify any unmet need and how this project will fulfill that need.

   Response: This application is not based on a specific unmet need, but on the continuing need to assure that clinical equipment at Hartford Hospital is appropriately replaced in a timely manner to assure the continued delivery of the highest quality services.

5. Are there any similar existing service providers in the proposed geographic area?

Response: Other hospitals within the Greater Hartford area that provide CT scanning services include Manchester Memorial Hospital, New Britain General Hospital, John Dempsey Hospital, and St. Francis Hospital and Medical Center.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

   This proposal is anticipated to assure the continuing quality of the health care delivery system within the State by assuring that clinical equipment, at the end of its useful life, at a centrally located tertiary acute care hospital, is replaced in an appropriate and timely manner.

7. Who will be responsible for providing the service?

   Response: Hartford Hospital will continue to be responsible for providing CT scanning services.

8. Who are the payers of this service?

   Response: The current payers of this service include Medicare, Medicaid, Anthem Blue Cross, Aetna, and Connecticare. There is no change in the payers of this service associated with this proposal.

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. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 13, 2005

Mr. J. Bryan Simmons
Vice President for Planning and Facilities Development
Hartford Hospital
80 Seymour St.
Hartford, CT 06102

Re: Letter of Intent, Docket Number 04-30419
Hartford Hospital
CT Scanner Replacement
Notice of Letter of Intent

Dear Mr. Simmons:

On December 29, 2004, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hartford Hospital ("Applicant") for a CT Scanner replacement, at a total capital expenditure of $2,762,400.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Hartford Courant* pursuant to Section 19a-639(c) of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:JH:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 13, 2005

Purchase Order # HCA05-151
FAX: 241-3866
Account # 700309

The Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Monday, January 17, 2005.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:bko

c: Kathy Howe, OHCA

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-639(c) of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant:	Hartford Hospital
Town:	Hartford
Docket Number:	04-30419
Proposal:	CT Scanner Replacement
Total Capital Expenditure:	$2,762,400

The Applicant may file its Certificate of Need application between February 27, 2005 and April 28, 2005. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

1ST

Request for Letter of Intent Newspaper Notice

Print Form | Close Form

Docket Number: 30419 | Laurie Greci

Title: CT Scanner Replacement

Desc: Replace 8 year old CT scanning unit

Estimated Total Capital Expenditure: $2,762,400

Location: Hartford | LOI Deemed Completed o: 12/29/2004

Applicant: Hartford Hospital

Contact: Mr. | J. Bryan | Simmons

Title: Vice President for Planning and Facilities Develop

Address: 80 Seymour Street

Hartford | CT | 06102 | 5037

Earliest Date: Sunday, February 27, 2005 | Latest Date: Thursday, April 28, 2005

Enter Statute(s): 19a-639(c)

Provide the following information before printing form:	***Enter the Date to put on Document:*** 1/13/2005	***Enter Date Document is Requested for:*** 1/13/2005

List of Newspapers

Hartford Courant

Note: Only the grayed out fields allow data entry or editing. If you need to change any of the information you must change it from within the database, not here on this form. Also, if your LOI has more than one applicant, you'll see more than one form displayed. You only need to fill in the info for dates and newspapers on the first form displayed.

Docket Number: 30419 | Jack Huber

Title: CT Scanner Replacement

Confirmation Report – Memory Send

Time : Jan-13-2005 14:25
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	868
Date	:	Jan-13 14:24
To	:	92413866
Document pages	:	002
Start time	:	Jan-13 14:24
End time	:	Jan-13 14:25
Pages sent	:	002
Status	:	OK

Job number : 868 *** SEND SUCCESSFUL ***

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 13, 2005

Purchase Order # HCA05-151
FAX: 241-3866
Account # 700309

The Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

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If there are any questions regarding this legal notice, please contact Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:bko

c: Kathy Howe, OHCA

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 13, 2005

J. Bryan Simmons
Vice President for Planning and Facilities Development
Hartford Hospital
80 Seymour Street
Hartford, CT 06102 5037

RE: Certificate of Need Application Forms, Docket Number: 04-30419-CON
Hartford Hospital
CT Scanner Replacement

Dear Mr. Simmons:

Enclosed are the application forms for Hartford Hospital's Certificate of Need ("CON") proposal for the CT Scanner Replacement with an associated capital expenditure of $2,762,400.

According to the parameters stated in Section 19a-639 of the Connecticut General Statutes as amended by Public Act 03-17, the CON application may be filed between February 27, 2005, and April 28, 2005.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and two hard copies; as well as an electronic copy on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Pro Forma and other data as appropriate be in MS Excel format.

The OHCA analyst assigned to the CON application is Jack Huber. Please feel free to contact him at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053

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

Please complete all questions. If any question is not relevant to your project, Not Applicable will be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than February 27, 2005, and may be submitted no later than April 28, 2005. The Analyst assigned to your application is Jack Huber and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 04-30419-CON

Applicant Name: Hartford Hospital

Contact Person: J. Bryan Simmons

Contact's Title: Vice President for Planning and Facilities Development

Contact's Address: Hartford Hospital
80 Seymour Street
Hartford, CT 06102 5037

Project Location: Hartford

Project Name: Computed Tomography Scanner Replacement

Proposal Type: Section 19a-639(c), C.G.S.

Estimated Capital Expenditure: $2,762,400

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, Change of Ownership, Service Termination. **No Fee Required**.	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required**.	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **Fee Required**.	
_____ 19a-638 and 19a-639. **Fee Required**.	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	$_____.00
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

w:\cert\conforms\confeenew

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Hospital for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology
☐ National Committee for Quality Assurance
☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers
☐ American College of Obstetricians & Gynecologists
☐ American College of Surgeons
☐ Report of the Inter-Society Council for Radiation Oncology
☐ American College of Radiology
☐ Substance Abuse and Mental Health Services Administration
☐ Other: Specify _____

B. Describe in detail how the Hospital plans to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Hospital's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

D. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH
☐ JCAHO
☐ Fire Marshall Report
☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC
☐ AAAASF
☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital, Physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any corrective plan of action which has been formulated to address the above action against the Hospital, Physician(s) working at the Hospital and/or any staff related to the proposal.

G. Provide a copy of the related Quality Assurance plan.

6. Improvements to Productivity and Containment of Costs

In the past year has your organization undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new or modified teaching/research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide a copy of the State of Connecticut Department of Public Health license currently held.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Hospital that has filed its most recently completed fiscal year audited financial statements, the Hospital may reference that filing for this proposal.

ii) Provide the latest cash equivalent balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	$
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	$
Capitalized Financing Costs	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide an itemization of the proposed new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	____ Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	Please submit a schedule of depreciation for the purchased equipment as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:

i. Letter of interest from the lending institution,

ii. Letter of interest from CHEFA,

iii. Amortization schedule (if not level amortization payments),

iv. Lease agreement.

13. Revenue, Expense and Volume Projections

A. Payer Mix Projection

Please provide the Hospital's current payer mix and the projected payer mix with the CON proposal for the Total Hospital based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

B. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

C. Provide the following for the financial and statistical projections:

i) A summary of Hospital's revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please refer to Financial Attachment F.** Please note that the actual results for the fiscal year reported in the first column must agree with the Hospital's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Please explain how the CON proposal will affect the rate structure of the Hospital?

v) Describe how this proposal is cost effective.

13. B(i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.