150 YEARS
1854-2004

31 March 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 renovation of patient rooms and common areas in the Donnelly Building, on the IOL portion of the Hospital's campus. 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 St. PO 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 St. 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:

Donnelly Building Patient Room Refurbishment Project

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):
200 Retreat Ave., Hartford, Connecticut (Institute of Living campus)

d. List all the municipalities this project is intended to serve:
This project will primarily serve greater Hartford cities and towns, although many patients are likely to come from elsewhere in Connecticut, and some from out of state.

e. Estimated starting date for the project: 31 March 2004.

f. Type of project: _____**9 & 31**_____ **(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
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $2,600,000

b. Please provide the following breakdown as appropriate:

Construction/Renovations	**$2,600,000**
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$2,600,000**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$2,600,000**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

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): _____

(Note: possibility of some donations as well.)

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.

AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that _____ complies with the appropriate and
(Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

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

Section IV: Project Description

This project entails the refurbishment of patient rooms and bathrooms and selected common areas and support spaces within the Donnelly Building. The Donnelly Building, which is located on the Institute of Living portion of the Hospital's campus, houses the Hospital's inpatient psychiatric units. This refurbishment would include the replacement of flooring and wall and ceiling finishes in all patient rooms and the replacement of plumbing fixtures and the finishes of the bathrooms associated with each room.

The Donnelly Building was completed in 1981 and has been fully occupied for the past 22 years. Most patient rooms are in need of upgrades to their finishes and flooring due to the age and intensive use of the facility. The proposed project would upgrade both the aesthetics and functionality of the wall and floor finishes within the patient rooms through the use of modern, durable, moisture-resistant materials that reflect the residential-style design typically used in IOL patient areas, and yet provide the physical environment for the full range of services required by behavioral health patients. Additional related improvements, such as increasing the capacity of the bathroom exhaust vents, will be incorporated into the project as necessary.

The project is intended to be carefully phased, to minimize the disruption of care on the units. To accommodate ongoing patient care requirements, it is anticipated that patient care units will be relocated, one-by-one, to permit the refurbishment of the space vacated, in approximately six phases. It is therefore estimated that the project will require approximately twenty-four months for completion.

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: The services being provided in the Donnelly Building are inpatient behavioral health services.

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

Response: The type of services will not be changed in any way by this proposed project.

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

Response: The current population, which will not be changed by the project, consists of psychiatric inpatients.

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

Response: While there is no region-wide unmet need that this project is intended to fulfill, the project will fulfill the need for modern, appropriately configured care facilities for an existing patient care population.

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

Response: Yes. Inpatient behavioral health services are provided in the Greater Hartford area by John Dempsey Hospital, Manchester Memorial Hospital, New Britain General 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?

Response: This project would have no effect on other providers; its effect on the patients of the Institute of Living would be to improve the condition of their bedrooms and bathrooms.

7) Who will be responsible for providing the service?

Response: Hartford Hospital's Behavioral Health Network at the Institute of Living will provide this service.

8) Who are the payers of this service?

Response: There will be no change in payers of service as a result of these proposed renovations. The Hospital's current payers include Medicare, Medicaid, Anthem Blue Cross, Aetna, and Connecticare.