MidState
Medical Center
HARTFORD HEALTHCARE

May 4, 2007

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

Re: Emergency Department and Facility Expansion Project

Dear Commissioner Vogel:

Pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of the Office of Health Care Access Regulations, MidState Medical Center is pleased to submit for your consideration the above referenced Letter of Intent (LOI).

Enclosed please find one (1) original and three (3) copies of the LOI and Hospital Affidavit, for the Emergency Department and Facility Expansion Project located at 435 Lewis Avenue, Meriden, Connecticut.

I would like to take this opportunity to thank you and your staff for the time and consideration you have already afforded MidState. I look forward to working with you on this project.

Sincerely,

Lucille Janatka

Lucille Janatka
President and Chief Executive Officer

cc: Susan Cole

File: LOI Cover.doc

435 Lewis Avenue, Meriden, Connecticut 06451

phone | 203 694 8200 fax | 203 694 7601 web | www.midstatemedical.org

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 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 this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	**MidState Medical Center**	**None**
Doing Business As	**MidState Medical Center**	
Name of Parent Corporation	**Hartford Healthcare Corporation**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	**435 Lewis Avenue Meriden, CT 06451**	
What is the Applicant's Status: P for Profit or NP for Nonprofit	**NP, Acute Care, General Hospital**	
Does the Applicant have Tax Exempt Status?	**Yes** No	Yes No **N/A**
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	**Karen T. Goyette Director of Business Development**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**435 Lewis Avenue Meriden, CT 06451**	

Contact Person's Telephone Number	**(203) 694-8009**	
Contact Person's Fax Number	**(203) 694-7601**	
Contact Person's e-mail Address	**Kgoyette@midstatemedical.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Emergency Department and Facility Expansion Project

b. Type of Proposal, please check all that apply:

X 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)

F Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

F Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

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

X Project expenditure/cost cost greater than $ 3,000,000

☐ Equipment Acquisition

☐ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

The proposed project would include an expansion to the existing Hospital campus located at 435 Lewis Avenue, Meriden, Connecticut.

d. List each town this project is intended to serve:

It is anticipated that the proposed project would serve MidState Medical Center's existing Service Area. MidState's service area includes the towns of: Berlin, Cheshire, Durham, Meriden, Middlefield, Middletown, Southington, and Wallingford.

e. Estimated starting date for the project: **Upon CON Approval.**

f. Type of project: **4, 9 and 17**
(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 or (Decrease)	Proposed Total Licensed
Medical / Surgical	**130**	**130**	**+ 30**	**160**

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$45,589,500**

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	**$4,645,000**
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	**$400,000**
Land/Building Purchases	
Construction/Renovation	**$32,662,500**
Other (Non-Construction) Specify: **Services & Contingency**	**$7,882,000**
Total Capital Expenditure	**$45,589,500**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	**$45,589,500**
Capitalized Financing Costs (Informational Purpose Only)	**$500,000**

* Provide an itemized list of all non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☒ Yes

If you checked "Yes" above, please check the appropriate box below:

☐ Energy ☐ Fire Safety Code ☒ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Letters of Support for the proposed expansion of MidState Medical Center are included as Exhibit I.

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 vendor contract or quotation for the major medical/imaging equipment.

This question is not applicable. MidState Medical Center is not proposing the acquisition of any major medical equipment as a part of this application.

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

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

SECTION IV. PROJECT DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

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

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

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

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

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

Project Description

MidState Medical Center is proposing an expansion to it's existing campus located at 435 Lewis Avenue, in Meriden, Connecticut. The proposed project would include the construction and renovation of approximately 105,000 square feet, and would include the addition of a four (4) story Pavilion that would be oriented on the South end of the existing campus.

The facility expansion project would include the following key aspects:

- **Expansion of the existing Emergency Services Department, including twenty-four (24) additional treatment spaces;**
- **Addition of thirty (30) inpatient medical / surgical beds;**
- **Re-distribution of the remaining inpatient psychiatry "swing" beds to a medical / surgical use;**
- **Creation of a covered Hospital main entrance, lobby, and patient "drop-off" area; and**
- **Construction of approximately 35,000 square feet of shelled space for a future outpatient service, medical office and/or inpatient use.**

Emergency Department Expansion

It is estimated that the Emergency Department (ED) at MidState Medical Center will treat nearly 50,000 patients in FY07* (*based on actual visits for the first six months of FY07, October 2006 – March 2007). This represents a 10% increase in overall emergency department visits from FY02-07, and a 29% increase in ED visits that result in a hospital admission during the same timeframe. A detailed summary of annual ED visits from FY02-07 is included on the following page as Figure 1.

Figure 1.

Fiscal Year / Visits	2002	2003	2004	2005	2006	2007*	FY02-07 Change/Average
ED Admissions	4,784	4,838	5,087	5,922	5,913	6,150	*29%*
ED Non Admissions	40,661	40,423	39,255	40,211	41,519	43,756	*8%*
Total	45,445	45,261	44,342	46,133	47,432	49,906	*10%*
Annual Increase		-0.4%	-2.0%	4.0%	2.8%	5.2%	*2%*
Percent ED Admit		10.7%	11.5%	12.8%	12.5%	12.3%	*12%*

When MidState Medical Center opened in September of 1998 (Docket Number 92-567), it was estimated that the annual ED visit volume would be 26,000 visits and twenty-four (24) treatment spaces were established to service that volume. In 2002, under Docket Number 01-566, MidState added an additional six (6) treatment spaces to the existing emergency services department, bringing the total number of treatment spaces to 30. Based on an analysis of historical ED visit volume and SA population trends, it is projected that MidState will treat approximately 56,000 ED patients in FY2011 – which is more than double the capacity of the original ED.

The addition of twenty-four (24) treatment spaces within the ED, combined with multiple operational improvement initiatives undertaken by the ED (including a Patient Throughput Action Group – which benchmarks various ED service indicators such as length of stay, length of time to be seen, and ancillary testing turn around times), will allow MidState the capacity to serve the existing and projected demand for emergency services within our existing SA.

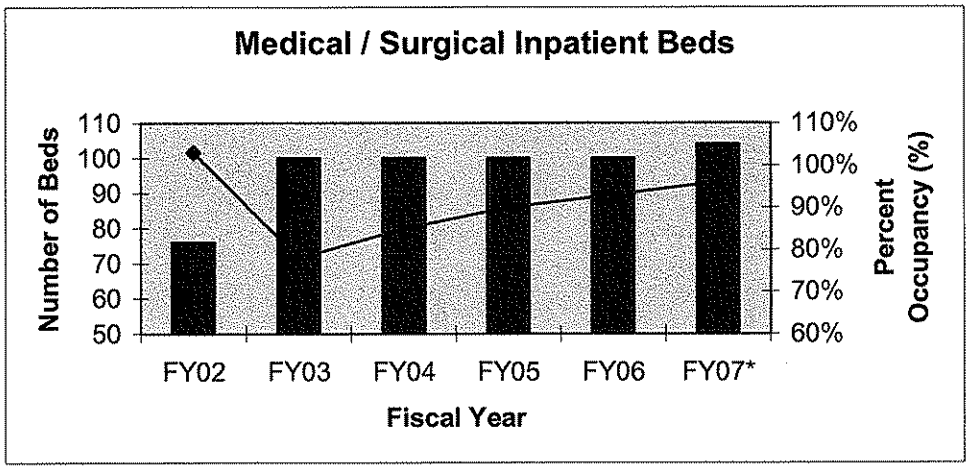
Inpatient Capacity

In FY06, MidState had 35,217 inpatient medical / surgical inpatient days – which represents a 23% increase over the last five years (FY02-06). In addition, due to the continued increase in the

proportion of the population that is 65+ years of age and the associated complexity of illnesses - it is projected that MidState's inpatient medical / surgical patient days will exceed 47,000 by FY015.

During the first six months of FY07, MidState Medical Center operated at 96% occupancy for inpatient medical / surgical beds. Figure 2 highlights MidState's occupancy over the past five years.

Figure 2.



Based on an efficient average industry standard of 90% occupancy for inpatient medical / surgical beds - MidState would need 147 beds to meet this demand.

Psychiatric Services

MidState is also proposing a re-distribution of it's existing inpatient psychiatric bed component at this time. Under the Hospital's original Docket 92-567, the Hospital established a ten (10) bed "swing unit" which would have the ability to serve either psychiatric or medical/surgical patients. However, due to ongoing medical/surgical occupancy constraints the service has operated as a 6 bed unit for the past year.

Because the unit is small, and serves the diverse needs of the inpatient psychiatric population – MidState has established a strong relationship with the Institute of Living (IOL), which allows the Hospital to stabilize and transfer psychiatric patients to a more appropriate setting. Currently, at any one time there can be patients with various psychiatric diagnosis (i.e. substance abuse, anorexia, depression, etc.) within the same unit.

Based on this, MidState is proposing an increase in dedicated psychiatric treatment spaces within the ED from four (4) to eight (8) spaces (including appropriate support spaces). This system-wide initiative would ensure psychiatric patients would be assessed by clinical staff, and if an inpatient stay is required, transferred to a facility (IOL) that has the capacity to serve this diverse population.

Conclusion

The proposed project will provide MidState Medical Center with the capacity to serve the existing emergency and inpatient care needs of it's existing service area. In addition, because the project's target population includes patients within our existing service area and those who currently seek services at MidState Medical Center – there will be no negative impact on other providers of acute care services.

AFFIDAVIT

To be completed by each Applicant

Applicant: **MidState Medical Center**

Project Title: **Emergency Department and Inpatient Facility Expansion Project**

I, **Lucille Janatka**, (Name) **President & Chief Executive Officer** (Position – CEO or CFO)

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

Lucille Janatka
Signature

5/4/07
Date

Subscribed and sworn to before me on the 4th day of May, 2007

Betsy G DuBois
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 12/31/11

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. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

EXHIBIT I

City of Meriden, Connecticut

OFFICE OF THE MAYOR

142 East Main Street, City Hall • Meriden, CT 06450
TELEPHONE (203) 630-4125 • FAX (203) 639-7008
E-Mail: mbenigni@ci.meriden.ct.us

MARK BENIGNI
MAYOR

April 5, 2007

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

Dear Commissioner Vogel:

On behalf of the City of Meriden, I would like to extend my support for MidState Medical Center, as you consider the application submitted by the Hospital of Saint Raphael for the Establishment of a Satellite Emergency Department to be located on the North Haven/ Wallingford town line area.

The City of Meriden is very proud to have access to an established, full-service, health care facility – in our own backyard. MidState has been consistently rated among the top hospitals in the State and in the nation for patient satisfaction, based on surveying conducted quarterly by an independent, national research company.

Located a minute off Route 691 in Meriden, MidState features free safe parking, private inpatient rooms, general surgery, emergency medicine and state-of-the-art health services in centers dedicated to cancer care, wound and hyperbaric care, family birthing, digestive health and cardiac care. MidState provides patients within our community the highest level of care.

MidState Medical Center has proven to be responsive to an ever-changing healthcare environment, developing new programs and services within our community as appropriate, investing in new technology, and most recently evaluating plans for emergency room expansion to the existing campus on Lewis Avenue.

The City of Meriden is committed to our collaboration and support of MidState Medical Center as our provider of choice.

Sincerely,

Mark Benigni

Mark Benigni
Mayor
City of Meriden

cc: Lucille Janatka, President and Chief Executive Officer
MidState Medical Center

OFFICE OF THE MAYOR

TOWN OF WALLINGFORD
CONNECTICUT

WILLIAM W. DICKINSON, JR.
MAYOR

45 SOUTH MAIN STREET
WALLINGFORD, CT 06492
TELEPHONE 203 294-2070
FAX 203 294-2073

April 4, 2007

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

Dear Commissioner Vogel:

I am writing in support of the existing urgent care services provided by MidState Medical Center to the Town of Wallingford. MidState Medical Center has a longstanding history of support for the Town of Wallingford; in fact, the Hospital was formerly known as the Meriden-Wallingford Hospital.

Approximately 70% of Wallingford residents who seek emergency hospital care currently select MidState medical Center for their emergency services needs. In addition, the MidState Medical Group Walk-in Center, located in the heart of Wallingford, has been providing evening and weekend urgent care services within our community for the past twenty years.

MidState Medical Center has supported our community for the past 100 years. Over those years, the Hospital has continued to foresee community health care needs that uniquely meet the needs of the public while being conscious of the balance of cost implications for the community they serve. This was most evident when the Meriden-Wallingford Hospital and the World War II Veterans Memorial Hospital combined in 1991, with the support of the Office of Health Care Access. This is one example of a hospital improving access to healthcare services while conserving invaluable financial and capital resources within the community.

Based on the above facts, I would like to express my support for MidState Medical Center and emphasize the hospital's long-standing support to the Town of Wallingford.

Sincerely,

William W. Dickinson, Jr.
Mayor

jms
cc: Lucille Janatka, President and Chief Executive Officer
MidState Medical Center

TOWN OF WALLINGFORD, CONNECTICUT

45 South Main Street, Room 220
Wallingford, CT 06492
(203) 294-2155 Fax (203) 294-0180

April 1, 2007

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

Dear Commissioner Vogel:

I would like to express my support regarding MidState Medical Center.

MidState Medical Center is our local hospital and has provided care to our community for many, many years. It has also performed community health screenings, made educational presentations, and supported area businesses. In addition to a full service emergency department on its main campus, MidState operates an urgent care center in the southeast corner of the city that is highly accessible to Wallingford residents and businesses. Most recently, MidState opened a walk-in center conveniently located on Route 68 in Wallingford.

The Town of Wallingford has a population of over 45,000 individuals, which is expected to increase by 5% over the next five years. Approximately 15% of the population are over 65 and require easy access to many healthcare services and programs. Currently at least 70% of Wallingford residents are using MidState Medical Center to meet those needs. MidState provides ample and multiple access points for care.

I urge you to consider that MidState Medical Center is clearly the primary provider for health care services, specifically emergency and urgent care, for the Town of Wallingford. MidState Medical Center's century long commitment to the community is invaluable

Sincerely,

Robert Parisi
Wallingford Town Council

cc: Lucille Janatka, President and Chief Executive Officer
MidState Medical Center

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 24, 2007

Karen Goyette
Director, Business Development
MidState Medical Center
435 Lewis Avenue
Meriden, CT 06451

RE: Certificate of Need Application Forms; Docket Number: 07-30964-CON
MidState Medical Center's Facility Building Project including Expansion of the ED, Addition of 30 Licensed M/S Beds and Other Facility Improvements

Dear Ms. Goyette:

Enclosed are the application forms for MidState Medical Center's Certificate of Need ("CON") proposal for the above referenced building project with an associated capital expenditure of $45,589,500. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes the CON application may be filed between July 3, 2007, and September 1, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The OHCA analysts assigned to the CON application are Alexis Fedorjaczenko and Jack Huber. Please feel free to contact either analyst at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosure

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 a response of "Not Applicable" will be an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than July 3, 2007, and may be submitted no later than September 1, 2007. The OHCA Analysts assigned to your application are Alexis Fedorjaczenko and Jack A. Huber. Either analyst may be reached at the Office of Health Care Access by dialing (860) 418-7001.

Docket Number:	07-30964-CON
Applicant Name:	MidState Medical Center
Contact Person:	Karen Goyette
Contact Title:	Director, Business Development
Contact Address:	MidState Medical Center 435 Lewis Avenue Meriden, CT 06451
Project Location:	Meriden
Project Name:	Facility Building Project including Expansion of the ED, Addition of 30 Licensed M/S Beds and Other Facility Improvements
Proposal Type:	Sections 19a-638 and 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$45,589,500

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: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____	FOR OHCA USE ONLY:		
PROJECT TITLE: _____		DATE	INITIAL
DATE: _____	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/Cost excluding 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)

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.

i) Provide the following information for each service/program affected by the proposal:
   a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The unit of service for the past three fiscal years by service area town.
   d) Describe the population being served. Include demographic information, as appropriate.
   e) Scheduling backlogs in the service areas.
   f) Travel distance from the medical center to service area towns.
   g) Hours of operation of each service/program.

ii) Identify the existing Hospital providers of the proposed services in your service area.

iii) Provide the information as outlined in the following table concerning the existing providers in the Hospital's PSA and SSA for each affected service/program:

Description of Service	Provider Name and Location	Hours and Days of Operation	Current Utilization

iv) What will be the effect of your proposal on existing hospitals (i.e. patient volume, financial stability, quality of care, etc.)?

v) Provide the units of service projected for the first three years of operation of the services/programs affected by the proposal. **Include the derivation/calculation for each service/program.**

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 Applicant 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 Medical Center plans to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Medical Center'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, its Physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, its Physicians and/or any staff related to the proposal.

G. Provide a copy of the following:

☐ A copy of the related Quality Assurance Plan ("QAP") and Annual Evaluation Report of the QAP Committee

6. Improvements to Productivity and Containment of Costs

In the past year has your facility 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 a change to) your teaching or 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. 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 Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant 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 existing plot plan of the medical center and a proposed plot plan showing all areas affected by the project.

D. Provide the following breakdown of the 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			

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

F. 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. 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. Any lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility 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.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

A.3. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

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

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please complete Financial Attachment 1, enclosed.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant'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.). Note: Include

consideration of the Deficit Reduction Act of 2005 and the reduction of Medicare and Medicaid reimbursements in the development of the financial projections.

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) Provide a copy of the rate schedule for the proposed service.

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.

13.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description
Type of Unit Description:
# of Months in Operation

Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 29, 2007

Ms. Karen Goyette
Director, Business Development
MidState Medical Center
435 Lewis Avenue
Meriden, CT 06451

Re: Letter of Intent, Docket Number 07-30964
MidState Medical Center
Facility Building Project including Expansion of the ED, Addition of 30 Licensed M/S Beds and Other Facility Improvements
Notice of Letter of Intent

Dear Ms. Goyette:

On May 4, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of MidState Medical Center ("Applicant") for the Facility Building Project, including Expansion of the ED, Addition of 30 Licensed M/S Beds and Other Facility Improvements, at a total capital expenditure of $45,589,500.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Record Journal* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:AF:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 29, 2007

Requisition # HCA07-198
FAX #: (203) 317-2233

Record Journal
1 Crown Street
Box 915
Meriden, CT 06450-0914

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 Saturday, **June 2, 2007 .**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AF:lmg

c: Sandy Salus, OHCA

Record Journal **Letter of Intent**
Docket Number 07-30964 **May 29, 2007**

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-638 and 19a-639
Applicant:	MidState Medical Center
Town:	Meriden
Docket Number:	07-30964
Proposal:	Facility Building Project including Expansion of ED, Addition of 30 Licensed M/S Beds and Other Facility Improvements
Capital Expenditure:	$45,589,500

The Applicant may file its Certificate of Need application between July 3, 2007 and September 1, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA 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 or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.