BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

May 10, 2007

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

RE: Letter of Intent –
Establish Walk-in Center & Draw Station Services in Fairfield

Dear Commissioner Vogel,

Pursuant to the applicable Connecticut general statutes and regulations, Bridgeport Hospital is pleased to submit the enclosed Letter of Intent for the establishment of walk-in center and draw station services in the town of Fairfield. The proposed service will increase access for the diagnosis and management of urgent non-life threatening conditions for the residents of Fairfield and the surrounding communities. The total capital expenditure for the project is $829,715.

Sincerely,

Augusta S. Mueller
Director of Planning

Enclosure

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120
203.384.3000

AFFIDAVIT

To be completed by each Applicant

Applicant: **Bridgeport Hospital**

Project Title: **Establish Walk-in Center and Draw Station Services in Fairfield**

I, **Robert J. Trefry** (Name), **President & Chief Executive Officer** (Position – CEO or CFO)

of **Bridgeport Hospital** 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 **Bridgeport Hospital** (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.

RECEIVED
2007 MAY 10 A11:41
OFFICE OF HEALTH CARE ACCESS

Signature

5/9/07
Date

Subscribed and sworn to before me on May 9, 2007

Notary Public/Commissioner of Superior Court

Mary Frances Pistura
Notary Public
State of Connecticut
My Commission Expires
February 28, 2009

My commission expires:

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
Full legal name	Bridgeport Hospital
Doing Business As	Bridgeport Hospital
Name of Parent Corporation	Bridgeport Hospital & Healthcare Services, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	267 Grant Street Bridgeport, CT 06610
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP
Does the Applicant have Tax Exempt Status?	Yes
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Augusta Mueller Director, Planning
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	267 Grant Street Bridgeport, CT 06610
Contact Person's Telephone Number	(203) 384-3126
Contact Person's Fax Number	(203) 384-3968
Contact Person's e-mail Address	kamuel@bpthosp.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establish Walk-in Center and Draw Station Services in Fairfield

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 $ 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:

309 Stillson Road, Fairfield CT 06825-3213

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

The proposed project is intended to serve residents within the Bridgeport Hospital primary service area. Municipalities include Bridgeport, Fairfield, Easton, Monroe, Shelton, Stratford and Trumbull.

e. Estimated starting date for the project: **August 2007**

f. Type of project: **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

Not applicable.

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$829,715**

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

Medical Equipment Purchases	**52,240**
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	**694,102**
Other (Non-Construction) Specify: **Imaging Equipment**	**83,373**
Total Capital Expenditure	**829,715**
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	**829,715**
Total Project Cost	**829,715**
Capitalized Financing Costs (Informational Purpose Only)	

* 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:

Not applicable.

☐ 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).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
X-ray Equipment	**Medical Imaging Systems**	**Elevator Radiographic System, Konica computed Radiography System**	**1**	**$83,373**

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

Please see Attachment I for a copy of the vendor quotations related to the X-ray equipment.

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.

   Bridgeport Hospital does not currently offer services at the proposed site. A copy of the Bridgeport Hospital acute care license is included as Attachment II.
2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.

   The proposed site would be added to the Bridgeport Hospital Department of Public Health license as a satellite facility. Services to be offered at the site include X-ray, diagnosis and management of urgent non-life threatening conditions on a walk-in basis.
3. Identify the current population served and who is the target population to be served.

   The proposed project is intended to serve residents within the Bridgeport Hospital primary service area. Municipalities include Bridgeport, Fairfield, Easton, Monroe, Shelton, Stratford and Trumbull.
4. Identify any unmet need and describe how this project will fulfill that need.

   The proposal will increase access to patients seeking diagnosis and management of non-life threatening conditions.
5. Are there any similar existing service providers in the proposed geographic area?

   Yes, St. Vincent's Immediate Health Center and Fairfield Family Medical Care.
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

   The proposal is anticipated to have a positive effect on the healthcare delivery system in the State of Connecticut by increasing access for the treatment of urgent non-life threatening conditions.
7. Who will be responsible for providing the service?

   Bridgeport Hospital will be responsible for providing the services at the proposed location. Services include diagnosis and management of non-life threatening conditions, X-ray services and laboratory services.
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

   Bridgeport Hospital does not currently offer services at the proposed site. Anticipated payors include Government payors such as Medicare and Medicaid, commercial insurers and health maintenance organizations.

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

Attachment I
Vendor Quotations – X-ray equipment

medical imaging systems Inc.

Two Corporate Drive
Suite 252
Shelton, CT 06484

203-944-0303
800-556-6007 NORTHEAST
203-944-0302 FAX

Quotation

Date: **April 12, 2007**

Quotation Number: **E-07-125**

To: **Bridgeport Hospital**
267 Grant Street
Bridgeport, CT 06610

In Reply Refer To:

***Attn:* Michael Tatta**

Quantity and System Number	Description	Price
	ELEVATOR RADIOGRAPHIC SYSTEM	
AM-1	**High Frequency Generator** - 300 High Frequency Generator - 40-125kV 1kV steps - 6 mA stations 50-300 - Digital Display of kVp - Digital Display of mAs/mA - Built in self diagnostics with error display - Programmable tube protection - If 240v is not available, step-up transformer for 208v is provided	
FWFT	**Elevating Four –Way Float Top Table System with:** - 440 lb. Patient rated table load - Elevating Table from 22" to 33" - Four way floating table top with electric locks - 34" longitudinal travel, 10" transverse travel - Grid Cabinet with 178 line 10:1 aluminum grid - Heavy duty cassette tray	
FT-10	**Floor/Wall Mounted Tubestand complete with:** - Longitudinal Floor/Ceiling or Wall Track for full room coverage - Electro-magnetic tilt and angulation locks - Full vertical travel for weight bearing knees - Full tubestand rotation for cross table exams - Certified manual collimator with swivel mount - Manual Collimator with light field & swivel mount	

Accepted as Quoted

Customer Signature or Authorized Officer _____ Date _____

Stephen W. Fermendez _____ Date _____

Quotation

F-07-125

4-12-07

Name: Bridgeport Hospital

Quantity and System Number	Description	Price
BXT-13100	**Radiographic X-Ray Tube** - Focal spots: 1.2 – 2.0 mm - 140,000 heat units - High tension cables of necessary length	
A-6400	**14 x 17 Upright Cassette Holder** - 10:1 178 line aluminum grid - Cassette stand lowers to floor for weight bearing knees - Heavy duty tray for all film sizes	
	NET TOTAL X-RAY PRICE.....	**$ 31,500.00**

Prices include installation, demonstration and 1 year Service and parts warranty MIS will do all layout and blueprint work for proper and complete installation.

TERMS: 20% deposit, 70% on delivery to site or storage
Balance on completion of installation.
Prepaid f.o.b. factory

medical imaging systems inc.

Two Corporate Drive
Suite 252
Shelton, CT 06484

203-944-0303
800-556-6007 NORTHEAST
203-944-0302 FAX

Quotation

Date: **March 7, 2007**

Quotation Number: **F-07-112**

To: **Bridgeport Hospital**
267 Grant Street
Bridgeport, CT 06610

In Reply Refer To:

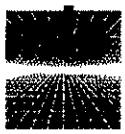
ATTN: Michael Tatta

Quantity and System Number	Description	Price
	KONICA COMPUTED RADIOGRAPHY SYSTEM	
Cat # 5900502	**IQ CR Special Edition Ultra:** Designed to meet the specific requirements of areas with more moderate image volumes. IQue SE combines innovative system's intelligence and unparalleled ease of use with the same reliable, proven reader platform used in higher volume areas. Includes: - REGIUS Model 190 High Capacity, Dual Bay CR Reader - 62 Plates per hour (14" x 17") - 58 Seconds Cycle Time - 12 bit grayscale output - Auto sensing 100/1000 mbps Network Interface - Uninterruptible Power Supply (UPS) - IQue Control Station w/ Uninterruptible Power Supply (UPS) Minimum Configuration: - Pentium IV, 2.15 GHz, 1GB RAM, CD-R - 80 GB HD (Holds approx. 5,000 CR images) - Auto-sensing 10/100/1000 mbps Network Interface - Automatic Exam View Recognition Feature - Self-Learning Image Processing Feature - Reject Reason Tracking And Data Export - Free Text Annotation - Automatic Masking - Equalization, Frequency & Gradation Processing - Set of Image Processing Parameter Presets - HIPPA compliance enabling features (Audit trail, Auto log-out)	**$49,300.00**

Accepted as Quoted

Customer Signature or Authorized Officer — Date

Stephen W. Fernandez 3/8/07 — Date



Quotation

F-07-112

3/8/07

Name: Bridgeport Hospital

Quantity and System Number	Description	Price
	- DICOM Modality Worklist - DICOM Store (One Connection) - Hybrid Processing to further enhance visualization of detail and improve image latitude - Installation & Applications Training	
(2) 5907314	Xpress/IQue Cassette/Plate 14x17	**Included**
(1) 5907314	Xpress/IQue Cassette/Plate 14x17	**$1,015.00**
(2) 5907310	Xpress/IQue Cassette/Plate 10x12	**Included**
5900463	Grid Suppression Soft Ware	**$1,044.00**
5900463	Barcode Reader-Plate Reg.	**$ 558.00**
	Shipping Charges	**$1,000.00**
	Net Investment.....	**$51,873.00**

This quotation includes installation on mutually agreeable timetable and one (1) Year warranty parts and labor. Plates covered by (2) Two year warranty.

This quote does not include network cabling or site preparation, which is the responsibility of the account. It also does not include applicable taxes.

Amount Due:	**(a) Grand Total Net Investment**	**$ 51,873.00**
	(b) Plus Applicable Taxes	**$0.00**
	(c) Cash Down Payment Required	**$ 15,561.90**

Attachment II
Bridgeport Hospital DPH License

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0040

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Bridgeport Hospital Inc. of Bridgeport, CT, d/b/a Bridgeport Hospital is hereby licensed to maintain and operate a General Hospital.

Bridgeport Hospital is located at 267 Grant Street, Bridgeport, CT 06610

The maximum number of beds shall not exceed at any time:
30 Bassinets
395 General Hospital beds

This license expires **March 31, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2006. RENEWAL.

Satellites
Geriatric Partial Hospital, 305 Boston Avenue, Stratford, CT
Child Partial Hospital, 305 Boston Avnue, Stratford, CT
Bridgeport Hospital Primary Care Center, 226 Mill Hill Avenue, Bridgeport, CT
Psychiatric Adult Partial Hospital Program, 305 Boston Avenue, Stratford, CT

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 24, 2007

Augusta Mueller
Director, Planning
Bridgeport Hospital
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610 0120

RE: Certificate of Need Application Forms, Docket Number 07-30966-CON
Bridgeport Hospital
Establishment of a Walk-In Medical Center in Fairfield, CT

Dear Ms. Mueller:

Enclosed are the application forms for Bridgeport Hospital's Certificate of Need ("CON") proposal for the establishment of a Walk-In Medical Center in Fairfield, CT with an associated capital expenditure of $829,715. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between July 9, 2007, and September 7, 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 analyst assigned to the CON application is Steven W. Lazarus. Please feel free to contact him at (860) 418-7012, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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" may be acceptable. Your Certificate of Need application will be eligible for submission no earlier than July 9, 2007, and may be submitted no later than September 7, 2007. The Analyst assigned to your application is Steven W. Lazarus and may be reached at the Office of Health Care Access by dialing (860) 418-7012 directly.

Docket Number: 07-30966-CON

Applicant Name: Bridgeport Hospital

Contact Person: Augusta Mueller
Contact Title: Director Planning
Contact Address: Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610

Project Location: Fairfield

Project Name: Establishment of a Walk-In Medical Center

Proposal Type: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: $829,715

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. Please list **and** provide a detailed discussion about the type of services that will be provided at the proposed Walk-In Clinic and how the proposed services differentiate from the services provided by an Emergency Department.

C. Provide the following information:
   a) List of the Primary Service Area ("PSA") towns.
   b) List of the Secondary Service Area ("SSA") towns.
   c) Please explain how the Applicant determined the proposed Primary and Secondary service area towns.
   d) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information, as appropriate.
   e) In a table format, provide for the Applicant the number of referrals from the proposed service area towns that are specific to the services for the proposed Walk-In Clinic for the past three fiscal years (By zip code and service).

f) In a table format, provide for the past three fiscal years, the number of "non-admits" in the Applicants Emergency Department (By zip code and service) who would utilize the Walk-In Center.
g) Scheduling backlogs in service area.
h) Travel distance from proposed site to service area towns.
i) Hours of operation of the proposed service.

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

iii) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant's PSA & SSA) current operations:

Primary Service Area:

Legal Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians by Specialty

Secondary Service Area:

Legal Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians by Specialty

iv) What will be the effect of your proposal on existing providers (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 proposed service. **Include the derivation/calculation.**

D. 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.

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

C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Medical Director, and financial officer(s), 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]

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant, 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 Applicant, its physicians working at the facility and/or any staff related to the proposal.

G. Provide a copy of the following:

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

What measures will your facility undertake 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)_____

[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.

7. Miscellaneous

A. Will this proposal result in any 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 the following licensing information:

i) The DPH licensure category you are seeking.

ii) If not applicable, please explain why.

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) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) 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.

iii) Provide the total current assets balance as of the date of submission of this application.

iv) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

v) Provide the name and units of service for the new cost center to be established for the proposal.

vi) Identify the entity that will be billing for the proposed service.

vii) Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

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 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			

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. 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.

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	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%

*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.

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 refer to 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.).

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 complete Financial Attachment II, enclosed.

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

vi) Describe how this proposal is cost effective.

vii) Please describe in detail the reimbursement structure for the proposed Walk-In Clinic and how it differentiates from reimbursement structure of an Emergency Department or a Freestanding Emergency Department.

Bridgeport Hospital

12.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

FY	(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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

Bridgeport Hospital

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

Total Facility: 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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$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.