HARTFORD HEALTHCARE

June 7, 2007

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

RE: Establishment of a Cardiac Catheterization
Lab at MidState Medical Center

Dear Commissioner Vogel:

I am writing this letter in support of the development of a diagnostic cardiac cath lab at MidState Medical Center. Since 2001, MidState and Hartford Hospital have implemented a number of initiatives to ensure the provision of the highest quality cardiac care throughout the Hartford Healthcare System.

In fiscal 2006, over 300 diagnostic caths at Hartford Hospital originated from MidState Medical Center's Emergency Department or Inpatient Unit alone. This does not include additional volume that may have come directly from MidState's physician offices.

As the provision of diagnostic cardiac cath capabilities has become standard of care for community hospitals, Hartford Hospital is in strong support of establishing a cardiac cath lab at MidState Medical Center.

Thank you in advance for your consideration of this important community initiative.

Sincerely,

John Meehan

John Meehan
President & CEO

CARDIOLOGY
ASSOCIATES OF
CENTRAL
CONNECTICUT, LLC

1062 BARNES RD., STE. 300, WALLINGFORD, CT 06492
TEL. 203-265-9831 FAX 203-265-2977

RICHARD A. BUGLIARI, M.D., F.A.C.C.
WILLIAM J. FARRELL, M.D., F.A.C.C.
ROBERT J. GOLUB, M.D., F.A.C.C.
MICHAEL V. McMAHON, P.A.-C
AMY JOCKLE, A.P.R.N.

97 BARNES RD., WALLINGFORD, CT 06492
TEL. 203-284-3137 FAX 203-284-3130

STEPHEN D. ROSSNER, M.D., F.A.C.P.
HAROLD S. WILKES, M.D., F.A.C.C.
GEORGE SPIVACK, M.D., F.A.C.C.
JOHN S. ZESK, M.D., F.A.C.C.

June 11, 2007

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

RE: Establishment of a Cardiac Catheterization
Lab at MidState Medical Center

Dear Commissioner Vogel:

I am writing to express my strong support towards the establishment of a cardiac cath lab at MidState Medical Center.

The prevalence of coronary artery disease has grown expeditiously within our community and the United States. We have seen cardiac cath rates increase by over 10% annually in our community alone.

Access to cardiac cath service within our patients' community is integral to my practice. Currently, 100% of my patients requiring cath services are transferred to Hartford Hospital. While I have been actively involved in developing the mechanism to ensure timely transfers, sharing of patient information and ensuring quality outcomes, it has become a standard of care for hospitals of MidState's size (approximately 50,000 ED visits annually) to provide diagnostic cath care. The cardiologists at MidState believe that this is a service that will greatly benefit the patients in our community.

I urge you to support this initiative and would be happy to offer any additional information to assist you in rendering a decision.

Sincerely,

William J. Farrell, M.D.

MidState
Medical Center
HARTFORD HEALTHCARE

June 12, 2007

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

Re: Establish a Diagnostic Cardiac Catheterization Laboratory
at MidState Medical Center

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 Establishment of a Cardiac Catheterization Laboratory at MidState Medical Center 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:

Establish a Diagnostic Cardiac Catheterization Laboratory

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.:

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:

The proposed project would include the establishment of a diagnostic cardiac catheterization laboratory on 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: **27**
(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
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$2,450,000**

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

Medical Equipment Purchases	**$1,450,000**
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	**$0**
Land/Building Purchases	
Construction/Renovation	**$750,000**
Other (Non-Construction) Specify: **Misc & Contingency**	**$250,000**
Total Capital Expenditure	**$2,450,000**
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	**$2,450,000**
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:

☐ 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
ADD				

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

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 the expansion of its existing Cardiology Service Line to include a Diagnostic Cardiac Catheterization Laboratory on it's existing campus located at 435 Lewis Avenue, in Meriden, Connecticut. The proposed project would include a total capital expenditure of $2,450,000, which would be funded through the applicants equity. The proposed project is intended to serve MidState Medical Center's existing service area, and as highlighted below, will pose no impact to other providers of this service.

Project Background

MidState Medical Center currently offers a comprehensive Cardiology Service Line including multiple ambulatory, surgical and inpatient capabilities. The Hospital's program currently offers: Chest Pain Observation Unit, ACS Risk Stratification Program, 24 hour access to cardio-diagnostics, vascular and neurology diagnostics, 64 Slice CT Scanner, nine (9) bed cardiac care unit, twenty-two (22) bed telemetry unit, and various outreach programs (such as diabetes management, cardiac rehab and community education). In addition, the hospital's existing medical staff currently perform various vascular procedures including the implantation of pacemakers and ICD's.

Since 2001, MidState and Hartford Hospital have implemented a number of initiatives to ensure the provision of high quality of care across their continuum of services. Some examples of this collaboration include:

- **Established policies and procedures to ensure the timely transfer of patients requiring cardiology interventions;**
- **APRN at HH, which is dedicated to MidState patients upon admission and discharge, coordinates patients follow up care with community cardiologists;**
- **MidState and HH share the same Patient Information System and Electronic Medical Record. Patient Information can be accessed system-wide from either campus and physician offices (all diagnostic testing, inpatient care, physician progress notes, and all consultant summaries);**
- **Single Cardiology Service Line, a multi-disciplinary team meets at each campus monthly and provides quarterly education conferences;**
- **Ongoing monitoring of Quality Measures and Outcomes.**

MidState Medical Center has seven (7) cardiologist on it's active medical staff, two (2) of which specialize in interventional cardiology. Since 2002, Dr. William Farrell, an Interventional Cardiologist on the staff of MidState Medical Center has been performing catheterizations at Hartford Hospital.

Trends

From FY04-06, Diagnostic Catheterizations originating at MidState Medical Center and performed at Hartford Hospital increased by 70% (this does not include additional transfers that occurred directly from physician offices). In FY07, it is projected that over

600 cardiovascular procedures and surgeries performed at Hartford Hospital will originate from MidState Medical Center. A summary of Cardiology Procedures performed at HH, originating from MidState is include as Figure 1.

Figure 1

Fiscal Year	Diagnostic Caths	Interventional Caths	Cardiovascular Surgery
2004	189	143	39
2005	244	164	38
2006	322	202	63
2007*	348	186	69
% Change	84%	30%	78%

* 2007 Annualized based on first four months.

In addition, nearly 1,000 Cardiac Catheterizations originated from MidState's Primary Service Area (PSA) alone in FY06, with the average outpatient Catheterization volume increasing 13% annually from FY01-06. (Source: CHA – CHIME database).

Future of Cardiology

In a study conducted by the Health Care Advisory Board (Future of Cardiology: Strategic Forecast and Investment Blue Print, 2006), it was noted that Cardiac Catheterization volume is anticipated to increase by nearly 40% from 2005-2010. This increase is based on the aging population, expanding indications, and technology advancements. In addition, another briefing notes that diagnostic catheterizations have become a "standard of care for community hospitals", with 67% of diagnostic caths being performed at hospitals with less than 200 beds. (Source: Cath Lab Services at Small Community Hospitals, Health Care Advisory Board).

Conclusion

The cardiac catheterization laboratory at MidState Medical Center will be located within the existing peri-operative suite and would be managed by the Director of Cardiology Services at MidState Medical Center. As highlighted above, MidState and Hartford Hospital have been working for a number of years towards providing access to high quality, comprehensive and seamless Cardiology care to the patients we serve.

In addition, as stated in the letters of support provided by Hartford Hospital and Dr. William Farrell, it is not anticipated that this project will have any adverse effect on other providers of this service – as Dr. Farrell currently performs 100% of his cardiology procedures at Hartford Hospital. It is the expectation that MidState and Hartford Hospital will mutually benefit from the efficient use of shared resources (i.e. policies and procedures, staffing, quality assurance, etc.). While patients of MidState's existing service area will benefit from access to what has become a standard of care for community hospital's of MidState's size and complement of programs and services.

AFFIDAVIT

To be completed by each Applicant

Applicant: **MidState Medical Center**

Project Title: **Establishment of a Diagnostic Cardiac Catheterization Laboratory**

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.

RECEIVED
2007 JUN 13 PM 12:42
OFFICE OF HEALTH CARE ACCESS

L. Janatka
Signature

6/12/07
Date

Subscribed and sworn to before me on the 12th day of June 2007

Betsey G. DuBois
Notary Public/~~Commissioner of Superior Court~~

Betsey G. DuBois
Notary Public, State of Connecticut
My Commission Expires Dec. 31, 2011

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. 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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 31, 2007

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

RE: Certificate of Need Application Forms, Docket Number 07-30984-CON
MidState Medical Center
Establishment of a Diagnostic Cardiac Catheterization Laboratory

Dear Ms. Goyette:

Enclosed are the application forms for MidState Medical Center's Certificate of Need ("CON") proposal for the establishment of a diagnostic cardiac catheterization laboratory, with an associated capital expenditure of $2,450,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 12, 2007, and October 11, 2007.

When submitting your CON Application:

1. Paginate and date each page contained in your submission.
2. Submit one (1) original and five (4) copies **in binders**; and
3. On a separate CD, include a **scanned** copy of the complete Application, including all attachments in **Adobe** format and provide **an electronic copy** of the Application in original format (i.e. Word, Excel etc.).

The analysts assigned to the CON application are Steven W. Lazarus and Alexis Fedorjaczenko. Please feel free to contact them at (860) 418-7001, 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, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 12, 2007, and may be submitted no later than October 11, 2007. The Analyst assigned to your application is Steven W. Lazarus and he may be reached at the Office of Health Care Access at (860) 418-7012.

Docket Number: 07-30984-CON

Applicant(s) Name: MidState Medical Center

Contact Person: Karen Goyette
Contact Title: Director, Business Development
MidState Medical Center
Contact Address: 435 Lewis Avenue
Meriden, CT 06451

Project Location: Meriden

Project Name: Establishment of a Diagnostic Cardiac Catheterization Laboratory

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

Est. Capital Expenditure: $2,450,000

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:

a) Primary and secondary service area towns.
b) Please explain how the service area towns were chosen for the proposed service area.
c) How and why do they differ from the Hospital's total service area.
d) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
e) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
f) Scheduling backlogs in service area
g) Travel distance from proposed site to service area towns
h) Hours of operation of existing/proposed service

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

iii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

iv) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant's proposed service area) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known. For MRI scanners, include Tesla strength, and whether or not the scanner is considered to be "open" or "closed".
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

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)
☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

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

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, 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.*

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

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

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

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

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

H. Provide a copy of the following (as applicable):

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

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
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

[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 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 the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

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

☐ Corporation (Inc.)
☐ Partnership
☐ Joint Venture
☐ Other (Specify):
☐ Limited Liability Company (LLC)
☐ Professional Corporation (PC)

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) If the Applicant is a hospital, provide the total current assets balance as of the date of submission of this application.

iii) If the Applicant is a hospital, provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) If the Applicant is a hospital, provide the name and units of service for the new cost center to be established for the proposal.

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

9. Major Cost Components/Total Capital Expenditure

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

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

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

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	____ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
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.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 and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
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.

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

C. 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. **See attached, Financial Attachment I.** 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) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, Financial Attachment II.**

iii) 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 Medicaid and Medicare reimbursements in the development of the financial projections.*

iv) 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.

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

vi) Describe how this proposal is cost effective.

vii) Provide a description of the additional staff, equipment, and supplies (including drug-eluting stents) required to provide the proposed services. Include a description of the availability of cardiac interventionalists, cardiac surgeons, nurses and anesthesiologists.

viii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the CON proposal.

14. Project Specific Questions

1. Identify how your proposal conforms with current professional guidelines (ACC, AHA, STS, etc.).

2. Provide recent literature (i.e. articles, journals, clinical trials, etc.) and/or data supporting your proposal.

3. If leasing or purchasing cineangiography equipment, provide a copy of any written agreement (e.g. vendor quote) or memorandum of understanding between the hospital and the vendor.

4. Provide a copy of an agreement between the MidState Medical Center and a tertiary care facility regarding this proposal.

14. 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:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	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.

14.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			Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Payer Category:									
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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 1, 2007

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

Re: Letter of Intent, Docket Number 07-30984
MidState Medical Center
Establishment of a Diagnostic Cardiac Catheterization Laboratory
Notice of Letter of Intent

Dear Ms. Goyette:

On June 13, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of MidState Medical Center ("Applicant") for the establishment of a diagnostic cardiac catheterization laboratory, at a total capital expenditure of $2,450,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Record Journal* pursuant to Section 19a-638 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:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 1, 2007

Requisition # HCA08-018
FAX: (203) 317-2233

Record Journal
11 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 **Sunday, August 5, 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 **Steven Lazarus or 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:SWL:lmg

c: Sandy Salus, OHCA

Record Journal
Docket Number 07-30984

Letter of Intent
August 1, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	MidState Medical Center
Town:	Meriden
Docket Number:	07-30984
Proposal:	Establishment of a Diagnostic Cardiac Catheterization Laboratory
Capital Expenditure:	$2,450,000

The Applicant may file its Certificate of Need application between August 12, 2007 and October 11, 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.

****
*** TX REPORT ***
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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

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Sincerely,

Kimberly R. Martone

30984

08/03/07

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MidState Cardiac
RJ RECORD JOURNAL

PO#: HCA08-018

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MERIDEN

LEGAL NOTICE

Letter of Intent

Statute Reference: 19a-638

Applicant: MidState Medical Center

Town: Meriden

Docket Number: 07-30984

Proposal: Establishment of a Diagnostic Cardiac Catheterization Laboratory

Capital Expenditure: $2,450,000

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