



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	Middlesex Hospital	
Doing Business As		
Name of Parent Corporation	Middlesex Health System, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	28 Crescent Street Middletown, CT 06457	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Vincent Capece Sr. VP & CFO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	28 Crescent Street Middletown, CT 06457	

Contact Person's Telephone Number	860-358-6140 phone	
Contact Person's Fax Number	860-346-5485 fax	
Contact Person's e-mail Address	Vinnie_Capece@midhosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Hospital Outpatient Surgical Services Capacity Expansion Project

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

√ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

√ New ☒ F ☐ S, Fnc)

☐ Replacement

☐ Additional (F, S, Fnc)

√ Expansion (F ☒ S, Fnc)

☐ Relocation

☐ Service Termination

☐ Bed Addition

☐ Bed Reduction

☐ Change in Ownership/Control

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

√ Project expenditure/cost 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:

512 Saybrook Road, Middletown, CT 06457

- d. List each town this project is intended to serve: **Middlesex Hospital's primary service area communities include the Connecticut towns of Middletown, Middlefield, Cromwell, Durham, Haddam, Killingworth, Portland, East Hampton, East Haddam, Marlborough, Colchester, Chester, Deep River, Essex, Old Saybrook, Westbrook, Clinton and Madison.**
- e. Estimated starting date for the project: March, 2009
- 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) No change in beds

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Project Cost: \$ 8,000,000 ^(a)
- b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	
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	\$8,000,000 ^(a)
Capitalized Financing Costs (Informational Purpose Only)	

- * Provide an itemized list of all non-medical equipment to be purchased and leased.
- (a) This represents the estimated value of the land, facility and equipment assets to which the Hospital will have access to through a lease and services agreement.

- 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).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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): **The Hospital will finance the surgical services expansion project with future annual operating expenses through a lease and services agreement to be executed between the Hospital and the developer of the outpatient surgical services facility.**

SECTION IV. PROJECT DESCRIPTION - See project description included on page 8

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?

AFFIDAVIT**To be completed by each Applicant**Applicant: Middlesex HospitalProject Title: Hospital Outpatient Surgical Services Capacity Expansion ProjectI, Vincent Capece, Sr. VP & CFO
(Name) (Position – CEO or CFO)

of Middlesex 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 Middlesex Hospital complies with the appropriate and (Facility Name)

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

Vincent Capece
Signature

6/20/07
Date

Subscribed and sworn to before me on June 20, 2007

Michael J. Murray
Notary Public/Commissioner of Superior Court

My commission expires: 3.31.09

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

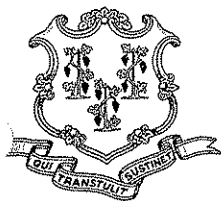
SECTION IV. PROJECT DESCRIPTION

Middlesex Hospital currently provides outpatient surgical services within the main operating rooms (ORs) located on the hospital's campus at 26 Crescent Street in Middletown as well as at its outpatient surgical services facility located at 530 Saybrook Road in Middletown. This project proposes the development of a new outpatient surgical services facility for the provision of orthopedic outpatient care that will be located on a site adjacent to the Hospital's current outpatient surgical services facility on Saybrook Road. This project will impact the Hospital's provision of orthopedic outpatient services and reflects no change in type of services which Middlesex Hospital currently provides under its DPH hospital license.

Middlesex Hospital and its affiliated physicians are the only providers of outpatient surgical services located within its primary service area. This project is needed to enable the Hospital to develop the capacity required to serve the future surgical care needs of the growing and aging primary service area population that it currently serves. Middlesex Hospital has determined that it needs to expand its overall capacity of surgical services facilities to meet demands projected over the next decade; specifically to increase its number of modern, appropriately-sized ORs. The development of this proposed orthopedic outpatient surgical services facility is the necessary first step to enable the Hospital to create the additional OR capacity that will be needed in the future. Middlesex Hospital would be licensed for and responsible for operating the services provided in the proposed orthopedic outpatient surgical services facility as an integral component of its overall surgical services program.

Middlesex Hospital and its affiliated physicians currently provide services to most insurance payers within the state and these same payer sources are anticipated to provide the revenues associated with the orthopedic outpatient surgical services provided by Middlesex Hospital in the future.

With this proposed project, Middlesex Hospital is making an important long-term commitment to expand its surgical services facilities to better meet the long-term needs of its primary service area population. In addition to providing the needed incremental OR capacity within the Middlesex Health System to better meet the community's needs, the creation of the dedicated center for the provision of orthopedic outpatient care proposed with this project will help to ensure the highest quality outcomes and an efficient operation. By providing these benefits to the Middlesex Hospital service area population, this project will help to enhance the overall healthcare delivery system in Connecticut.



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

June 28, 2007

Mr. Vincent Capece
Senior Vice President and Chief Financial Officer
Middlesex Hospital
28 Crescent Street
Middletown, CT 06457

Re: Letter of Intent, Docket Number 07-30992
Middlesex Hospital
Establish and Operate a new outpatient surgical services facility for orthopedic
outpatient care adjacent to the current outpatient surgical service facility on
Saybrook Road, Middletown
Notice of Letter of Intent

Dear Mr. Capece:

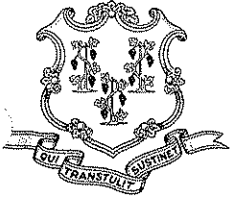
On June 21, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital's ("Applicant") proposal to establish and operate a new outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown Project, at a total capital expenditure of \$8,000,000. A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* pursuant to Sections 19a-638 and 19a-639, C.G.S. of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in cursive script, reading "Kim R Martone".

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

June 28, 2007

Requisition # HCA07-222
FAX #: 646-9867

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, July 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 **Laurie Greci** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,



Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:img

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-638 and 19a-639, C.G.S.
Applicant:	Middlesex Hospital
Town:	Middletown
Docket Number:	07-30992
Proposal:	Establish and Operate a new outpatient surgical services facility for orthopedic outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown
Capital Expenditure:	\$8,000,000

The Applicant may file its Certificate of Need application between August 20, 2007 and October 19, 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 ***

TRANSMISSION OK

TX/RX NO 2303
RECIPIENT ADDRESS 96469867
DESTINATION ID
ST. TIME 06/28 14:38
TIME USE 00'20
PAGES SENT 2
RESULT OK



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

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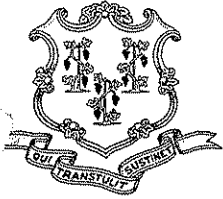
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Sincerely,

A handwritten signature in cursive script, reading "Kimberly R. Martone".

Kimberly R. Martone
Certificate of Need Supervisor



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

January 12, 2007

Vincent Capece
Senior Vice President and Chief Financial Officer
Middlesex Hospital
28 Crescent Street
Middletown, CT 06457

RE: Certificate of Need Application Forms, Docket Number 07-30992-CON
Middlesex Hospital
Establish and operate a new outpatient surgical services facility for orthopedic outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown.

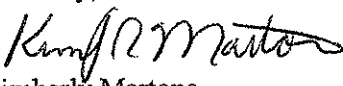
Dear Mr. Capece:

Enclosed are the application forms for Middlesex Hospital's Certificate of Need ("CON") proposal to establish and operate a new outpatient surgical services facility for orthopedic outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown, with an associated capital expenditure of \$8,000,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between August 20, 2007, and October 19, 2007. A CD is enclosed that contains the MS Word document for the application and MS Excel workbooks for the financial attachments.

When submitting your CON Application, please paginate and date each page contained in your submission. Submit one (1) original and five hard copies. In addition, electronic file copies are required. Provide a scanned copy of the complete Application, including all attachments, using Adobe Acrobat, on CD or Diskette. Please submit electronic copies of the Application in an MS Word document and electronic copies of the financial attachments and other data as appropriate in MS Excel workbooks.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact her 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 20, 2007, and may be submitted no later than October 19, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30992-CON

Applicant's Name: Middlesex Hospital

Contact Person: Vincent Capece
Contact Title: Senior Vice President and Chief Financial Officer
Middlesex Hospital
Contact Address: 28 Crescent Street
Middletown, CT 06457

Project Location: Middletown

Project Name: Establish and operate a new outpatient surgical services facility for orthopedic outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown.

Type proposal: Sections 19a-638 and 19a-639, C.G.S.

Est. Capital Expenditure: \$8,000,000

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.
- B. Provide the primary and secondary service area towns.
- C. Provide the rationale for choosing the proposed primary and secondary service area towns.
- 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

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

Provider Name, Street Address, Town, and Zip Code	Number of Operating Rooms				Estimated Capacity for Proposal		Current Util- ization ⁷
	Avail- Able ¹	Util- ized ²	Not Util- ized ³	Equipped for Proposal ⁴	Minimum ⁵	Maximum ⁶	
Total							

¹ Include used, equipped, and shell space.

² Include those actually used to perform surgeries.

³ Include those not used and those that are equipped or are only shell space.

⁴ Include those rooms that are uniquely equipped to perform the type of surgeries included in the proposal.

⁵ Minimum number of surgeries to be performed in a single operating room for one year. Provide an explanation of the criteria or basis used to estimate the number.

⁶ Maximum number of surgeries of the type included in the proposal that can optimally be performed in a single operating room(s) in one year. Provide an explanation of the criteria or basis used to estimate the number.

- J. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?
- K. Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**
- L. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

- | | |
|---|---|
| <input type="checkbox"/> Cultural | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Geographic | <input type="checkbox"/> Economic |
| <input type="checkbox"/> Other (Identify) | |
| <input type="checkbox"/> None, Please provide an explanation. | |

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

- | | |
|--|--|
| <input type="checkbox"/> Epidemiological studies | <input type="checkbox"/> Needs assessments |
| <input type="checkbox"/> Public information reports | <input type="checkbox"/> Market share analysis |
| <input type="checkbox"/> Other (Identify) | |
| <input type="checkbox"/> None, <i>Explain</i> 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> American College of Cardiology | <input type="checkbox"/> National Committee for Quality Assurance | <input type="checkbox"/> Public Health Code & Federal Corollary |
| <input type="checkbox"/> National Association of Child Bearing Centers | <input type="checkbox"/> American College of Obstetricians & Gynecologists | <input type="checkbox"/> American College of Surgeons |
| <input type="checkbox"/> Report of the Inter-Council for Radiation Oncology | <input type="checkbox"/> American College of Radiology | <input type="checkbox"/> Substance Abuse Society and Mental Health Services Administration |
| <input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> DPH | <input type="checkbox"/> JCAHO |
| <input type="checkbox"/> Fire Marshall Report | <input type="checkbox"/> Other States Health Dept. Reports (New Out-of-State Providers) |
| <input type="checkbox"/> AAAHC | <input type="checkbox"/> AAAASF |
| <input type="checkbox"/> Other: | |

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?

- | | |
|--|---|
| <input type="checkbox"/> Energy conservation | <input type="checkbox"/> Group purchasing |
| <input type="checkbox"/> Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.) | <input type="checkbox"/> Reengineering |
| <input type="checkbox"/> None of the above | |
| <input type="checkbox"/> 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 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)

<input type="checkbox"/> Corporation (Inc.)	<input type="checkbox"/> Limited Liability Company (LLC)
<input type="checkbox"/> Partnership	<input type="checkbox"/> Professional Corporation (PC)
<input type="checkbox"/> Joint Venture	
<input type="checkbox"/> 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. The Hospital 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) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.
- iv) 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 equipment.

** Provide a current vendor quote for each piece of major medical equipment proposed for purchase or lease.

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. Land/ Building Purchase

If the CON involves any land/building purchase, please answer all of the following that apply:

Please submit a copy of the Real Estate Property Appraisal.	\$ _____
What is the useful life of the building?	____ Years
Please submit a schedule of depreciation for the purchased building as an attachment.	

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

13. 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:

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	FY _____ Year 1 Projected Payer Mix	FY _____ Year 2 Projected Payer Mix	FY _____ 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				
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.

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

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

- i) Provide 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. Note: 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) List the assumptions utilized in developing the projections reported on Financial Attachments I and II (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 copy of the Hospital's charity care policy and sliding fee scale applicable to the proposal.

14. Project Specific Questions:

- A. List the anesthetic and/or sedating drugs that will be used at the Facility.
List the drug's common chemical name and/or brand name.

- B. List the monitoring equipment currently available at the Facility.

- C. List the emergency resuscitative equipment that will be available at the Facility.

- D. Attach a copy of the Facility's proposed Conscious Sedation Protocol and/or Anesthesia Protocol as amended to date.

- E. Categorize the outpatient surgical procedures that have been performed by the Hospital during the past three fiscal years (See Question 4 A. i) b)) and report the total time required to perform the procedures in each category using the following format:

Procedure Category	FY 2004		FY 2005		FY 2006	
	No. of Procedures	Total Time	No. of Procedures	Total Time	No. of Procedures	Total Time

- F. Using the total number of procedures performed and the total number of minutes as reported above, report the operating room utilization at the Hospital for the outpatient surgical procedures using the following format:

Item	2004	2005	2006	FY 2007 to date*
Total number of procedures performed				
Annual increase in procedures performed	-	%	%	
Number of operating rooms				
Average annual number of procedures per room				
Total number of procedure hours				
Number of hours available per year				
Percent of Total Hours Utilized	%	%	%	

*FY 2007 reported from __/__/__ to __/__/__.

OFFICE OF HEALTH CARE ACCESS
REQUEST FOR NEW CERTIFICATE OF NEED
FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">DATE</th> <th style="width: 15%; text-align: center;">INITIAL</th> </tr> </thead> <tbody> <tr> <td>1. Check logged (Front desk)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>2. Check rec'd (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>3. Check correct (Superv.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>4. Check logged (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		DATE	INITIAL	1. Check logged (Front desk)	_____	_____	2. Check rec'd (Clerical/Cert.)	_____	_____	3. Check correct (Superv.)	_____	_____	4. Check logged (Clerical/Cert.)	_____	_____
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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							
<p>1. Check statute reference as applicable to CON application (see statute for detail):</p> <p>_____ 19a-638. Additional function or service, change of ownership, service termination. No Fee Required.</p> <p>_____ 19a-639 Capital expenditure exceeding \$3,000,000 or capital expenditure exceeding \$3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. Fee Required.</p> <p>_____ 19a-638 and 19a-639. Fee Required.</p> <p>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.</p> <p>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 less than \$3,000,000</p> <p>4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding \$3,000,000 or other capital expenditure exceeding \$3,000,000 is checked above <u>OR</u> if both 19a-638 and 19a-639 are checked):</p> <p style="margin-left: 20px;">a. Base fee: _____</p> <p style="margin-left: 20px;">b. Additional Fee: (Capital Expenditure Assessment) _____</p> <p style="margin-left: 40px;">(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) (\$ _____ x .0005)</p> <p style="margin-left: 20px;">c. Sum of base fee plus additional fee: (Lines A4a + A4b) _____</p> <p style="margin-left: 20px;">d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 20%; text-align: right;">\$ 1,000.00</td> </tr> <tr> <td></td> <td style="text-align: right;">\$ _____ .00</td> </tr> <tr> <td></td> <td style="text-align: right;">\$ _____ .00</td> </tr> </table>		\$ 1,000.00		\$ _____ .00		\$ _____ .00
	\$ 1,000.00						
	\$ _____ .00						
	\$ _____ .00						
SECTION B TOTAL FEE DUE: _____	\$ _____ .00						

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

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: _____

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

<u>Total Facility:</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>	<u>FY</u>
<u>Description</u>	<u>Actual</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>	<u>Projected</u>
	<u>Results</u>	<u>W/out CON</u>	<u>Incremental</u>	<u>With CON</u>	<u>W/out CON</u>	<u>Incremental</u>	<u>With CON</u>	<u>Incremental</u>	<u>With CON</u>
NET PATIENT REVENUE									
Non-Government									
Medicare									
Medicaid and Other Medical Assistance									
Other Government									
Total Net Patient Patient Revenue	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Operating Revenue									
Revenue from Operations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OPERATING EXPENSES									
Salaries and Fringe Benefits									
Professional / Contracted Services									
Supplies and Drugs									
Bad Debts									
Other Operating Expense									
Subtotal	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Depreciation/Amortization									
Interest Expense									
Lease Expense									
Total Operating Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Gain/(Loss) from Operations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Plus: Non-Operating Revenue									
Revenue Over/(Under) Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
FTEs									
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 <u>incremental</u> revenue, expense and volume statistics <u>attributable to the proposal</u> in the following reporting format:									
Type of Service Description									
Type of Unit Description:									
# of Months in Operation									
FY _____ (Year _)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses
				Col. 2 * Col. 3				Col. 4 - Col. 5	Col. 1 Total *
Total Facility by								-Col. 6 - Col. 7	Col. 4 / Col. 4 Total
Payer Category:									
Medicare				\$0				\$0	\$0
Medicaid		\$0		\$0				\$0	\$0
CHAMPUS/TriCare		\$0		\$0				\$0	\$0
Total Governmental			0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial Insurers		\$0	5	\$0				\$0	\$0
Uninsured		\$0	2	\$0				\$0	\$0
Total NonGovernment		\$0	7	\$0	\$0	\$0	\$0	\$0	\$0
Total All Payers		\$0	7	\$0	\$0	\$0	\$0	\$0	\$0

2

510 APARTMENTS FOR RENT

MANCHESTER-Available Market Rate Units 1, & 2, \$716-\$823 includes heat & hot water, fully appliances kitchen, gas cooking range, wall-to-wall carpet, 24-hour Emergency Maintenance, laundry facilities and easy highway access. Sorry no pets. Please call 646-1280 for additional information. Vouchers and Certificates accepted. EHO-CHFA FINANCED.

MANCHESTER Lge 1 BR, HH incl. \$700, no pets 3rd fl. on Main St. Call John 643-2181

MANCHESTER-Lrg 1 BR, eat in kitch, all appl, 2 AC's, pool. \$700+ util. Keith R.E. 646-4126

MANCHESTER "Move in Today!" 1,2,3, or 4 Br apts/houses. Section 8 ok. Call 646-4144

MANCHESTER - Nice 3 room apt. Heat & electricity. Sec. dep. No pets. Call 643-8552.

MANCHESTER spacious 3BR, 2nd flr, \$945. incl. heat/hw and garage, no pets, 268-3130

MANCHESTER Super Special 1BR/cottage house, \$1100 incl. ht/hw & gar, w/d. 268-3130.

Manchester/Vernon Av immed, 1BR, \$695 & \$730, HT/HW incl, 24 hr maint No dogs 876-7000

ROCKVILLE Enormous 2BR & 3BR in quiet bldg. w/w, Laundry, FREE HEAT/ HOT WATER. \$750 & \$895. Call 875-9500.

ROCKVILLE-Modern spac 2 BR, priv entry, deck, w/w, cats OK. \$725. 872-0670, 424-2330

SOMERS-136 Mountain View Rd. 2 BR, all appl. \$900. 1st & last mo. Call 860-749-1197

Overhead of "Shall Office," 3-phase elec, \$1000+utils, sec 649-1079

MANCHESTER Comm./Ind. 3200 S/F, 6-bay gar w/office, 3 phase elec. Avail 7/1. 649-9559

520 BUSINESS PROPERTY FOR RENT

Ellington Industrial Center

2000 S.F.

Rte 83. New 2000 S/F rental area with drive-in door and loading dock. Also 1000 S/F with loading dock and office. Ideal for service, distribution, office, machine shop, printing, hi-tech, etc.

Call James J. Gessay
@ 860-875-0134

SOUTH WINDSOR Sullivan Ave., 1600 S/F, \$1190/mo. & 1200 S/F, \$990/mo 521-1744

525 CONDOMINIUMS FOR RENT

SUFFIELD Waters Edge Condo by the River. 1350 sq. ft townhouse. Convenient to I91, many amenities. \$1100/mo. +util & heat. No pets. 1st & last mo. sec. 860-741-0623 or 394-9990

WINDSOR LOCKS Concorde Landing Immac. 2BR, 2BA, \$960 +util. Keating RE/745-2030

540 HOUSES FOR RENT

Coventry - Rent to own. All rent towards purchase. 2BR Ranch. Totally renovated. New heating & electrical & plumbing. Short walk to Lake. \$4,900 down, \$995/mo. plus costs, \$189,900, 38 Squirrel Trl. Owner 742-9295

Enfield - 21 Parsons Rd. Rent to own, all rent towards purchase, \$9,200 down, \$1,000/mo. plus costs, \$189,900, 38 Squirrel Trl. Owner 742-9295
Fairfield Berkshires at Bently Brook, Hancock, MA. Floating, Red time, 2 bedroom, deeded. Paid \$15,000 selling for \$7,000. Call 877-4160

610 CONDOMINIUM FOR SALE

COVENTRY Rarely available condo in Country Place. Complete redecoration/ update. Finished basement. RE/ R.E., Call Mary Riley, 742-056

MANCHESTER No. Field Gr 3BR, 2 1/2BA Condo, new turn., wind. \$187,500 643-47

625 FINANCIAL

"NOTICE"
It is illegal in Connecticut for brokers of unsecured loans to require that applicants pay a fee before loan proceeds are disbursed. If you have paid a fee, or would like more information, please contact the Consumer Affairs Unit of the Connecticut Department of Banking at 860-240-8299 or www.ct.gov/dob. This notice is provided as a public service: the Journal Inquirer.

640 HOUSES FOR SALE

MANCHESTER - 3BR Ranch, 1 owner. Gar. Ansaldi built \$209,900. Tully R.E. 643-000

650 LOTS & ACREAGE

VERNON Wildwood Rd. Lake rights 2 approved bldg. lots Call 860-645-6611

655 MOBILE HOMES

SOUTH WINDSOR 1 BR, 99 Shamrock, \$18,500

Journal Inquirer

CHANGES TO THE STATE MEDICAID PLAN CLAIMS FOR FINANCIAL PARTICIPATION

its Medicaid State Plan, effective July 1, 2007 as follows:

19A, Section 15, of the Medicaid State Plan pertaining to additional providers serving low-income persons under SSA Section 1923 (c) (3). This includes those lawfully operated general hospitals in hospitals that provide services to low-income persons and that meet security Act.

08 is \$14,169,584 for the portion of Section 15 of the state plan per- s, excluding outpatient clinic services and associated ancillary serv- ics Data Services.

in any increases in hospital disproportionate share expenditures

ch of the following locations:

PUBLIC NOTICE

PUBLIC NOTICE

Statute References: 19a-638 and 19a-639, C.G.S.
Applicant: Middlesex Hospital
Town: Middletown
Docket Number: 07-30992
Proposal: Establish and Operate a new outpatient surgical services facility for orthopedic outpatient care adjacent to the current outpatient surgical service facility on Saybrook Road, Middletown
Capital Expenditure: \$8,000,000

The Applicant may file its Certificate of Need application between August 20, 2007 and October 19, 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.

Journal Inquirer
July 2, 2007

Department of Social Services web site: www.dss.state.ct.us. Go to

to: