BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

October 1, 2007
Via Federal Express

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

Re: Middlesex Hospital & The Middlesex Center for Advanced Orthopedic Surgery, LLC's Submission of Form 2030 to replace 07-31020-LOI

Dear Commissioner Vogel:

Enclosed please find an original and three (3) copies of a Letter of Intent, Form 2030, regarding The Middlesex Center for Advance Orthopedic Surgery, LLC. The Applicants hereby withdraw their original Letter of Intent on file as 07-31020-LOI and replace it with the enclosed Letter of Intent.

Please do not hesitate to contact me if you have any questions or require additional information.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosures
cc: Vincent Capece, Jr., Lawrence Berson, M.D., Steven M. Luster, M.D., Terry F. Reardon, M.D., Paul Knag

F:\Doc\07 4101-4150\074145 Middlesex ASC JV\Docs\LOI\OHCA (Comm Vogel 9.27.07).doc

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**	**The Middlesex Center for Advanced Orthopedic Surgery, LLC**
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**	**28 Crescent Street Middletown, CT 06457**
What is the Applicant's Status: P for Profit or NP for Nonprofit	**NP**	**P**
Does the Applicant have Tax Exempt Status?	Yes √ No	Yes No √
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	**Vincent Capece, Jr. Senior Vice President, Finance and Operations**	**Michele M. Volpe, Esq.**
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**28 Crescent Street Middletown, CT 06457**	**Bershtein, Volpe & McKeon P.C. 105 Court Street Suite 304**

		New Haven, CT 06511
Contact Person's Telephone Number	**(860) 344-6120**	**(203) 777-6995**
Contact Person's Fax Number	**(860) 346-5485**	**(203) 777-5806**
Contact Person's e-mail Address	**Vinnie_Capece@midhosp.org**	**michelemvolpe@aol.com**

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

The Middlesex Center for Advanced Orthopedic Surgery, LLC

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:

512 Saybrook Road, Middletown, CT 06457

d. List each town this project is intended to serve: **The Middlesex Center for Advanced Orthopedic Surgery, LLC's primary service area will include the Connecticut**

cities and 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: **June, 2009**

f. Type of project: **11**
(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: **$ 7,794,500**

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	**3,239,500**
Other (Non-Construction) Specify: **Development Costs and Start Up Working Capital Requirements**	**2,087,000**
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	**2,218,000**
Non-Medical Equipment – Fair Market Value of Leases*	**250,000**
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	**$ 7,794,500**
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).

Major Medical and/or Imaging Equipment Acquisition: [Specifics Not Yet Available]

Equipment Type	Name	Model	Number of Units	Cost per unit
Not Yet Available				

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

Contracts with vendors for the proposed equipment purchases included in this proposed project are not yet available.

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 - See project description included on page 9

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 Hospital** _____

Project Title: ___ **The Middlesex Center for Advanced Orthopedic Surgery, LLC** ____

I, ____ **Vincent Capece**_____, _____ **Senior VP, Finance and Operations**__
(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 _____ 9/27/07 _____
Signature Date

Subscribed and sworn to before me on September 27, 2007

Abby Ann Cole _____
Notary Public ~~Commissioner of Superior Court~~

ABBY ANN COLE
NOTARY PUBLIC
MY COMMISSION EXPIRES JAN. 31, 2010

My commission expires: _____

AFFIDAVIT

To be completed by each Applicant

Applicant: ___ **The Middlesex Center for Advanced Orthopedic Surgery, LLC**____

Project Title: ___ **The Middlesex Center for Advanced Orthopedic Surgery, LLC**____

I, ____ **Vincent Capece**_____, _____ **Duly Authorized Agent**_____
(Name) (Position – CEO or CFO)

of **The Middlesex Center for Advanced Orthopedic Surgery, LLC** 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 _ **The Middlesex Center for Advanced Orthopedic Surgery, LLC**
(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.

Vincent Capece
Signature

9/27/07
Date

Subscribed and sworn to before me on September 27, 2007

Abby Ann Cole
Notary Public/~~Commissioner of Superior Court~~

ABBY ANN COLE
NOTARY PUBLIC
MY COMMISSION EXPIRES JAN. 31, 2010

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

SECTION IV. PROJECT DESCRIPTION

Middlesex Hospital and its affiliated orthopedic physicians (the "Providers") currently provide orthopedic surgical services to the residents of the Middlesex Health System primary service area, which includes Middlesex County and a number of surrounding communities as described in Section II. d. of this Letter of Intent. The Providers are currently the only providers of orthopedic surgical services located within this service area.

This Certificate of Need application for this project will be submitted jointly by Middlesex Hospital and The Middlesex Center for Advanced Orthopedic Surgery, LLC to develop a new orthopedic ambulatory surgical services facility. The Middlesex Center for Advanced Orthopedic Surgery, LLC will be owned fifty percent (50%) by Middlesex Hospital and fifty percent (50%) by orthopedic physicians on the medical staff of the Hospital. The Middlesex Center for Advanced Orthopedic Surgery, which will be dedicated to the provision of orthopedic surgical care, will be located on a site adjacent to Middlesex Hospital's current outpatient facility on Saybrook Road in Middletown, CT.

This project is needed to enable Middlesex Hospital to develop the capacity required to serve the existing and future surgical care needs of the growing and aging population in its service area. Middlesex Hospital has determined that it needs to expand the overall capacity of surgical services to meet the growth in demand projected over the next decade. The development of The Middlesex Center for Advanced Orthopedic Surgery will allow the Providers to service the needs of the community in a more cost effective and accessible facility.

The Middlesex Center for Advanced Orthopedic Surgery, LLC will seek licensure from the Department of Public Health and will be the provider. The Middlesex Center for Advanced Orthopedic Surgery will serve as an integral component of the overall surgical services of the Middlesex Health System. Middlesex Hospital and its orthopedic physicians currently participate in nearly all private and government third party payer programs within the state and will continue to do so through The Middlesex Center for Advanced Orthopedic Surgery, LLC in the future.

With this proposed project, the partnership of Middlesex Hospital and its orthopedic physicians is making an important commitment to expand surgical services to meet the needs of the population in their service area. In addition to providing the incremental OR capacity within the Middlesex Health System that is needed, the creation of The Middlesex Center for Advanced Orthopedic Surgery, as a dedicated center for the provision of ambulatory orthopedic surgical care, will contribute favorably to the quality of services provided, the ongoing accessibility of these services, and cost effective operations for these services. By providing these benefits to the Middlesex community, this project will help to enhance the overall healthcare delivery system in Connecticut.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 4, 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 07-31047
Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC
Establish and operate a new outpatient surgical services facility in Middletown
Notice of Letter of Intent

Dear Mr. Capece:

On August 2, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC ("Applicant") to establish and operate a new outpatient surgical services facility in Middletown, at a total capital expenditure of $7,794,500.

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 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R Martone (RKS)

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

October 4, 2007

Requisition # HCA08-063
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, October 8, 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 (RRG)

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

Journal Inquirer
Docket Number 07-31047

Letter of Intent
October 4, 2007

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-638 and 19a639
Applicant:	Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC
Town:	Middletown
Docket Number:	07-31047
Proposal:	Establish and operate a new outpatient surgical services facility in Middletown
Capital Expenditure:	$7,794,500

The Applicant may file its Certificate of Need application between December 1, 2007 and January 30, 2008. 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	2685
RECIPIENT ADDRESS	96469867
DESTINATION ID	
ST. TIME	10/05 12:18
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 4, 2007

Requisition # HCA08-063
Fax: 646-9867

Journal Inquirer
306 Progress Drive
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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone (RKS)

Kimberly R. Martone
Certificate of Need Supervisor

Greer, Leslie

From: legals@journalinquirer.com
Sent: Friday, October 05, 2007 5:08 PM
To: Greer, Leslie
Subject: RE: Legal Ad 07-31047

Hi Leslie:

You should be all set for Mon. Oct. 8th
Have a nice weekend.
Thanks,
Kathie
Classified

---- Original Message ----
From: Leslie.Greer@po.state.ct.us
To: legals@journalinquirer.com
Subject: Legal Ad 07-31047
Date: Fri, 5 Oct 2007 15:13:16 -0400

>Legal Ad,
>
Please place the attached public notice in your newspaper no later than
>October 8, 2007. Please notify me that you have received this request.
>
>
>
>Thank you,
>
>
>
>Leslie M. Greer
>
>Office of Health Care Access
>
>State of Connecticut
>
>410 Capitol Avenue
>
>Hartford, CT 06134
>
>Phone: (860) 418-7001
>
>Fax: (860) 418-7053

>Website: www.ct.gov/ohca <http://www.ct.gov/ohca>
>
>
>

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 9, 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 07-31047-CON
Middlesex Hospital and The Middlesex Center for Advanced Orthopedic Surgery, LLC
Proposal to Establish and Operate a New Outpatient Surgical Services Facility in Middletown

Dear Mr. Capece:

Enclosed are the application forms for Middlesex Hospital and The Middlesex Center for Advanced Orthopedic Surgery, LLC's Certificate of Need ("CON") proposal to establish and operate a new outpatient surgical services facility in Middletown with an associated capital expenditure of $7,794,500. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes, the CON application may be filed between December 1, 2007, and January 30, 2008.

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 an electronic copy of the Applicant be submitted in MS Word, or similar, format and that the Financial Attachments and other data as appropriate be in MS Excel format.

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 December 1, 2007, and may be submitted no later than January 30, 2008. 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:	07-31047-CON
Applicants' Names:	Middlesex Hospital Middlesex Center for Advanced Orthopedic Surgery, LLC
Contact Person: **Contact Title:**	Vincent Capece 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 surgical 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 Cost:	$7,794,500

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. Applicants' Long Range Plans

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. List the primary service area (PSA) towns for the proposed new ambulatory surgery center. Provide the rationale for choosing the selected PSA towns.

C. List the secondary service area (SSA) towns. Provide the rationale for choosing the selected SSA towns.

D. Report the number of procedures performed for the past three fiscal years by service area town *and* type of procedure performed for Middlesex Hospital and for the physicians of the Middlesex Center for Advanced Orthopedic Surgery.

E. Report 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 Utilization[7]
	Available[1]	Utilized[2]	Not Utilized[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.

☐ Cultural
☐ Geographic
☐ Other (Identify)
☐ None, Please provide an explanation.
☐ Transportation
☐ Economic

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

- ☐ Epidemiological studies
- ☐ Public information reports
- ☐ Needs assessments
- ☐ 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 Applicants' Chief Executive Officers (CEO) and Chief Financial Officers (CFO), Medical Directors, 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. Middlesex Hospital may reference that filing for this proposal.

ii) Report Middlesex Hospital's 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 for Middlesex Hospital, 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) Submit audited financial statements for the most recently completed fiscal year for The Middlesex Center for Advanced Orthopedic Surgery, LLC. If no audited financial statements are available, submit a compilation report or an unaudited Balance Sheet as of the date of the submission of this application and a Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

vi) 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.

14. 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.

15. 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 __/__/____.

14. 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:

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										
***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 (i). Please provide one year of actual results and three years of projections of **Middlesex Center for Advanced Orthopedic Surgery, LLC's** 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										
***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 _____ (Year _)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue Col. 2 * Col. 3	Deductions	Care	Debt	Revenue Col.4 - Col.5	Expenses Col. 1 Total *	from Operations Col. 8 - Col. 9
Total Facility by Payer Category:								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Facility Name) said facility 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.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION 1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure 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.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 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)