GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

November 2, 2007

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

Dear Commissioner Vogel:

Enclosed please find an original Letter of Intent as well as three hard copies from Greenwich Hospital to establish Hyperbaric Oxygen Therapy Services at the Hospital.

Thank you in advance for your consideration of this project. If you have any questions, please call me at (203) 863-3909.

Sincerely,

Nancy M. Hamson

Nancy M. Hamson
Director of Planning

CC: Frank A. Corvino, Greenwich Hospital
Melinda Agsten, Wiggin and Dana

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	Greenwich Hospital	
Doing Business As	Greenwich Hospital	
Name of Parent Corporation	Greenwich Health Care Services, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	5 Perryridge Road Greenwich, CT 06830	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Nancy Hamson Director of Planning	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	5 Perryridge Road Room 3-3307 Greenwich CT 06830	

Contact Person's Telephone Number	203-863-3909	
Contact Person's Fax Number	203-863-4784	
Contact Person's e-mail Address	nancyh@greenhosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establish Hyperbaric Oxygen Therapy Services

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:

5 Perryridge Road, Greenwich CT 06830

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

This project would serve the patients currently served by Greenwich Hospital. Towns in Connecticut include: Greenwich, Stamford, Darien, New Canaan, Norwalk, Westport, Weston and Wilton. Towns in New York include: Port Chester, Rye, White Plains, Harrison, Bedford, Mamaroneck, New Rochelle, Larchmont, Pound Ridge and Scarsdale.

e. Estimated starting date for the project: **October 2008**

f. Type of project: **27**
(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$ 1,042,442**

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

Medical Equipment Purchases	$267,442
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$775,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,042,442**
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	**$1,042,442**

Total Project Cost	**$1,042,442**
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:

Equipment Type	Name	Model	Number of Units	Cost per unit
Hyperbaric System	Secrist	3600ER	2	$118,400

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

Attachment I

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

☒ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

Attachment II

AFFIDAVIT

To be completed by each Applicant

Applicant: Greenwich Hospital

Project Title: Establish Hyperbaric Oxygen Therapy Services

I, Frank A. Corvino (Name), President/CEO (Position – CEO or CFO)

of Greenwich 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 Greenwich Hospital 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

October 24, 2007
Date

Subscribed and sworn to before me on October 24, 2007

Notary Public/Commissioner of Superior Court

SHEILA G. VENTO
NOTARY PUBLIC
MY COMMISSION EXPIRES MAR. 31, 2012

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

ATTACHMENT I

SECHRIST
Industries, Inc.

4225 E. La Palma Ave.
Anaheim, CA 92807
Phone: 714-579-8400
Fax: 714-579-0814
Website: SechristUSA.com

QUOTE TO:

David Polaski
Manager of Respiratory
Greenwich Hospital
5 Perry Ridge Road
Greenwich, CT 06830
203-863-3173
davep@greenhosp.org

QUOTATION NUMBER:	06-0280R2
QUOTATION VALID:	30 Days
PREPARED BY:	Sandy Niakamal
STANDARD TERMS:	30% Down with P.O. 50% Prior to Shipment 20% Net 30 Days Based on Credit Approval
EX FACTORY:	Anaheim, CA.
SHIP VIA:	Prepaid truck. Add to invoice
DELIVERY:	Subject to Availability
QUOTATION DATE:	10/1/07

Qty	Part No.	Description	Price Each	Ext. Price
1	3600E	Monoplace Hyperbaric System, 36" Diameter, Electronic Control Panel	$148,000.00	$148,000.00
		Less Special Discount Based on Multiple Chamber Purchase		$29,600.00
		Chamber Subtotal		**$118,400.00**
1	3600ER	Monoplace Hyperbaric System, 36" Diameter, Electronic Control Panel - Reverse Option	$148,000.00	$148,000.00
		Less Special Discount Based on Multiple Chamber Purchase		$29,600.00
		Chamber Subtotal		**$118,400.00**

Each chamber comes complete with the following:

1	21464	Standard Gurney Assembly with Deluxe Wide Patient Stretcher and Mattress	N/C	N/C
1	23051	Patient Call Assembly	N/C	N/C
1	21345	Accessory Mount Assembly	N/C	N/C
1	35243	19 Pin Electrical Port – door side hull	N/C	N/C
1	22156	19 Pin Patient Cable – exterior to chamber	N/C	N/C
1	22157	19 Pin Patient Cable – interior of chamber	N/C	N/C
3	HB 228-IV	I.V. Pass Through Ports	N/C	N/C
1	20354	Cotton Cover	N/C	N/C
Lot	----	Non Stock Hoses and Adapters for Installation	N/C	N/C
Lot	----	Non Stock Spare Parts Kit	N/C	N/C
1	----	*Installation and Technical In-service Training*	N/C	N/C

Subtotal (2) Chambers	$236,800.00
Shipping Crates	$1,842.00
Freight and Insurance	$6,800.00
Total (2) Chambers	**$245,442.00**

Option at time of Purchase:

Qty	Part No.	Description	Price Each	Ext. Price
	----	Upgrade Standard Gurney to Hydraulic Gurney with Deluxe Wide Patient Stretcher & Mattress (p/n 21465)	$3,050.00	
			Quote	**06-0280R2**

Ancillary Equipment:

Qty	Part No.	Description	Price Each	Ext. Price
1	20480	HBO TV System (Model 3600E) Includes TV, power supply, mounting rack, cables/adapters, installation instructions	$1,899.00	**N/C**
1	20481	HBO TV System (Model 3600ER) Includes TV, power supply, mounting rack, cables/adapters, installation instructions	$1,899.00	**N/C**
	20087	Air Break Breathing Assembly (includes one demand valve, pass-through port, two masks, hoses & fittings).	$896.00	

Maintenance Options:

Qty	Part No.	Description	Price Each	Ext. Price
	----	Total Care™ Maintenance Agreement Annual preventative maintenance with 12 month service coverage. The agreement goes into effect after the warranty period.	$2,780.00	
		or		
	----	Preventative Maintenance Agreement Annual preventative maintenance only. This program offers a one-time yearly service during the time that one of our service technicians is in your area. Under this program, we offer a 30 day warranty period starting from the time the service has been performed.	$1,980.00	

- **Tax has not been included in the quote, but does apply. If you are tax exempt, your tax exempt certificate must accompany your order.**
- All purchases are subject to standard terms, based on approved credit, unless other arrangements are made and agreed upon by Sechrist Industries.
- Acceptance of a purchase order will be based upon a written confirmation from Sechrist Industries, Inc. documenting the agreed upon terms of sale and is subject to final credit approval.
- Freight charges are based on current rates and tariffs and are subject to change.
- Prices are subject to change without notice.
- Parts and labor are warranted for one year from date of purchase.

By: Chris Patrick, U.S. Regional V.P. of Sales- Hyperbaric Systems
Toll-free: 800-732-4747 ext. 242
Direct: 714-579-8358
Cell: 714-321-7739
Fax: 714-579-0814
Email: cpatrick@sechristusa.com

Attachment II

PROJECT DESCRIPTION

Greenwich Hospital is a progressive medical center offering a wide range of medical, surgical, diagnostic and preventive programs. A member of the Yale New Haven Health System, Greenwich Hospital is a community teaching hospital, affiliated with the Yale University School of Medicine. Greenwich Hospital is committed to providing the highest quality of care to the communities it serves. Greenwich Hospital's Department of Public Health License is presented in Appendix I. With this Letter of Intent, Greenwich Hospital is seeking approval to provide Hyperbaric Oxygen Therapy (HBOT) at the Hospital.

HBOT would be a complement to the wound care services offered at Greenwich Hospital. Greenwich Hospital currently provides comprehensive wound care services to patients in the Hospital's service area. HBOT is defined by the Undersea Hyperbaric Medical Society as the intermittent administration of 100% oxygen inhaled while in an enclosed system at a pressure greater than sea level. The increased pressure changes the normal cellular respiration process and causes the oxygen to dissolve in the plasma. The result of this process is a substantial increase in tissue oxygenation. This increase in tissue oxygenation is beneficial as it stimulates the growth of new blood vessels and increases oxygenation that can arrest certain types of infections and enhance wound healing.

HBOT is state-of-the-art care for treatment of chronic wounds that have not responded to conventional treatments. HBOT provides high quality care to enhance the services provided to this patient population in the Hospital's service area. The majority of patients requiring HBOT are frail and ill with complicated medical problems. Since HBOT treatments generally range from fifteen to twenty-five treatments, two to three days per week, it is beneficial to patients to have local access to HBOT with limited patient travel. Currently, Norwalk Hospital is the only other known provider of HBOT in the Hospital's local service area.

The addition of HBOT to the complement of services offered by Greenwich Hospital will enhance the State of Connecticut health care delivery system. The proposed service would not impact other area providers. The payer source and target market would remain unchanged. Greenwich Hospital will be able to provide patients with state-of-the-art, easily accessible, excellent quality care when they need it, as soon as they need it.

APPENDIX I

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0045

General Hospital

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

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

Greenwich Hospital is located at 5 Perryridge Road, Greenwich, CT 06830

The maximum number of beds shall not exceed at any time:
32 Bassinets
174 General Hospital beds

This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007. RENEWAL.

Satellites
The Endoscopy Center Of Greenwich Hospital, 500 West Putnam Avenue, Greenwich, CT

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

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

Form 2030
Revised 7/06

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 8, 2007

Nancy Hamson
Director of Planning
5 Perryridge Road
Room 3-307
Greenwich, CT 06830

Re: Letter of Intent, Docket Number 07-31057
Greenwich Hospital
Establish Hyperbaric Oxygen Therapy Services
Notice of Letter of Intent

Dear Ms. Hamson:

On November 5, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Greenwich Hospital ("Applicant") to establish Hyperbaric Oxygen Therapy Services, at a total capital expenditure of $1,042,442.

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

Sincerely,

Kimberly Martone (AGF)

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

November 8, 2007

Requisition # HCA08-082
Email: legal.notices@scni.com

Greenwich Times
20 East Elm Street
Greenwich, CT 06830

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, November 12, 2007.**

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

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

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly Martone (AGF)

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AGF:lmg

c: Sandy Salus, OHCA

Greenwich Times
Docket Number 07-31057

Letter of Intent
November 8, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Greenwich Hospital
Town:	Greenwich
Docket Number:	07-31057
Proposal:	Establish Hyperbaric Oxygen Therapy Services
Capital Expenditure:	$1,042,442

The Applicant may file its Certificate of Need application between January 4, 2008 and March 4, 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.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 8, 2007

Nancy Hamson
Director of Planning
5 Perryridge Road
Room 3-3307
Greenwich, CT 06830

RE: Certificate of Need Application Forms; 07-31057-CON
Greenwich Hospital
Proposal to Establish Hyperbaric Oxygen Therapy Services

Dear Ms. Hamson:

Enclosed are the application forms for Greenwich Hospital's Certificate of Need ("CON") proposal to establish Hyperbaric Oxygen Therapy Services at 5 Perryridge Road, Greenwich, CT, with an associated capital expenditure of $1,042,442. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between February 3, 2008, and April 3, 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 in Adobe Acrobat format. OHCA requests that an electronic copy of the applicant (without attachments) be in submitted in MS Word format and that the Financial Attachments and other data, as appropriate, be in MS Excel format.

The analyst assigned to the CON application is Alexis Fedorjaczenko. Please feel free to contact her at (860) 418-7067, if you have any questions.

Sincerely,

Kimberly Martone (agf)

Kimberly Martone
Certificate of Need Supervisor

Enclosures
KM:agf

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 February 3, 2008 and may be submitted no later than April 3, 2008. The Analyst assigned to your application is Alexis Fedorjaczenko, who may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	07-31057-CON
Applicant(s) Name:	Greenwich Hospital
Contact Person:	Nancy Hamson
Contact Title:	Director of Planning
Contact Address:	5 Perryridge Road Room 3-3307 Greenwich, CT 06830
Project Location:	Greenwich
Project Name:	Establish Hyberbaric Oxygen Therapy Services
Type of proposal:	Sections 19a-638 C.G.S.
Est. Capital Expenditure:	$1,042,422

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 following information:

i) List the service area towns for the proposed service. Provide a rationale for choosing the selected towns.

ii) Describe the population to be served, including the number of diabetic individuals to receive the proposed service as in the following table. Include demographic Information as appropriate.

Population with Diabetes	
Diabetic Population with Chronic Wounds	
Diabetic Population requiring HBOT	

iii) Scheduling backlogs in service area.

iv) Travel distance from the proposed site to service area towns.

v) Hours of operation of existing and the proposed service.

C. Provide the units of service projected for the first three years of operation of the proposed service. **Include all assumptions used in the derivation/calculation of your projections.**

D. Provide the information as outlined in the following table concerning the existing providers' in the Applicant's service area:

Name and Location of Provider	**Similar Services Provided? (Y/N)**	**Affiliated Physicians**

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

F. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

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

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

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

☐ Other: Specify _____

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

C. 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.

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

☐	DPH	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

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

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

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

G. Provide a copy of the related Quality Assurance plan.

6. Improvements to Productivity and Containment of Costs

In the past year, has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

---

[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.

C. Provide a copy of the State of Connecticut Department of Public Health license currently held.

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the 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 all non-medical equipment.

10. Construction/Renovation 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 information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

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

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	____Years
Please submit a copy of the vendor quote or invoice as an attachment.	
Please submit a schedule of depreciation for the purchased equipment as an attachment.	

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

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	$_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$_____
CON Proposed debt financing	$_____
Interest rate	_____%

Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Amortization schedule (if not level amortization payments),
   iii. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current and the payer mix for the **proposed service only, based on Gross Patient Revenue** in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
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. Do the Applicants have Tax Exempt Status? ☐ Yes ☐ No

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

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicants audited financial statements.

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Please complete CON Financial Attachment II.

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). *Note: Include consideration of the Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

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

vi) Describe how this proposal is cost effective.

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)

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 ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System:	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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

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

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