HARTFORD HOSPITAL

80 Seymour Street
P.O. Box 5037
Hartford, CT 06102-5037
860/545-5000

31 December 2007

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

Re: Letter of Intent

Dear Commissioner Vogel:

I have enclosed an original and three copies of a Letter of Intent for a forthcoming Certificate-of-Need application regarding our proposal to relocate and expand our central Pharmacy. We look forward to submitting our project application to you; and we request from your office the necessary application forms.

Please feel free to contact me if you have any questions about this matter. Thank you.

Sincerely,

J. Bryan Simmons
Vice President for Planning
and Facilities Development

JBS/km

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 the Applicant(s), 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	Hartford Hospital	
Doing Business As	Hartford Hospital	
Name of Parent Corporation	Hartford Health Care Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037	
Identify Applicant 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 Designee to receive all correspondence in this matter.	J. Bryan Simmons, Vice President for Planning and Facilities Development	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Seymour Street Hartford, CT 06102-5037	
Contact Person Telephone Number	860-545-2232	
Contact Person Fax Number	860-545-3600	
Contact Person e-mail Address	bsimmon@harthosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Pharmacy Relocation and Expansion Project

b. Project Proposal: This is a proposal to relocate the Hospital's pharmacy, to an appropriately sized renovated space within Harford Hospital.

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☒ Other Inpatient *(specify)* ___Pharmacy_____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☒ Other Outpatient *(specify)* ___Pharmacy _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☒ Non-Medical Equipment ☒ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☐ Yes ☒ No

If you checked "Yes" above, please check the appropriate box below:

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service

☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☒ Yes ☐ No

If you checked "Yes" above, please check the boxes below, as appropriate:

☒ New equipment acquisition and operation

☒ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

80 Seymour Street, Hartford CT 06102-5037

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

Response: This project will not change the municipalities, primarily within the Hospital's primary and secondary service areas, served by the Hospital's existing Pharmacy. The municipalities within these primary and secondary service areas include the following:

Primary Service Area:

Avon	Hartford	Simsbury
Bloomfield	Manchester	South Windsor
Bolton	New Britain	West Hartford
East Hartford	Newington	Wethersfield
Farmington	Rocky Hill	Windsor
Glastonbury		

Secondary Service Area:

Andover	Enfield	Portland
Barkhamsted	Franklin	Preston
Berlin	Granby	Salem
Bozrah	Haddam	Somers
Bristol	Hartland	Southington
Burlington	Harwinton	Stafford
Canton	Hebron	Suffield
Colchester	Lebanon	Tolland
Columbia	Mansfield	Torrington
Coventry	Marlborough	Union
Cromwell	Meriden	Vernon
East Granby	Middlefield	Wallingford
East Haddam	Middletown	Winchester
East Hampton	New Hartford	Windham
East Windsor	Norwich	Windsor Locks
Ellington	Plainville	

h. Estimated starting date for the project: 1 May 2009

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 5,200,000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$35,000
Non-Medical Equipment Purchases*	$87,000
Land/Building Purchases	
Construction/Renovation	$5,078,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$5,200,000**
Major Medical Equipment – Fair Market Value of Leases 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	**$5,200,000**
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

Response: The medical equipment consists of pharmacy hoods costing $35,000. The non-medical equipment consists of refrigerators at $27,000 and high-density shelving at $60,000.

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

Response: Because the capital costs of the project do not exceed the specified thresholds, the question is considered to be not applicable. Irrespective of that conclusion, the project is considered non-substantive because it is anticipated to have no significant impact on Hartford Hospital's rates or patient charges and it will have no substantial impact on the delivery of health services or in Hartford Hospital's service area.

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Response: Not Applicable.

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

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

e. 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

In paragraph format, 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 being proposed and what DPH licensure categories will be sought, if applicable.

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

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

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

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

7. Who will be responsible for providing the service?

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

Project Description

This is a proposal for the renovation of space on the 13th floor of the Hospital's High Building – as well as a limited renovation of the 7th floor of the Building – to permit the relocation of the Pharmacy to the 13th floor space, at a total project cost of approximately $5.2 million. The need for this project is based on, 1) the limited physical size of the existing Pharmacy, 2) the widely dispersed nature of existing pharmacy functions, 3) operational problems and regulatory concerns that have arisen because of the existing space constraints, and 4) regulatory requirements that require the development of a new IV admixture space and the physical impossibility of developing this space within the current pharmacy location. In terms of the specifics of the renovation, this project entails the refurbishment of space on the 7th floor of the High Building to accommodate Environmental Services offices which would be displaced by the new Pharmacy space, and then the renovation of approximately 9,000 square feet of space on the 13th floor of the High Building to accommodate a new Pharmacy facility.

Background and Context: The hospital Pharmacy is a critical link for all clinical services, as it must accurately prepare and deliver prescribed medications to inpatient units and outpatient programs. It is imperative that this facility, along with the appropriate equipment, be located in a sufficiently sized space. Existing Pharmacy Department space is located in several areas and buildings: the main dispensing/sterile preparation on the third floor of the High Building; storage in the Bliss basement; management and clerical offices on the second floor of the Jefferson Building; staff and management on the third floor of the Conklin Building; staff and residents in the ERC; staff on the third floor of the Data Building; and dispensing in the Brownstone Building and on the IOL campus. This wide distribution of Pharmacy space is the result of the lack of adequate space in any single area, and the acquisition of space in piecemeal increments over a thirty-year period.

Apart from resolving the deficiencies associated with the present Pharmacy location, the proposed new location is easily accessible by way of elevators and the Hospital's pneumatic tube system, and will greatly improve distribution of medications to all areas of the hospital.

With regard to specific questions within the Letter of Intent form, the following information is provided:

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

   Response: Hartford Hospital is providing Pharmacy services to both inpatients and outpatients consistent with those provided by other tertiary care hospitals.

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

   Response: No new types of service will result from this proposal, so no DPH licensure changes will be sought.

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

   Response: The current and target populations consist of inpatients and outpatients served by Hartford Hospital. There will be no change in this service population as a result of the proposed project.

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

   Response: In general, this application is based on the continuing general need to assure that the Hospital's physical facilities are kept up-to-date to assure the delivery of the highest quality patient care. The Hospital's existing Pharmacy functions out of several widely dispersed

spaces, and this impedes efficient operation. The proposed project will establish a new, larger space for main Pharmacy operations which will permit the consolidation of these dispersed areas and therefore the improvement of overall Pharmacy operations. In addition and more specifically, new regulatory requirements concerning facilities for the preparation of intravenous (IV) admixtures have been introduced, and this project will result in the development of new facilities for the preparation of IV admixtures and therefore the compliance with these regulatory requirements.

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

   Response: Yes. All area hospitals, which include St. Francis Hospital and Medical Center, the John Dempsey Hospital, Hospital of Central Connecticut and Manchester Memorial Hospital, have on-site pharmacies.

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

   Response: This proposal is expected to enhance the quality of health care delivery by improving the physical environment for a critically important clinical service that supports the delivery of inpatient and ambulatory care at one of Connecticut's principal regional referral centers.

7. Who will be responsible for providing the service?

   Response: Hartford Hospital's Department of Pharmacy will provide the service.

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

   Response: Hartford Hospital's existing payers, which would not be changed by this proposal, include but are not limited to: Medicare, Medicaid, Anthem Blue Cross, Aetna and Connecticare.

AFFIDAVIT

To be completed by each Applicant

Applicant: Hartford Hospital

Project Title: Pharmacy Relocation and Expansion Project

I, John Meehan (Name), President and CEO (Position – CEO or CFO)

of Hartford 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 Hartford Hospital (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

John Meehan
Signature

12/31/07
Date

RECEIVED
DEC 31 2007
OFFICE OF
HEALTH CARE ACCESS

Subscribed and sworn to before me on 12-31-07

Janet Howland
Notary Public/Commissioner of Superior Court

JANET HOWLAND
NOTARY PUBLIC
MY COMMISSION EXPIRES JAN. 31, 2009

My commission expires:

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 7, 2008

J. Bryan Simmons
Vice President Planning and Facilities Development
Hartford Hospital
80 Seymour Street
P.O. Box 5037
Hartford, CT 06102 - 5037

RE: Certificate of Need Application Forms, Docket Number 07-31078-CON
Hartford Hospital
Pharmacy Relocation and Expansion Project at Hartford Hospital

Dear Mr. Simmons:

Enclosed are the application forms for Hartford Hospital's Certificate of Need ("CON") proposal to relocate pharmacy and expansion project at Hartford Hospital with an associated capital expenditure of $5,200,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between February 29, 2008 and April 2, 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 (5) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette in Adobe PDF format. OHCA requests that the electronic copy of the Application (attachments optional) be 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 Diane Duran. Please feel free to contact him/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 February 29, 2008, and may be submitted no later than April 29, 2008. The Analyst assigned to your application is Diane Duran and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	07-31078-CON
Applicant(s) Name:	Hartford Hospital
Contact Person:	J. Bryan Simmons
Contact Title:	Vice President Planning and Facilities Development
Contact Address:	Hartford Hospital 80 Seymour Street P.O. Box 5037 Hartford, CT 06102
Project Location:	Hartford
Project Name:	Pharmacy Relocation and Expansion Project at Hartford Hospital
Type proposal:	Section 19a-639, C.G.S.
Est. Capital Expenditure:	$5,200,000

1. State Health Plan

No questions at this time.

2. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

3. Clear Public Need

A. Explain how it was determined there was a need for the proposed acquisition.

B. Hours of operation of proposed pharmacy project.

C. 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.

D. 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:

4. Quality Measures

A. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), related to the proposal and a copy of their Curriculum Vitae.

B. 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]

5. 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

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

☐ None of the above

☐ Other (identify): _____

6. 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.

[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.

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

7. 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):

8. 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.

9. 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	

10. 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

☐ Other financing alternatives:

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

11. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				

CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

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

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

iii) The **assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).**

iv) Describe how this proposal is cost effective.

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

Total Facility: / Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

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

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

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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

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

Total Facility: Description	FY Actual Results	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
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

*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.

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: _____

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 9, 2008

J. Bryan Simmons
Vice President for Planning and Facilities Development
Hartford Hospital
80 Seymour Street
Hartford, CT 06102-5037

Re: Letter of Intent, Docket Number 07-31078
Hartford Hospital
Proposal of Pharmacy Relocation and Expansion Project at Hartford Hospital
Notice of Letter of Intent

Dear Mr. Simmons:

On December 31, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hartford Hospital ("Applicant") for the pharmacy relocation and expansion project at Hartford Hospital, at a total capital expenditure of $5,200,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hartford Courant* pursuant to Section 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 9, 2008

Requisition # HCA08-108
Email: Publicnotices@courant.com

Hartford Courant
285 Broad Street
Hartford, CT 06115

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, January 14, 2008.**

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 Diane Duran at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:DD:lmg

c: Sandy Salus, OHCA

Hartford Hospital
Docket Number 07-31078

Letter of Intent
January 9, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Hartford Hospital
Town:	Hartford
Docket Number:	07-31078
Proposal:	Proposal of pharmacy relocation and expansion at Hartford Hospital
Capital Expenditure:	$5,200,000

The Applicant may file its Certificate of Need application between February 29, 2008 and April 29, 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.

31078

The Hartford Courant.

A TRIBUNE PUBLISHING COMPANY

Affidavit of Publication

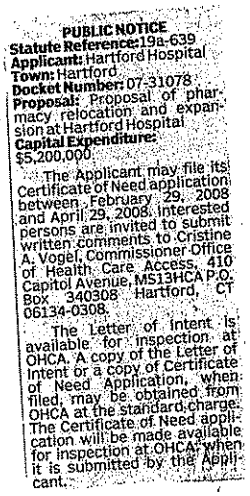
State of Connecticut

Thursday, January 10, 2008

County of Hartford

I, Joy Shroyer, do solemnly swear that I am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.

On dates as follows: 01/10/2008



PUBLIC NOTICE
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In the amount of $140.05
ST OF CT OFFICE OF HLTH.ACC hca08108
700309
Full Run

Financial Operations Assistant
Joy Shroyer

Subscribed and sworn to before me on January 10, 2008

Notary Public

LISA CARDINI
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2011