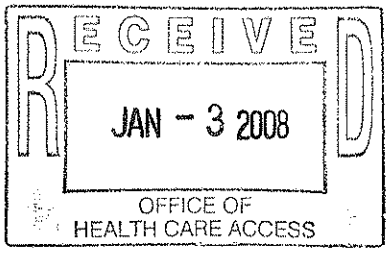
John M. Pierro
Vice President
Planning and Business Development

Norwalk Hospital

Norwalk, Connecticut 06856



December 31, 2007

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

Re: Norwalk Hospital
Establishment of PAMI Program

Dear Commissioner Vogel,

Enclosed ,please find an original and five copies of Norwalk Hospital's Letter of Intent with respect to the above project. We look forward to working with you and the Office of Health Care Access staff on this Certificate of Need application. Please feel free to contact me should you have any questions at 203-852-3271.

Sincerely,

John Pierro
Vice President Planning and Business Development

cc: Geoffrey Cole, Norwalk Hospital
Susan Davis, St. Vincent's Medical Center
Dr. Jose Missri, St. Vincent's Medical Center
Robert J. Anthony, Esq., Brown Rudnick

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	The Norwalk Hospital Association	
Doing Business As	Norwalk Hospital	
Name of Parent Corporation	Norwalk Health Services Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	34 Maple Street Norwalk, Connecticut 06856	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	John Pierro Vice President Planning and Business Development and Hospital Services	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	34 Maple Street Norwalk, Connecticut 06856	
Contact Person Telephone Number	203 852-3271	
Contact Person Fax Number	203 852-1553	
Contact Person e-mail Address	John.Pierro@norwalkhealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: ***Establish a Primary Angioplasty Program at Norwalk Hospital.***

b. Project Proposal: ***Establish and operate a Primary Angioplasty Myocardial Infarction (PAMI) Program at Norwalk 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)* _____

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)* _____

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: ***34 Maple Street, Norwalk, Connecticut 06856***

g. List each town this project is intended to serve: ***Norwalk Hospital's historical service area (Norwalk, Westport, New Canaan, Wilton and Weston) and surrounding communities.***

h. Estimated starting date for the project: **10/1/08**

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

Response:
Not applicable for this project does not involve any change in staffed or licensed beds.

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$0.00**

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$0.00**
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	**$0.00**
Total Project Cost	**$0.00**
Capitalized Financing Costs (Informational Purpose Only)	$

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

Response:
Norwalk Hospital received OHCA authorization to replace and upgrade its cardiac catheterization laboratory equipment including the associated non-medical equipment on February 23, 2007 under Docket # 30919-WVR for a total project cost of $2,899,794. The newly upgraded and renovated laboratory occupies approximately 1,000 square feet of space in the cardiology section on the third floor of the Hospital's main building.

There is no anticipated new capital cost associated with this project.

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:
Not Applicable.

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

Response:
Not Applicable.

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

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

Response:
Not Applicable

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)* _____

Response:
Not Applicable

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?

SECTION IV. PROJECT DESCRIPTION

Norwalk Hospital, in collaboration with St. Vincent's Medical Center (St. Vincent's), is requesting Office of Health Care Access approval to expand its cardiovascular services to include the provision of Primary Angioplasty Myocardial Infarction (PAMI) for patients presenting at the Hospital's emergency department with ST-Segment Elevation during Myocardial Infarction (STEMI).

The cardiovascular program at Norwalk Hospital currently provides an array of acute and ambulatory services including diagnostic cardiac catheterization, inpatient coronary and telemetry care, cardiac imaging, cardiac rehabilitation, echocardiography, cardiopulmonary testing, electrocardiology, electrophysiology, holter monitoring, intra-aortic balloon pumping, nuclear stress testing, pulmonary function testing, stress testing, tilt table testing, and vascular and thoracic surgical services.

St. Vincent's, a member of Ascension Health, a nationally based Catholic health system, operates a comprehensive cardiology and cardiothoracic program, and has been nationally recognized as one of the seventeen hospitals in the United States with heart attack death rates lower than the national rate.

This project represents a regional approach to the delivery of PAMI services developed in a collaborative effort between St. Vincent's and Norwalk Hospital. This effort will extend to the development of Program policies, procedures, and protocols including clinical standards of care, nursing protocols, admission and discharge criteria, and continuing education requirements. The Hospitals will jointly participate in quality improvement activities including the formation of a Quality Committee that will monitor clinical performance and outcomes. A transfer agreement with St. Vincent's will be established for patients requiring emergency open heart surgery. A web based application /digital link for the transmission of coronary angiography and angioplasty images between the Hospitals will also be developed. St. Vincent's and Norwalk Hospital plan to standardize supply inventory which is anticipated to result in a cost effective program. Nurses and other technical staff, who will be employees of Norwalk Hospital, will rotate through St. Vincent's for training.

Experienced interventional cardiologists affiliated with both St. Vincent's Medical Center and Norwalk Hospital will provide physician coverage for the Norwalk Hospital PAMI Program.

PAMI Services will be performed in the Norwalk Hospital Cardiac and Vascular Laboratory located on the third floor of the Hospital and will be available on a 24 hour/ 7 days per week basis. The targeted patient population will be patients who present at Norwalk Hospital's emergency department with the appropriate clinical indications for PAMI.

PAMI is now the preferred treatment for opening occluded coronary arteries during acute myocardial infarction. Current published industry literature indicates that patients presenting to hospitals with ST-segment elevation during myocardial infarction can be appropriately treated with angioplasty without the on-site availability

of cardiac surgery backup. At present, patients presenting at Norwalk Hospital's emergency department that are eligible for PAMI must be treated on-site with thrombolytics and/or transferred to an existing interventional cardiac program. Norwalk Hospital is located in Southeastern Fairfield County, a densely populated region with highways and roads that are commonly congested. Transportation to another interventional program, especially at peak rush hour times, can be an obstacle to the timely delivery of care. The proposed PAMI Program will provide for more timely and reliable opening of occluded arteries for those patients presenting at Norwalk Hospital's emergency department.

At present, all major payers (Medicare, Medicaid, commercial and managed care insurance) reimburse for primary angioplasty services. There is no anticipated change to Norwalk Hospital's payer mix as a result of the implementation of this project. Norwalk Hospital will bill for all services provided and the volume will be recorded on the Hospital's books.

It is not anticipated that this program will require any change to the Hospital's Department of Public Health license.

There are no healthcare providers in Norwalk Hospital's primary service area that offer primary angioplasty services. In its secondary service area, PAMI providers include St. Vincent's Medical Center, Stamford Hospital, Greenwich Hospital, and Bridgeport Hospital.

It is anticipated that the establishment of this PAMI program at Norwalk Hospital through a collaborative relationship with St. Vincent's Medical Center, a very experienced and nationally recognized provider, will ensure that high quality interventional services can be provided at the community and regional level.

AFFIDAVIT

To be completed by each Applicant

Applicant: **Norwalk Hospital**

Project Title: **Establish a Primary Angioplasty Program at Norwalk Hospital**

I, **Geoffrey F. Cole** , **President and Chief Executive Officer**

(Name) (Position – CEO or CFO)

of **Norwalk 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 **Norwalk 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.
(Facility Name)

Geoffrey F. Cole 12/30/07

Signature Date

Subscribed and sworn to before me on DECEMBER 30, 2007

Lynn K. Hanuck

Notary Public/Commissioner of Superior Court

My commission expires: MAY 31, 2010

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 9, 2008

John Pierro
Vice President Planning and Business Development
Norwalk Hosapital
34 Maple Street
Norwalk, Connecticut 06856

RE: Certificate of Need Application Forms, Docket Number 08-31079-CON
Norwalk Hosapital
Establish and Operate a Primary Angioplasty Myocardial Infarction (PAMI) Program at Norwalk Hospital

Dear Mr. Pierro:

Enclosed are the application forms for Norwalk Hospital's Certificate of Need ("CON") proposal to establish and operate a Primary Angioplasty Myocardial Infarction (PAMI) program at Norwalk Hospital with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between March 3, 2008 and May 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 analysts assigned to the CON application are Alexis G. Fedorjaczenko and Steven W. Lazarus. Please feel free to contact them at (860) 418-7001 if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than March 3, 2008 and may be submitted no later than May 2, 2008. The Analysts assigned to your application are Alexis G. Fedorjaczenko and Steven W. Lazarus; they may be reached at the Office of Health Care Access at (860) 418-7001.

OHCA has designated St Vincent's Medical Center ("St. Vincent") as an Applicant in this proposal. St. Vincent must complete and submit the attached affidavit, as well as Financial Attachments I and II (see question 12.D I & ii).

Docket Number:	08-31079-CON
Applicant(s) Name:	Norwalk Hospital and St Vincent's Medical Center
Contact Person: **Contact Title:**	John Pierro Vice President Planning and Business Development and Hospital Statistics
Contact Address:	34 Maple Street Norwalk, CT 06856
Project Location	Norwalk
Project Name:	Establish and Operate a Primary Angioplasty Myocardial Infarction (PAMI) Program at Norwalk Hospital
Type of proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$0

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. Include any cardiovascular disease prevention and health promotion programs.

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

Note: Sections 19a-634 and 19a-637 of the Connecticut General Statutes specifically mandate that OHCA consider the availability, scope and need for services for the residents of Connecticut. Therefore, OHCA does not consider out-of-state volume in its evaluation of need for the proposed service.

A. Explain how it was determined there was a need for the cardiac program in your service area.

B. Primary and secondary service area towns specific to the proposed service.

C. Provide the methodology used to delineate the service areas, and/or the rationale used to choose the proposed primary and secondary service area towns.

D. Travel distances from service area towns to existing providers of the proposed service.

E. Hours of operation of proposed cardiac service.

F. Provide the information as outlined in the following table concerning the existing providers of the proposed cardiac service in the Applicant(s) PSA and SSA:

Description of Service	Provider Name and Location	Hours and Days of Operation (1)	Current Utilization

(1) Specify days of the week and start and end time for each day.

G. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)? Please respond for all providers listed in the table above, and be sure to address specifically the impact on Stamford Hospital.

H. Scheduling backlogs for the proposed cardiac service in service area.

I. Has the Applicant held any discussions with the local emergency medical service ("EMS") regarding the proposed service? Provide evidence.

J. Cardiovascular health statistics and risk factors in the service area.

K. The number of inpatient and outpatient diagnostic cardiac catheterizations performed in the Hospital laboratory over the past three fiscal years.

L. The number of diagnostic cardiac catheterizations performed in the Hospital laboratory by unique physician identifier (e.g., Dr. A, B, C, etc.).

M. The number of patients with a diagnosis of ST-segment elevation acute myocardial infarction (AMI) that present at the Hospital's emergency room for the most recent fiscal year.

N. The number of doses of thrombolytic medication, issued through its pharmacy, to patients with a diagnosis of AMI for the most recent fiscal year.

O. Please identify the number of physicians that will be providing coverage for the proposed program. Explain whether the physicians will be full time with the proposed program or also providing coverage at other hospitals.

P. Provides letters of referral and support from interventional cardiologists related to the proposal. Include the number of referrals projected from each cardiologist.

Q. Provide the following for the projected utilization of the proposed service*:

a. The projected number of inpatient and outpatient diagnostic cardiac catheterizations using procedure codes 37.21, 37.22, 37.23, 88.55 and 88.56 for the first three years of operation.

b. The projected number of primary angioplasties using procedure codes 0.66, 36.01, 36.02, 36.05, 36.06 and 36.07 for the first three years of operation.

c. The number of diagnostic cardiac catheterizations by unique physician identifier (e.g., Dr. A, B, C, etc.).

d. The number of primary angioplasties by unique physician identifier (e.g., Dr. A, B, C, etc.).

*** In answering this question be sure to include the method, basis and/or assumptions utilized in the above projections. If any additional procedure codes are used other than the ones indicated above, please explain why they are appropriate to include.**

R. 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.

S. 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) _____

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. Provide a brief summary of how the Applicants plan to meet the American College of Cardiology/American Heart Association practice guidelines related to this proposal. If the Applicants do not expect the proposed cardiac service to meet these guidelines and protocols, please explain how quality of the cardiac service will be maintained.

E. Submit a list of all key professional and administrative personnel, including the Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director of Cardiac Catheterization Laboratory, Medical Director of Proposed Cardiac Service, Interventional Cardiologists, etc. related to the proposal and a copy of their Curriculum Vitae.

Note: Please provide a list of hospitals where the cardiologists have admitting privileges.

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

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

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

[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 Ambulatory Surgery Facilities, Inc.

G. 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.

H. 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.

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

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. Affiliations

A. Provide a copy of any and all agreements or memorandum of understandings related to the proposal. Include a copy of the collaboration agreement with St. Vincent's, which should indicate at a minimum a description of each Applicants' responsibilities, patient selection guidelines, provision of emergency transfers, joint quality assurance reviews and joint training.

B. Provide a copy of each Applicants' Board of Directors or governing body resolutions approving the proposal.

C. Provide the travel distance and travel times between the Applicants. Will patients requiring surgical backup be transferred to the nearest surgical facility? Provide additional agreements with cardiac surgical facilities for emergency transfers, if applicable.

9. 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:

a. 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.

b. The name of the entity that will be billing for the proposed service.

10. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	
Non-Medial Equipment (Lease (FMV))*	
Fair Market Value of Space – Capital Lease	
Total Capital Cost	**$**
Capitalized Financing Cost	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

11. Type of Financing

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	$ _____
Amount of total debt	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing:

Capital or operating	$ _____
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.)	_____

12. Revenue, Expense and Volume Projections

A. 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 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)				
TriCare (CHAMPUS)				
Total Government Payers				
Commercial Insurers*				
Self-Pay				
Workers Compensation				
Total Non-Government Payers				
Uncompensated Care				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

C. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

D. Provide the following for the financial projections for each Applicant:

i) A summary of revenue, expense and volume statistics, with the CON project, without the CON project and incremental to 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. ***Submit a copy of Financial Attachment I for each applicant.***

ii) Please complete the enclosed, OHCA's **Financial Attachment II.** ***Submit a copy of Financial Attachment II for each applicant.***

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

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

vi) Describe how this proposal is cost effective.

vii) Provide a description of the additional staff, equipment, and supplies (including drug-eluting stents) required to perform primary angioplasty.

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, or 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 $3,000,000 is checked above <u>OR</u> if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ 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: Norwalk Hospital

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: _____

HOSPITAL AFFIDAVIT

Applicant: St. Vincent's Medical Center

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: _____

Norwalk Hospital

12. D (i). Please provide one year of actual results and three FULL 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: Description	FY 2007 Actual Results	FY 2008 Projected W/out CON	FY 2008 Projected Incremental	FY 2008 Projected With CON	FY 2009 Projected W/out CON	FY 2009 Projected Incremental	FY 2009 Projected With CON	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON
NET PATIENT REVENUE													
Non-Government				$0			$0			$0			$0
Medicare				$0			$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0			$0
Other Government				$0			$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$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	$0	$0	$0
OPERATING EXPENSES													
Salaries and Fringe Benefits				$0			$0			$0			$0
Professional / Contracted Services				$0			$0			$0			$0
Supplies and Drugs				$0			$0			$0			$0
Bad Debts				$0			$0			$0			$0
Other Operating Expense				$0			$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0			$0
Interest Expense				$0			$0			$0			$0
Lease Expense				$0			$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				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.

Norwalk Hospital

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

St. Vincent's Medical Center

12. D (i). Please provide one year of actual results and three FULL 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: Description	FY 2007 Actual Results	FY 2008 Projected W/out CON	FY 2008 Projected Incremental	FY 2008 Projected With CON	FY 2009 Projected W/out CON	FY 2009 Projected Incremental	FY 2009 Projected With CON	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON
NET PATIENT REVENUE				$0			$0			$0			$0
Non-Government				$0			$0			$0			$0
Medicare				$0			$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0			$0
Other Government													
Total Net Patient Patient Revenue	$0	$0	$0	$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	$0	$0	$0
OPERATING EXPENSES													
Salaries and Fringe Benefits				$0			$0			$0			$0
Professional / Contracted Services				$0			$0			$0			$0
Supplies and Drugs				$0			$0			$0			$0
Bad Debts				$0			$0			$0			$0
Other Operating Expense				$0			$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0			$0
Interest Expense				$0			$0			$0			$0
Lease Expense				$0			$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				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.

St. Vincent's Medical Center

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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2008

John Pierro, Vice President
Planning and Business Development and Hospital Services
Norwalk Hospital
34 Maple Street
Norwalk, CT 06856

Re: Letter of Intent, Docket Number 08-31079-LOI
Norwalk Hospital & St. Vincent's Medical Center
Establishment and Operation of a Primary Angioplasty Myocardial Infarction (PAMI) Program at Norwalk Hospital
Notice of Letter of Intent

Dear Mr. Pierro:

On January 3, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Norwalk Hospital & St. Vincent's Medical Center ("Applicants") for the Establishment and operation of a Primary Angioplasty Myocardial Infarction (PAMI) at Norwalk Hospital, at a total capital expenditure of $0.

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

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2008

Requisition # HCA08-124
Fax: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Sunday, January 27, 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 Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SWL:lmg

c: Sandy Salus, OHCA

Connecticut Post
Docket Number 08-31079

Letter of Intent
January 22, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Norwalk Hospital & St. Vincent's Medical Center
Town:	Norwalk
Docket Number:	08-31079
Proposal:	Establishment and operation of a Primary Angioplasty Myocardial Infarction (PAMI) program at Norwalk Hospital
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between March 4, 2008 and May 3, 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	3100
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DESTINATION ID	
ST. TIME	01/22 16:52
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2008

Requisition # HCA08-124
Fax: (203) 384-1158

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410 State Street
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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

/Kimberly R. Martone

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2008

Requisition # HCA08-123
Fax: 225-2611

The Hour
One Herald Square
New Britain, CT 06050

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Sunday, January 27, 2008.**

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

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SWL:lmg

c: Sandy Salus, OHCA

Connecticut Post
Docket Number 08-31079

Letter of Intent
January 22, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Norwalk Hospital & St. Vincent's Medical Center
Town:	Norwalk
Docket Number:	08-31079
Proposal:	Establishment and operation of a Primary Angioplasty Myocardial Infarction (PAMI) program at Norwalk Hospital
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between March 4, 2008 and May 3, 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	3101
RECIPIENT ADDRESS	92252611
DESTINATION ID	
ST. TIME	01/22 16:53
TIME USE	00'44
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2008

Requisition # HCA08-123
Fax: 225-2611

The Hour
One Herald Square
New Britain, CT 06050

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

LETTER OF INTENT
DOCKET NUMBER 08-31079
January 22, 2008

Statute Reference:	19a-638
Applicants:	Norwalk Hospital & St. Vincent's Medical Ctr.
Town:	Norwalk
Docket Number:	08-31079
Proposal:	Establishment and operation of a Primary Angioplasty Myocardial Infarction (PAMI) program at Norwalk Hospital
Capital Expenditure:	$0

The applicant may file its Certificate of Need application between March 4, 2008 and May 3, 2008. Interested persons are invited to submit written comments to Christine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA, P.O. Box 340308, Hartford, CT. 06134-0308.

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