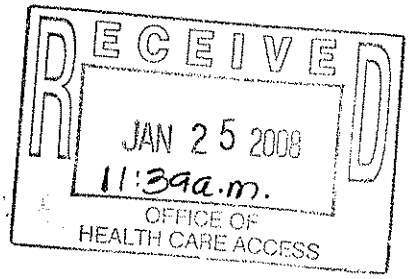
Johnson
Memorial
Hospital, Inc.

Alfred A. Lerz, *President*

Quality service from people who care



January 18, 2008

Cristine Vogel
State of Connecticut
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Re: Expansion of Johnson Memorial Hospital Outpatient Infusion Therapy Services

Dear Commissioner Vogel,

I am pleased to submit the enclosed Certificate of Need Determination regarding the expansion of Johnson Memorial Hospital's outpatient infusion services to Enfield, CT. Johnson Memorial Hospital in Stafford Springs has and will continue to provide outpatient chemotherapy/infusion therapy in Stafford Springs for patients who require the level of care available in an acute care setting. In addition, chemotherapy/infusion services will be provided at the Hospital for those patients who require weekend therapy or treatments. We are requesting that we be granted permission to expand these services in Enfield, closer to the majority of patients served. This expansion will also enhance care by providing services in a centralized location that includes medical oncology, radiation therapy and the American Cancer Resource Center. To ensure we have met all of the Office of Health Care Access requirements, we are submitting the enclosed Certificate of Need Determination for your review.

Thank you for your support of Johnson Memorial Hospital's programs that bring patient service close to home.

Sincerely,

Peter A. Kuzmickas
Acting President

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enclosures

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

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All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Johnson Memorial Hospital	
Doing Business As	Johnson Memorial Hospital	
Name of Parent Corporation	Johnson Memorial Corporation	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	Johnson Memorial Hospital 201 Chestnut Hill Road Stafford Springs, CT 06076	
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	Peter A. Kuzmickas Acting President	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	201 Chestnut Hill Road Stafford Springs, CT 06076	
Contact Person's Telephone Number	T: 860-684-8102	
Contact Person's Fax Number	F: 860-684-8165	
Contact Person's e-mail Address	Peter.Kuzmickas@jmhosp.org	

SECTION II. GENERAL PROPOSAL INFORMATION

Proposal/Project Title: Johnson Memorial Hospital Infusion Center

a. Location of proposal, identifying Street Address, Town and Zip Code: Phoenix Cancer Center, 142 Hazard Avenue, Enfield, CT 06082

b. List each town this project is intended to serve:
Bordering Massachusetts' Towns; Enfield; Ellington, East Windsor; South Windsor, Windsor Locks; Granby; Somers; Stafford; Suffield; Willington

c. Estimated starting date for the project: March 1, 2008

d. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☐	☒	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 102,422

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	0
Major Medical Equipment Purchases	0
Non-Medical Equipment Purchases*	$59,422
Land/Building/Asset Purchases	0
Construction/Renovation	$43,000
Other (Non-Construction) Specify:_____	0
Total Capital Expenditure	$102,422.00
Medical Equipment - Fair Market Value of Leases	0
Major Medical Equipment - Fair Market Value of Leases	0
Non-Medical Equipment - Fair Market Value of Leases*	0
Fair Market Value of Space –Capital Leases Only	0
Total Capital Cost	**0**
Total Project Cost	$102,422
Capitalized Financing Costs (Informational Purpose Only)	$0

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
None				

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☒ Petitioner's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

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

SECTION IV. PROPOSAL 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 elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are 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 the entity that will be providing the service(s).

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

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

SECTION IV. PROPOSAL DESCRIPTION

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

   Response
   Johnson Memorial Hospital currently provides some Chemotherapy/Infusion services on an outpatient basis.

   See Attachment A: Johnson Memorial Hospital General License.

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

   Response
   Johnson Memorial Hospital is seeking to expand it's outpatient infusion services to the Phoenix Cancer Center in Enfield and combine its existing volume with the Chemotherapy/Infusion volume being provided by medical oncologist(s) in the Enfield area. It will be a JMH Infusion Service in Enfield. Outpatient infusion services will also continue to be provided at Johnson Memorial Hospital.

   No new DPH licensure categories are being sought.

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

   Response
   The current population served and targeted population to be served are as follows: Bordering Massachusetts' Towns; Enfield, Ellington, East Windsor, South Windsor, Windsor Locks, Granby, Somers, Stafford, Suffield and Willington. We are expanding the outpatient infusion therapy services to Enfield to be closer to the Phoenix Cancer Center and to the majority of our current population being served. The Enfield location is more convenient and should mean less travel for most of our population.

4. Identify the entity that will be providing the service(s).

   Response
   Johnson Memorial Hospital will be responsible for providing this service at both locations.

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

   Response
   Johnson Memorial Hospital will be responsible for this service at both locations.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

   Response
   Johnson Memorial Hospital is the entity that will lease physical space from the medical oncologist in Enfield.

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

   Response
   Not applicable.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

   Response
   Johnson Memorial Hospital is the sole party affiliated with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

   Response
   See Attachment B: Johnson Memorial Hospital Organizational Chart

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

    Response
    Not applicable.

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

    Response
    Johnson Memorial Hospital contracts with all governmental and third party payers that operate in Connecticut. The payer mix is not expected to be impacted by the expansion of this service.

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SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: Johnson Memorial Hospital

Project Title: Johnson Memorial Hospital Infusion Center Relocation and Expansion

I, Peter A. Kuzmickas (Name), Acting President (Position – CEO or CFO)

of Johnson Memorial Hospital (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Johnson Memorial 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.

Peter A. Kuzmickas — Signature

1/23/08 — Date

Subscribed and sworn to before me on 1/23/08

Lisa Corrivean

Notary Public/Commissioner of Superior Court

My commission expires: 5/31/2010

Attachment A

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0033

General Hospital

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

Johnson Memorial Hospital, Inc. of Stafford Springs, CT, d/b/a Johnson Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Johnson Memorial Hospital is located at 201 Chestnut Hill Road, Stafford Springs, CT 06076

The maximum number of beds shall not exceed at any time:

9 Bassinets
92 General Hospital beds

This license expires **December 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2008. RENEWAL.

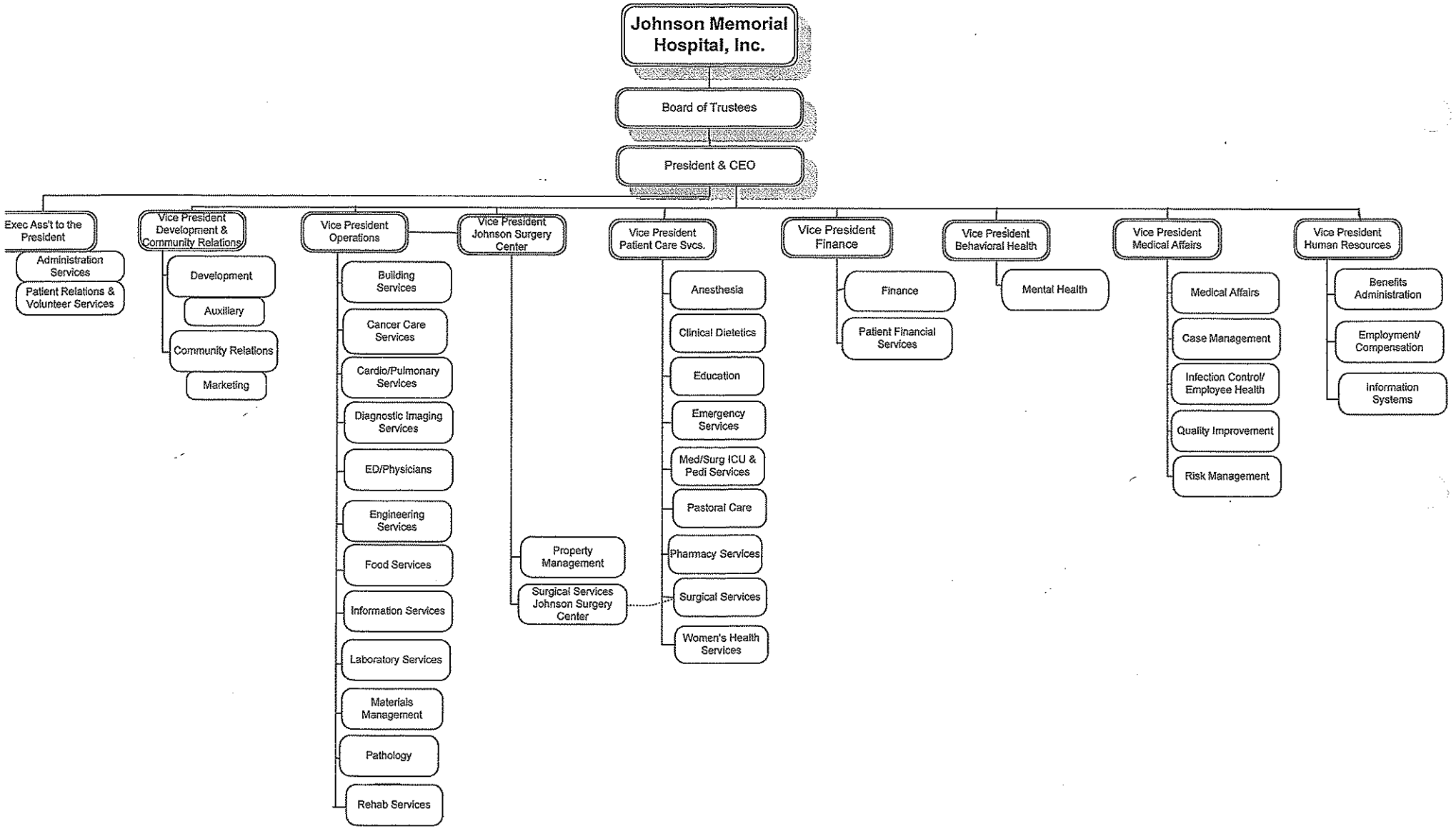
Satellites

JMH Behavioral Health Services, 151 Hazard Avenue, Enfield, CT
JMH Outpatient Surgery at JSC, 148 Hazard Avenue, Enfield, CT

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

Attachment B



JMH
11/2007

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 30, 2008

Peter A. Kuzmickas
Acting President
Johnson Memorial Hospital
201 Chestnut Road
Stafford Springs, CT 06076

RE: Certificate of Need Determination; Report Number 08-31091-DTR
Establish Outpatient Infusion Services in Enfield
Johnson Memorial Hospital

Dear Mr. Kuzmickas:

On January 25, 2008, the Office of Health Care Access ("OHCA") received your certificate of Need ("CON") Determination request concerning the proposal of Johnson Memorial Hospital ("JMH") to establish outpatient infusion services in Enfield, at a total capital expenditure of $102,422. OHCA has reviewed the information contained in the request and makes the following findings:

1. JMH is an acute care hospital located at 201 Chestnut Hill Road in Stafford Springs, Connecticut.

2. JMH is planning to establish outpatient chemotherapy/infusion services at the Phoenix Community Cancer Center ("PCCC") at 142 Hazard Avenue, Enfield.

3. JMH currently and will continue to provide chemotherapy/infusion services on an outpatient basis in Stafford Springs for patients who require the level of care available in an acute care setting, or who require weekend therapy or treatments.

4. JMH states that the new location will be closer to the majority of their current population being served and is in a centralized location that includes medical oncology, radiation therapy, and the American Cancer Resource Center.

5. Section 19a-638 of the Connecticut General Statutes ("C.G.S.") states, in part, that the introduction of any additional function or services requires authorization from OHCA.

As such, Certificate of Need authorization from OHCA is required in this matter. Johnson Memorial Hospital shall not establish outpatient infusion services at the Phoenix Cancer Center, 142 Hazard Avenue, Enfield until it receives CON authorization from OHCA.

If the petitioner is agreeable, OHCA will consider the submission of information received on January 25, 2008 as the Letter of Intent for this matter; therefore Johnson Memorial Hospital may file a completed CON application with OHCA between March 25, 2008 and May 24, 2008. The CON application is being mailed to your attention separately.

This CON application will replace the CON application previously transmitted to JMH under Docket Number 07-31066 for the termination of outpatient chemotherapy/infusion services in Stafford Springs and establishment of outpatient chemotherapy/infusion services in Enfield.

If you have any questions concerning this letter, please contact Paolo Fiducia, Associate Health Care Analyst, at (860) 418-7001.

Sincerely,

Cristine A. Vogel
Commissioner

CAV:agf

Copy: Rose McLellan License and Applications Supervisor, DPH, DHSR

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 31, 2008

Peter Kuzmickas
Vice President, Operations
Johnson Memorial Hospital
201 Chestnut Hill Road
Stafford Springs, CT 06076

Re: Letter of Intent, Docket Number 08-31091
Johnson Memorial Hospital
Establishment of Outpatient Infusion Therapy Service in Enfield
Notice of Letter of Intent

Dear Mr. Kuzmickas:

On January 25, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Johnson Memorial Hospital ("Applicant") for the Establishment of Outpatient Infusion Therapy Service in Enfield, at a total capital expenditure of $102,422.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* pursuant to Section19a-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 31, 2008

Requisition # HCA08-131
Email: Legals@JournalInquirer.com

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, February 5, 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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

Journal Inquirer
Docket Number 08-31091

Letter of Intent
January 31, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Johnson Memorial Hospital
Town:	08-31091-LOI
Proposal:	Establishment of Outpatient Infusion Therapy Service in Enfield
Capital Expenditure:	$102,422

The Applicant may file its Certificate of Need application between March 25, 2008 and May 25, 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

January 31, 2008

Peter A. Kuzmickas
Acting President
Johnson Memorial Hospital
201 Chestnut Road
Stafford Springs, CT 06076

RE: Certificate of Need Application Forms, Docket Number 08-31091-CON
Johnson Memorial Hospital
Establish outpatient infusion services in Enfield

Dear Mr. Kuzmickas:

Enclosed are the application forms for Johnson Memorial Hospital's Certificate of Need ("CON") proposal to establish outpatient infusion services in Enfield with an associated capital expenditure of $102,422. According to the parameters stated in Sections 19a-638 of the Connecticut General Statutes, the CON application may be filed between March 25, 2008 and May 24, 2008.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and three (3) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him 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 25, 2008 and may be submitted no later than May 24, 2008. The Analyst assigned to your application is Paolo Fiducia, who may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31091-CON

Applicant(s) Name: Johnson Memorial Hospital

Contact Person: Peter A. Kuzmickas
Contact Title: Acting President
Johnson Memorial Hospital
Contact Address: 201 Chestnut Road
Stafford Springs, CT 06076

Project Location: Enfield

Project Name: Establish outpatient infusion services in Enfield

Type of proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $102,422

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. Regarding the services in Stafford Springs, please answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Stafford Springs location.

ii) Explain how the above array of service components at the Stafford Springs location will change with the proposal. Include any changes to the type or number of patient seen at this location. Explain in detail the Applicant's rationale for any changes.

iii) Describe the pattern of referrals to the Stafford Springs service location.

iv) Provide details on whether any scheduling backlogs exist.

B. Regarding the establishment of services in Enfield, Please provide the following:

i. Explain how it was determined there was a need for the proposal in Enfield. Please provide a copy of and explain any needs assessment conducted for the proposed service in Enfield. If a needs assessment was not conducted, please explain why not.

ii. Has the applicant considered alternative locations other than Enfield? If so, provide a list and describe all of the alternative locations.

iii. Is the proposed service currently provided at the Phoenix Cancer Community Cancer Center? Please provide detail.

iv. Provide information and supporting documentation addressing the issue of transportation for the Stafford Springs patients. Describe how patients would be able to travel to a new service location if without benefit of a personal vehicle.

C. Provide the following information:

i. Primary and secondary service area towns for:
a. The existing services in Stafford Springs; and
b. The proposed site in Enfield.

ii. The unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years at the Stafford Springs site, by service area town.

iii. Travel distance from proposed site in Enfield to the service area towns served by the Stafford Springs Site.

iv. Hours of operation for:
a. The existing services in Stafford Springs; and
b. The proposed site in Enfield.

v. The units of service projected for the first three years of operation . for the following: **(Include the derivation/calculation.)**
a. The existing services in Stafford Springs; and
b. The proposed site in Enfield.

D. Provide the information as outlined in the following table concerning the existing provider's of infusion services in:

a. The Stafford Springs service area; and

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

b. The Enfield service area.

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

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. 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 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 _____

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

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.
Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

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

☐ 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]

F. 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 ☐ 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.

C. Provide the following licensing information:

[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.

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

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

☐ Corporation (Inc.) ☐ 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. (For new service only)

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 Information

A. Provide a detailed description of the any new construction or required renovation. Including the related gross square feet.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

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

11. 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. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. 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 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				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

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

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

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** 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) 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.).

iii) Please complete the enclosed, OHCA's **Financial Attachment II**.

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.

13. 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:	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	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 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.

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										
Year 1	(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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, 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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ 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)