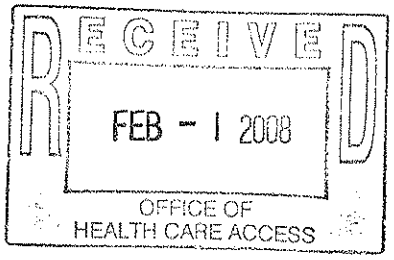
BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

January 30, 2008



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

RE: Letter of Intent – Replacement HVAC System

Dear Commissioner Vogel,

Pursuant to the applicable Connecticut general statutes and regulations, Bridgeport Hospital is pleased to submit the enclosed Letter of Intent for the replacement of an HVAC System. The purpose of this proposal is to replace an HVAC system, which is well beyond the useful life of the equipment, as estimated by the American Hospital Association. The total capital expenditure for the project is $5,400,000.

Sincerely,

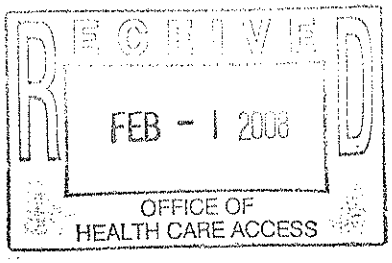
Augusta S. Mueller
Director of Planning

Enclosure

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120
203.384.3000

AFFIDAVIT

To be completed by each Applicant



Applicant: **Bridgeport Hospital**

Project Title: **Replacement HVAC System**

I, **Robert J. Trefry, President and Chief Executive Officer**
(Name) (Position – CEO or CFO)

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

Signature _____ Date 1/28/08

Subscribed and sworn to before me on January 28, 2008

Susan Castagna _____ Susan Castagna
Notary Public/Commissioner of Superior Court
State of CT

My commission expires: January 31, 2010

JAN 3 0 2009

02

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
Full legal name	**Bridgeport Hospital**
Doing Business As	**Bridgeport Hospital**
Name of Parent Corporation	**Bridgeport Hospital & Healthcare Services, Inc.**
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**267 Grant Street Bridgeport, CT 06610**
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.	**Augusta S. Mueller Director of Planning**
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**Planning & Marketing Department 267 Grant Street Bridgeport, CT 06610**
Contact Person Telephone Number	**(203) 384-3126**
Contact Person Fax Number	**(203) 384-3968**
Contact Person e-mail Address	**kamuel@bpthosp.org**

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Replacement HVAC System**

b. Project Proposal: **Bridgeport Hospital is seeking authorization from OHCA to replace the 40 year old HVAC system providing heating and cooling to the West Tower of the main campus. Patient care areas located on the West Tower include the women's care center, oncology, inpatient rehabilitation, psychiatry, cardiology, sleep center and MedEase services.**

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: **HVAC Replacement System**

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:

267 Grant Street, Bridgeport, CT 06610

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

Not applicable, the proposal is for a replacement HVAC system.

h. Estimated starting date for the project: **October 1, 2008**

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$5,400,000**

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	3,860,000
Other (Non-Construction) Specify: **HVAC System**	1,540,000
Total Capital Expenditure	**$5,400,000**
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	**$5,400,000**
Total Project Cost	**$5,400,000**
Capitalized Financing Costs (Informational Purpose Only)	

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

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

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).

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.

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.

Bridgeport Hospital is proposing to replace the HVAC system supplying heating and cooling services to the West Tower of its main campus. Patient care areas located on the West Tower include the women's care center, oncology, inpatient rehabilitation, psychiatry, cardiology, sleep center and MedEase services. The current HVAC system is 40 years old, which is well in excess of the 15 year average life span for HVAC equipment recommended by the American Hospital Association.

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.
   Not applicable, the proposal is for the replacement of HVAC equipment.

   The Department of Public Health license currently held by Bridgeport Hospital is included as Attachment I.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.
   Not applicable, the proposal is for the replacement of HVAC equipment.

3. Identify the current population served and the target population to be served.
   Not applicable, the proposal is for the replacement of HVAC equipment. The patient care areas located on the West Tower include Patient the women's care center, oncology, inpatient rehabilitation, psychiatry, cardiology, sleep center and MedEase services. These services are utilized by residents from the Bridgeport Hospital primary and secondary service areas. Municipalities include Ansonia, Bethel, Bridgeport, Derby, Easton, Fairfield, Milford, Monroe, Newtown, Orange, Redding, Seymour, Shelton, Stratford, Trumbull, Weston, Westport, and Wilton.

4. Identify any unmet need and describe how this project will fulfill that need.
   Not applicable, the proposal is for the replacement of HVAC equipment.

5. Are there any similar existing service providers in the proposed geographic area?
   In addition to Bridgeport Hospital, Griffin Hospital, Milford Hospital and St. Vincent's Medical Center also provide acute care services in the geographic area.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   Not applicable, the proposal is for the replacement of HVAC equipment.

7. Who will be responsible for providing the service?
   Not applicable, the proposal is for the replacement of HVAC equipment.

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?
   Not applicable, the proposal is for the replacement of HVAC equipment.

Attachment I

STATE OF CONNECTICUT

JAN 30 2008

Department of Public Health

LICENSE

License No. 0040

General Hospital

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

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

Bridgeport Hospital is located at 267 Grant Street, Bridgeport, CT 06610

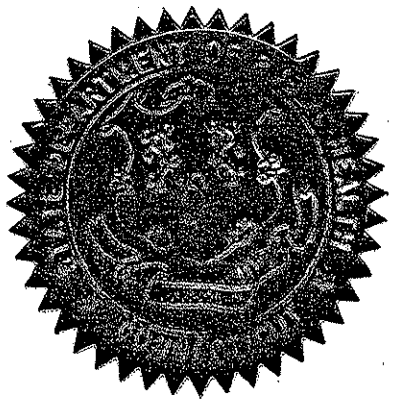
The maximum number of beds shall not exceed at any time:
30 Bassinets
395 General Hospital beds

This license expires **March 31, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2006. RENEWAL.

Satellites

Geriatric Partial Hospital, 305 Boston Avenue, Stratford, CT
Child Partial Hospital, 305 Boston Avnue, Stratford, CT
Bridgeport Hospital Primary Care Center, 226 Mill Hill Avenue, Bridgeport, CT
Psychiatric Adult Partial Hospital Program, 305 Boston Avenue, Stratford, CT



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

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 14, 2008

Agusta S. Mueller
Director of Planning
Planning & Marketing Department
Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610

RE: Certificate of Need Application Forms, Docket Number 08-31101-CON
Bridgeport Hospital
Replacement of HVAC System in Bridgeport

Dear Ms. Mueller:

Enclosed are the application forms for Bridgeport Hospital's Certificate of Need ("CON") proposal of replacement of HVAC system in Bridgeport with an associated capital expenditure of $5,400,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between April 1, 2008, and May 20, 2008.

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

Enclosure

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 April 1, 2008 and may be submitted no later than May 20, 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: 08-31101-CON

Applicant(s) Name: Bridgeport Hospital

Contact Person: Augusta S. Mueller
Contact Title: Director of Planning
Planning & Marketing Department
Bridgeport Hospital
Contact Address: 267 Grant Street
Bridgeport, CT 06610

Project Location: Bridgeport

Project Name: Replacement of HVAC System in Bridgeport

Type proposal: Section 19a-639, C.G.S.

Est. Capital Expenditure: $5,400,000

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. 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.

C. 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.

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

☐ Yes ☐ No

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

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

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

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. Land/ Building Purchase

If the CON involves any land/building purchase, please answer all of the following that apply:

1.	Please submit a copy of the Real Estate Property Appraisal(s).	$_____
2.	What is the useful life of each building found on the	___ Years

	proposed parcels of land to be acquired?	
3.	Please submit a schedule of depreciation for each of the parcels to be acquired as an attachment.	
4.	Please submit a legible site plan, identifying the proposed parcels to be acquired and their relationship to existing Hospital properties.	
5.	Identify the short-term and future (long-term) use(s) of the proposed parcels of land to be acquired.	

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

11. Type of Financing

A. Check type o f 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.)	_____

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 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. 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, 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 _____ **FY Projected Incremental** Total Incremental Expenses:	(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
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

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:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	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

February 14, 2008

Augusta S. Mueller
Director of Planning
Planning & Marketing Department
Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610

Re: Letter of Intent, Docket Number 08-31101
Bridgeport Hospital
Replacement of HVAC System in Bridgeport
Notice of Letter of Intent

Dear Ms. Mueller:

On February 1, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Bridgeport Hospital ("Applicant") for the Replacement of HVAC System in Bridgeport Project, at a total capital expenditure of $5,400,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Connecticut Post* 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

February 14, 2008

Requisition # HCA08-141
Fax: (203) 384-1158
Acct# 106794

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 **Monday, February 18, 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

Connecticut Post
Docket Number 08-31101

Letter of Intent
February 14, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Bridgeport Hospital
Town:	Bridgeport
Docket Number:	08-31101-LOI
Proposal:	Replacement of HVAC System in Bridgeport
Capital Expenditure:	$5,400,000

The Applicant may file its Certificate of Need application between April 1, 2008 and May 20, 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 ***
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TRANSMISSION OK

TX/RX NO	3186
RECIPIENT ADDRESS	912033841158
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TIME USE	00'26
PAGES SENT	2
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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

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Sincerely,

CONNECTICUT POST

410 State Street • Bridgeport, CT 06604

3101

OFFICE OF HEALTHCARE ACCESS
410 CAPITOL AVE., MS#13HCA,ATTN SANDY
HARTFORD CT 06134-0308

LETTER OF INTENT
DOCKET NUMBER 08-31101
February 14, 2008

Statute Reference:	19a-639
Applicant:	Bridgeport Hospital
Town:	Bridgeport
Docket Number:	08-31101-LOI
Proposal:	Replacement of HVAC System in Bridgeport
Capital Expenditure:	$5,400,00

The applicant may file its Certificate of Need application between April 1, 2008 and May 20, 2008. Interested persons are invited to submit written comments to Cristine A. Vo- Commissioner Office of Health Care Ac- 410 Capitol Avenue, MS13HCA P.O. Box 340408, 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.

CONNECTICUT POST
CERTIFICATE OF PUBLICATION

This is to certify that the attached advertisement was published in the Connecticut Post newspaper as stated below.

(Advertising Representative)

Subscribed and sworn to before me, on this 18th day of February, A.D. 2008

Pamela E. Calvesi

Notary Public
State Commission Expires 1/31/2013