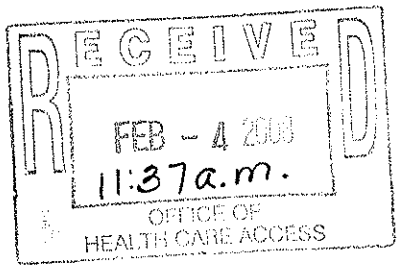
MIDDLESEX
HOSPITAL

ADMINISTRATION



January 31, 2008

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

Dear Commissioner Vogel:

Re: Middlesex Hospital North Building Fifth Floor Renovations

We are hereby submitting one (1) original and five (5) copies of Middlesex Hospital's Letter of Intent to Renovate the Fifth Floor North Building.

Very truly yours,

Harry Evert
Vice President, Administration

HE/rdo
Enclosure

28 Crescent Street
Middletown, Connecticut 06457-3650

tel 860 344-6000
fax 860 346-5485

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	**Middlesex Hospital**	
Doing Business As		
Name of Parent Corporation	**Middlesex Health System Inc.**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	**28 Crescent St. Middletown,CT. 06457**	
What is the Applicant's Status: P for Profit or NP for Nonprofit	**NP**	
Does the Applicant have Tax Exempt Status?	Yes √ No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	**Harry Evert Vice President**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**28 Crescent St. Middletown,CT. 06457**	

Contact Person's Telephone Number	**(860) 358-6120**	
Contact Person's Fax Number	**(860) 346-5485**	
Contact Person's e-mail Address	**Harry_Evert@midhosp.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Middlesex Hospital North Building Fifth Floor Renovations

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than $ 3,000,000

☐ Equipment Acquisition

☐ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

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

28 Crescent Street, Middletown, CT., 06457

d. List each town this project is intended to serve: **The Middlesex Hospital primary service area includes the Connecticut cities and towns of Middletown, Middlefield, Cromwell, Durham, Haddam, Killingworth, Portland, East Hampton, East Haddam, Marlborough, Colchester, Chester, Deep River, Essex, Old Saybrook, Westbrook, Clinton and Madison.**

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

f. Type of project: **#4**
(Fill in the appropriate number(s) from page 7 of this Form)

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

Type	Existing Beds ***Physically Available to be*** Staffed	Existing Licensed Beds	Proposed Increase (Decrease) in Beds ***Physically Available to be*** Staffed	Proposed Total Licensed Beds
Adult Med/Surg and ICU Beds	**153**	**226**	**20**	**226**

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ **5,198,410**

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

Medical Equipment Purchases	**$ 500,000**
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	**$ 4,548,410**
Other (Non-Construction) Specify: **Telephone + Computer Equip.**	**$ 150,000**
Total Capital Expenditure	**$ 5,198,410**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**$ 5,198,410**
Total Project Cost	**$ 5,198,410**
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition: (Not Applicable)

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☒	Applicant's Equity	☐	Capital Lease	☐	Conventional Loan
☐	Charitable Contributions	☐	Operating Lease	☐	CHEFA Financing
☒	Funded Depreciation	☐	Grant Funding	☐	Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: ____ **Middlesex Hospital** _____

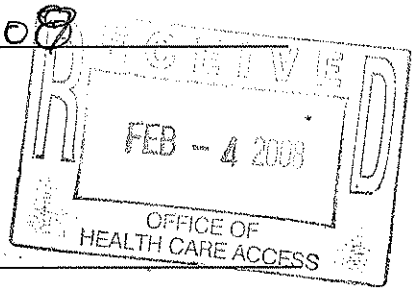
Project Title: ___ **Middlesex Hospital North Building Fifth Floor Renovations** ____

I, ____ **Vincent Capece**_____, _____ **Senior VP & Chief Operating Officer**__
(Name) (Position – CEO or CFO)

of ___ **Middlesex 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 _ **Middlesex 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 1/31/08



Subscribed and sworn to before me on 1/31/08

Notary Public/Commissioner of Superior Court

My commission expires: 3-31-09

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

30. Facility Development
31. Non-Medical Equipment
32. Land and Building Acquisitions
33. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
34. Renovations
35. Other Non-Clinical

SECTION IV. PROJECT DESCRIPTION

Middlesex Hospital North Building Fifth Floor Renovations

With this project, Middlesex Hospital proposes to renovate the fifth floor of the Hospital's North Building, which had previously been functioning as an adult inpatient medical/surgical unit and is currently utilized for various support offices. This floor will require significant renovations in order to properly outfit and equip it to continue to operate as Adult Med/Surg unit into the future. The new inpatient floor will be designed and equipped to meet all current standards for inpatient units.

This project is just one part of a longer-term bed planning effort that has been underway at Middlesex Hospital since 2004 to ensure that an adequate number of its licensed beds are physically available when needed as demand grows in the future. Between 2000 and 2004, inpatient Med/Surg discharges had increased over 30% at Middlesex Hospital and as a result the Hospital was experiencing annual occupancy rates of nearly 90% of its total capacity of Adult Med/Surg beds that were physically available to be staffed. In 2005, Middlesex Hospital obtained Certificate of Need Approval, under Docket Number 05-30509-CON, to convert the fourth and sixth floors of the Hospital's South Building back to patient care functions, which resulted in the addition of 29 Adult Med/Surg beds. (Note: this was not an increase in the total number of licensed beds.)

In addition to adding some needed bed capacity to better meet current levels of Adult Med/Surg demand, the incremental inpatient capacity that was brought on line in the South Building was also intended to enable the Hospital to complete necessary renovations to the North Building's inpatient Adult Med/Surg units in the future. When these two inpatient units were opened in the South Building the Hospital was able to relocate 20 Adult Med/Surg beds that had previously been located on North 5 to these new units so as to be able to begin to vacate the 5th floor of the North Building and prepare it for these necessary renovations. Once these proposed renovations to North 5 are complete, the Hospital will have realized a net increase of 20 in the total number of Adult Med/Surg beds that will be physically available to be staffed.

This project will not result in an increase to the Hospital's licensed bed capacity of Adult Med/Surg beds and no changes in the Hospital's clinical services, charges, or the population served will occur as a result of this project.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 21, 2008

Harry Evert
Vice President
Middlesex Hospital
28 Crescent Street
Middletown, CT 06457

Re: Letter of Intent, Docket Number 08-31102
Middlesex Hospital
Renovations of North Building Fifth Floor in Middlesex Hospital
Notice of Letter of Intent

Dear Mr. Evert:

On February 4, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital ("Applicant") for the Renovations of North Building Fifth Floor in Middlesex Hospital, at a total capital expenditure of $5,198,410.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Middletown Press* 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 21, 2008

Requisition # HCA08-142
Fax: (860) 347-3380

The Middlesex Press
2 Main Street
Box 471
Middletown, CT 06457

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 26, 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

The Middlesex Press
Docket Number 08-31102

Letter of Intent
February 21, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Middlesex Hospital
Town:	Middletown
Docket Number:	08-31102-LOI
Proposal:	Renovations of North Building Fifth Floor in Middlesex Hospital
Capital Expenditure:	$5,198,410

The Applicant may file its Certificate of Need application between April 4, 2008 and May 23, 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	3207
RECIPIENT ADDRESS	918603473380
DESTINATION ID	
ST. TIME	02/21 17:06
TIME USE	00'55
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 21, 2008

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 21, 2008

Harry Evert
Vice President
Middlesex Hospital
28 Crescent Street
Middletown, CT 06457

RE: Certificate of Need Application Forms, Docket Number 08-31102-CON
Middlesex Hospital
Renovations of North Building Fifth Floor in Middlesex Hospital

Dear Mr. Evert:

Enclosed are the application forms for Bridgeport Hospital's Certificate of Need ("CON") proposal of renovations of the north building fifth floor in Middlesex Hospital with an associated capital expenditure of $5,198,410. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between April 4, 2008, and May 23, 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 4, 2008 and may be submitted no later than May 23, 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: 08-31102-CON

Applicant(s) Name: Middlesex Hospital

Contact Person: Harry Evert
Contact Title: Vice President
Middlesex Hospital
Contact Address: 28 Crescent Street
Middletown, CT 06457

Project Location: Middlesex

Project Name: Renovations of North Building Fifth Floor in Middlesex Hospital

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

Est. Capital Expenditure: $5,198,410

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

☐ Applicant's equity:

Source and amount:

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

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or

☐ Other financing alternatives:

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

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.

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: _____

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

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

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

Type of Service Description

Type of Unit Description:
# of Months in Operation

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