YALE-NEW HAVEN HOSPITAL

March 19, 2008

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

Re: 2 Howe Street Garage and Multi-purpose Facility

Dear Commissioner Vogel:

Yale-New Haven Hospital (YNHH) is pleased to submit an original and five (5) copies of a Letter of Intent for the 2 Howe Street Garage and Multi-purpose Facility.

Given the parking situation in the immediate area of the Hospital, the 2 Howe Street Garage and Multipurpose Facility will significantly alleviate the parking shortage for patients, their families, and Hospital employees. The facility will also provide patient families with lodging close to the Hospital for longer-term stays, with two units designated for families of Medicaid-eligible patients. Short-term transitional housing will also be available for new employee recruits.

The total estimated cost of the project is $69,000,000.

Please forward any correspondence to:

Jean Ahn, System Director
Yale-New Haven Hospital
20 York Street
New Haven, CT 06504

Thank you for your consideration.

Sincerely,

Norman G. Roth
Senior Vice President
Administration

cc: William Aseltyne, Esq.

20 York Street
New Haven, CT 06510-3202

000001

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Yale-New Haven Hospital	
Doing Business As	Yale-New Haven Hospital	
Name of Parent Corporation	Yale-New Haven Network Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	20 York Street New Haven, CT 06504	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes X No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Jean Ahn System Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Yale-New Haven Hospital, 20 York Street New Haven, CT 06504	
Contact Person Telephone Number	(203) 688-2609	
Contact Person Fax Number	(203) 688-5013	
Contact Person e-mail Address	Jean.ahn@ynhh.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **2 Howe Street Garage and Multipurpose Facility**

b. Project Proposal: Proposal seeks to fit-out, lease and buy-out within 3 years a garage and multipurpose facility at 2 Howe Street for required patient and employee parking, long-term patient family and short-term transitional employee housing, and office space

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: ☒ Parking, Office Space, and Residential/Retail Space

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:

2 Howe Street, New Haven, CT 06510

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

Please see response to Question 3 in the Project Description.

h. Estimated starting date for the project: **Upon OHCA approval**

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

000004

a. Estimated Total Project Expenditure/Cost: $ 69,000,000

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	$63,000,000
Construction/Renovation	$6,000,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$69,000,000**
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Total Capital Cost	$69,000,000
Total Project Cost	$69,000,000
Capital Leases (see note below)**	$ 54,000,000**

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

**This transaction consists of a capital lease of $54 million recorded in FY 2010 representing the cost of the overall project. The Hospital will then make a three-year payment stream under this lease obligation from March 2010 through March 2013. In March 2013, this capital lease will be replaced by the Hospital's guaranteed obligation to purchase this building for approximately $63 million. At that time, the unamortized capital lease obligation and the related asset will be replaced on the Hospital's books by the $63 million purchase cost of the building.

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.

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

000006

To be completed by each Applicant

Applicant: **Yale-New Haven Hospital**

Project Title: **2 Howe Street Garage and Multipurpose Facility**

I, **James Staten**, **Chief Financial Officer**, of **Yale-New Haven 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 **Yale-New Haven Hospital** complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

James Staten — 3.19.08

Signature — Date

Subscribed and sworn to before me on 3/19/08

Patricia C. Fiorentino

Notary Public/Commissioner of Superior Court

Patricia C. Fiorentino
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2009

My commission expires:

RECEIVED
2008 MAR 19 P 2:54
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

SECTION IV. PROJECT DESCRIPTION

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.**

   Yale-New Haven Hospital (YNHH) is the primary teaching hospital for the Yale School of Medicine and a major community hospital for residents of the greater New Haven area. The Hospital offers a full array of primary to quaternary patient services; many quaternary services have been designated as regional or national referral services.

   A copy of YNHH's Department of Public Health (DPH) License is presented as Appendix I.

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

   No changes in YNHH services are being proposed. No additional DPH licensure is required.

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

   The current population served and the target population to be served include the residents of Ansonia, Bethany, Branford, Cheshire, Clinton, Deep River, Derby, East Haven, Essex, Guilford, Hamden, Killingworth, Madison, Meriden, Milford, New Haven, North Branford, North Haven, Old Saybrook, Orange, Oxford, Seymour, Wallingford, Westbrook, West Haven and Woodbridge.

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

   The current parking facilities are at maximum capacity and are unable to be expanded. In addition, the Hospital lacks long-term housing options for patient families who must spend several weeks or months at the Hospital. Lastly, the Hospital, which employs over 7,000 employees, lacks adequate on-site office space for all employees.

   The proposal to fit out, lease and buy-out the 2 Howe Street Garage and Multipurpose Facility will enable the Hospital to meet several critical needs: The 2 Howe Street Garage will allow YNHH to fulfill its certificate of occupancy requirements tied to the opening of the Cancer Hospital, and provide adequate parking to meet the needs of patients and staff. The facility will provide patient families with convenient lodging for long-term stays that is in close proximity to the Hospital, with two units designated for families of Medicaid-eligible patients. Short-term transitional housing will also be available for new employee recruits. Lastly, the facility will provide much-needed on-site office space.

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

   Griffin Hospital, Hospital of Saint Raphael, MidState Medical Center and Milford Hospital, as well as the Middlesex Hospital Outpatient Center are the other existing service providers in the proposed service area.

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

   Given the parking shortage in the immediate medical center area, which is estimated to equal roughly 1,400 spots, the 2 Howe Street Garage and Multipurpose Facility will significantly alleviate the parking situation for patients, their families, and Hospital employees. The facility will greatly enhance access to patient care services required by patients and families who must travel to the Hospital for cancer and other tertiary and quaternary care, thereby improving the overall delivery of healthcare to the community and patients the Hospital serves.

7. **Who will be responsible for providing the service?**

   Yale-New Haven Hospital 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?**
   The payers for this service include Medicare, Medicaid, Aetna, Blue Cross, Cigna, Connecticare, HMC PPO, Oxford, PHS, United Healthcare, Workers Compensation, Yale Health Plan and others.

APPENDIX I

COPY OF YNHH'S DEPARTMENT OF PUBLIC HEALTH (DPH) LICENSE

STATE OF CONNECTICUT

Department of Public Health

000020

LICENSE

License No. 0044

General Hospital

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

Hill Health Corporation of New Haven, CT, d/b/a Yale-New Haven Hospital, Inc. is hereby licensed to maintain and operate a General Hospital.

Yale-New Haven Hospital, Inc. is located at 20 York Street, New Haven, CT 06504

The maximum number of beds shall not exceed at any time:
852 General Hospital beds
92 Bassinets

This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007. RENEWAL.

Satellites

Hill Regional Career High School, 140 Legion Avenue, New Haven, CT
Branford High School Based Health Center, 185 East Main Street, Branford, CT
Walsh Middle School, 185 Damascus Road, Branford, CT
James Hillhouse High School Based Health Center, 480 Sherman Parkway, New Haven, CT
Sheriden Acadamy of Excellence School Based Health Center, 191 Fountain Street, New Haven, CT
Vincent E. Mauro Elementary School Based Health Center, 130 Orchard Street, New Haven, CT
Weller Building, 425 George Street, New Haven, CT
Yale-New Haven Psychiatric Hospital, 184 Liberty Street, New Haven, CT
Yale-New Haven Shoreline Medical Center, 111 Goose Lane, Guilford, CT
Pediatric Dentistry Center, 860 Howard Avenue, New Haven, CT
Ynhasc Temple Surgical Center, 60 Temple Street, New Haven, CT
Ynhasc Women's Surgical Center, 40 Temple Street, New Haven, 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

March 25, 2008

Jean Ahn
Systems Director
Yale-New Haven Hospital
20 York Street, CB-1007
New Haven, CT 06504

RE: Certificate of Need Application Forms; Docket Number: 08-31125-CON
Yale-New Haven Hospital
Construction of the Howe Street Garage and Mulitpurpose Facility

Dear Ms. Ahn:

Enclosed are the application forms for Yale-New Haven Hospital's Certificate of Need ("CON") proposal for the construction of the Howe Street Garage and Mulitpurpose Facility with an associated capital expenditure of $69,000,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between May 18, 2008, and July 17, 2008.

When submitting your CON Application, please paginate and date each page contained in your submission. Subsequent filings to OHCA dealing with responses to completeness letters, prefile testimony, late file submissions and the like must similarly be paginate and dated. Pagination of each of these subsequent filings must be numbered sequentially from the Applicant document which precedes it. For example, if the CON application concludes with page 100, your completeness letter response would begin with page 101. In addition, please submit one (1) original and six (6) 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 Attachments and other data as appropriate be in MS Excel format.

The CON analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, 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 a response of "Not Applicable" may be considered acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than May 18, 2008, and may be submitted no later than July 17, 2008. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached directly at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number:	08-31125-CON
Applicant(s) Name:	Yale-New Haven Hospital
Contact Person:	Jean Ahn
Contact Title:	Systems Director
Contact Address:	Yale-New Haven Hospital 20 York Street, CB-1007 New Haven, CT 06504
Project Location:	New Haven
Project Name:	Construcion of the Howe Street Garage and Mulitpurpose Facility
Proposal Type:	Section 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$69,000,000

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, 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)

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: _____

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. Explain how it was determined there is a need for each component of the proposed building project.

   B. Describe the current parking situation at the Hospital and how the proposed garage will address/benefit the current parking status.

   C. Provide an explanation of the accommodations and arrangements that will be made to address patient family lodging for longer-term patient stays.

   D. Describe the type of office space that will be provided at the proposed building. Why is this space incorporated in the design plans for the proposed structure?

   E. Provide an explanation of the accommodations and arrangements that will be made to address short-term transitional housing for newly recruited employees.

   F. Will your proposal remedy any of the following barriers? 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 any engineering/management plans, studies or reports related to your proposal.

5. Quality Measures

A. Submit a list of **all** key professional and administrative personnel, including the Hospital'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]

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)_____

[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.

7. Miscellaneous

A. Will this proposal result in any 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 a copy of the State of Connecticut Department of Public Health license currently held.

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 latest cash equivalent 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.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Capitalized Financing Costs	
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 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 and plot plan.

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. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	____Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	Please submit a schedule of depreciation for the purchased equipment as an attachment.	

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

12. 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.	$_____
2.	What is the useful life of the building?	____Years
3.	Please submit a schedule of depreciation for the purchased building as an attachment.	

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

13. Type of Financing

A. Provide a narrative regarding the various phases of the proposed project with respect to fit-out, lease and eventual buy-out for the proposed structure within a three year period.

B. Why is the Hospital pursuing this course of action?

C. 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.)	_____

D. 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. Capital Lease agreement.

13. 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 or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

A.3. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please complete Financial Attachment I included in the forms package. 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 projection of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. Please complete Financial Attachment II included in the forms package.**

iii) List 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.). Please Note*: Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.***

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) Describe how this proposal is cost effective.

13. B(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 Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
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
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 Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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