YALE-NEW HAVEN HOSPITAL



April 22, 2008

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

**Re: Replacement of Electrophysiology Laboratory**

Dear Commissioner Vogel:

Yale-New Haven Hospital (YNHH) is pleased to submit an original and three copies of a Letter of Intent for the Replacement of an Electrophysiology (EP) Laboratory.

This project involves the purchase of a GE Inova Single-Plane imaging system to replace an outdated procedure suite, which will enable YNHH to continue to provide high quality electrophysiology services. The total cost of this project is estimated to be $1,749,654.

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: **Replacement of Electrophysiology Laboratory**

b. Project Proposal: **The proposal seeks to replace an outdated electrophysiology (EP) laboratory and equipment (installed in 1994) with a modern EP laboratory and equipment**

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: **Navigation system**

**Non-Clinical:**

- ☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
- ☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
- ☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
- ☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

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

- ☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☒ Replacement
- ☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service

☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☒ Yes ☐ No

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

☐ New equipment acquisition and operation

☒ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

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

**20 York 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Not applicable.**

## SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$3,857,448**

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

| | |
|---|---|
| Major Medical Equipment Purchases* | $ 660,000 |
| Medical Equipment Purchases* | $1,668,058 |
| Non-Medical Equipment Purchases* | |
| Land/Building Purchases | |
| Construction/Renovation | $1,529,390 |
| Other (Non-Construction) Specify:_____ | |
| **Total Capital Expenditure** | **$3,857,448** |
| 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** | **$3,857,448** |
| **Total Project Cost** | **$3,857,448** |
| 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 |
|---|---|---|---|---|
| Bi-Plane Imaging System for EP | GE | Inova2100 IQ | 1 | $1,668,058 |
| Navigation | Hansen Medical | Sensei Robotic Catheter Syst. | 1 | $660,000 |

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

**A copy of the vendor's quote is attached as Appendix I.**

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: **Replacement of Pediatric Cardiac Catheterization Laboratory**

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 4/21/08

Signature Date

Subscribed and sworn to before me on 4/21/08

Patricia Fiorentino

Notary Public/Commissioner of Superior Court

My commission expires: Patricia C Fiorentino NOTARY PUBLIC MY COMMISSION EXPIRES DEC. 31, 2009

RECEIVED
2008 APR 22 P 12:24
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 University 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.

   The current electrophysiology (EP) laboratory provides electrodiagnostic electrophysiology testing, intracardiac electrical conduction system mapping, radiofrequency ablation, pacemaker implantation, defibrillator implantation, post-implant defibrillator testing, and other related electrophysiologic tests/procedures.

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

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

   The proposal seeks to replace YNHH's existing outdated electrophysiology (EP) laboratory and equipment (which was installed in 1994) with a modern EP laboratory and equipment, which will provide the same services as noted above. Additionally, a state-of-the-art navigation system is being requested for complex ablation procedures such as atrial fibrillation ablations.

   Additional DPH licensure is not 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 proposed project seeks to replace an outdated EP laboratory within the Hospital. Given the age of the existing equipment and imaging technology, the laboratory is outdated and limited in terms of the quality and service it can provide in terms of imaging, visualization and mapping. Compared to modern systems, the current laboratory provides limited soft-tissue resolution to differentiate structures and takes significantly longer time for catheter localization.

   The proposed replacement EP laboratory with robotic navigation system will provide state-of-the-art imaging, mapping and precise remote instrument control, which will enable greater efficiency in terms of site identification, catheter localization and stabilization. The

significant clinical advantage resides in the ability to utilize the technology to efficiently move catheters in the heart that would be difficult to execute manually in highly complex procedures. For example, available navigation systems' tight bend radius enables easier navigation in complex anatomy. In addition, the replacement equipment will reduce the length of patient procedures and subsequently the patient's radiation exposure, contributing significantly to both patient safety and comfort.

Replacing the EP laboratory will allow YNHH to better serve its patients by improving its ability to provide safe, high quality care through EP laboratory procedures benefiting from enhanced site identification, catheter localization, catheter stabilization, imaging and visualization, in addition to shorter procedures resulting in lowered radiation exposure.

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

   The Hospital of Saint Raphael provides EP services in the proposed geographic area. However, as far as YNHH is aware, state-of-the-art navigation system technology is not currently available in the immediate service area.

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

   Replacement of the outdated electrophysiology laboratory will enable Yale-New Haven Hospital to provide a complex array of high quality electrophysiology services and state-of-the-art-care to all of its patients with arrhythmia related disorders. Given the fact that atrial fibrillation increases with age and will become more prevalent as the population ages, this proposal will greatly improve the comprehensiveness and accessibility of EP services for YNHH patients, who are part of a rapidly aging state.

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

# GE Healthcare

## Preliminary Proposal

To:
YALE-NEW HAVEN HOSPITAL
20 YORK ST
New Haven, CT 06504

From:
Andrew M Dinitz
7 Terhune Dr
Westport, CT 06880
(203)395-2480
fax: (203)702-5405

GTWC36.GTW01 Wednesday, March 19, 2008

Innova 2100IQ EP Cardiology YNHHS

| Qty | ID | Description | Price |
|---|---|---|---|
| | | **Innova 2100IQ X-Ray System, Table and Functional Accessories** | |
| 1 | S18751AP | Innova 2100IQ Cardiovascular and Interventional<br>Single Plane System<br><br>Revolution Solid State Digital Detector<br>o Flat Panel, Solid State Detector<br>o Detector Dose Efficiency<br>o Dynamic Exposure Optimization and Temporal Dose Efficiency<br><br>Innova DL Digital Imaging Subsystem<br>o DSA - Digital Angiography Subtraction (option) at .5 to 7.5 fps<br>o Dynamic Cine Acquisition of 15 and 30 fps<br>o On-the-Fly Field of View adjustment with four magnification selections ( 20 cm, 17 cm, 15 cm, and 12 cm)<br>o Integrated X-ray Dose Tracking with In-room Display of cumulative dose and dose area product<br>o Dose information stored on the Exam Browser<br>o Image Storage of 136,000 1024 x 1024 Images<br>o DICOM Image Output on 100 mbit Ethernet with background auto-send<br>o Images may be sent at either 1024 x 1024 acquisition resolution or in a standard 512 x 512 DICOM format in uncompressed<br>o Automatic background transfer of images to either the AW Workstation or a Cardiac Review Station depending on the image content<br>o Automatiic injection capability for contrast media injector initiation<br>o User defined acquisition protocols via procedure edit<br><br>Image Display<br>o Interpolated Zoom w/Panning, Window/Level,<br>Edge Enhancement and Noise Reduction Filters<br><br>Image Management and Connectivity<br>o Image Storage Capacity of 136,000 1024x1024 Images<br>o Automatic Background Transfer of Images<br><br>Innova LC Cardiac Positioner<br>o Patented 3-Axis Isocentric Design w/Floor Mounted L-Arm and Offset C-Arm<br>o The InnovaTrace System enables movement of<br>the pivot and C-arm of up to 20 degrees per second.<br><br>Innova Real-Time System Manager<br>o Single point control of all system operations<br>o Instant application of up to 240 preprogrammed protocols, including image quality customization protocols<br><br>Innova Angiographic Collimator<br>o Automated Spectral filters<br>- .1, .2, .3, .6 and .9 mm thick<br>o Three independent motorized contour filter plates including a central leg filter<br>o Functions controlled from tableside | |

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Innova 2100IQ EP Cardiology YNHHS

| Qty | ID | Description | Price |
|---|---|---|---|
| | | Innova VMP 100kW High Frequency Generator<br>o Reliable, Consistent Power<br>o Grid Pulsed Fluoro<br><br>MX-160BG X-ray Tube<br>o Water Cooled X-ray Tube w/Closed Loop<br>o 1.95 MHU Heat Capacity and High Heat Dissipation Rate Minimize Cooling Delays, even with aggressive techniques<br><br>Broadband Built In<br><br>System is ready for high speed internet connection. Enables customer to access GE Healthcare Digital Services designed to improve quality, expand imaging capabilities, increase productivity, reduce costs, reduce downtime, and increase privacy and security of data transmission.<br><br>Warranty<br>o Full One Year Warranty on System and Revolution Detector<br>o Three Year Non-prorated Warranty on the X-Ray Tube as Detailed in Warranty Documentation.<br>o Standard warranty coverage hours for this Innova system are 9 AM to 9 PM local time, Monday through Friday, excluding GE Healthcare holidays. | |
| 1 | S18721AD | Administration Package<br><br>DICOM Patient Worklist Capability provides single point of entry of patient data, increasing staff productivity and eliminating clerical errors. Patient information can easily be imported into the digital system from information systems that support DICOM Worklist Service Provider.<br><br>The Administration Package is required for two-way information exchange with the Mac Lab 7000 Hemodynamic Monitoring System (optional). | |
| 1 | S18751SS | InnovaSense Patient Contouring - Frontal Plane Only<br><br>Patient contouring feature leverages advanced capactive sensor technology in real time to sense the distance of the patient from the detector. Ability to do so is critical in moving the detector rapidly near the patient, and also positioning it optimally close to the patient to reduce skin dose. | |
| 1 | S18061CR | Omega IV Compact Table with Slicker Cover (Non Motorized) and Table Upgrade | |
| 1 | S18751TS | Innova Central Touch Screen<br><br>The Touch Screen User Interface is a gateway to tableside integration of multiple work-flow enhancing features. The Touch Screen controls not only Innova functions, but also Maclab cardiolab functions (optional). In the future this centralized tableside platform is going to have ability to connect with, and control third-party devices as well. | |
| 1 | S18061TS | Smart Box | |
| 1 | E8015JA | Omega V Tempurpedic Table Pad (2 in. Thick), 131 in. L | |

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Innova 2100IQ EP Cardiology YNHHS

| Qty | ID | Description | Price |
|---|---|---|---|
| | | GE has partnered with Tempurmedic to produce a 2 in. thick pad that improves patient comfort for long procedures. This mattress is designed for use in acute, sub-acute, and long-term care settings. It is a superior therapeutic adjunct that has been clinically demonstrated effective in supporting comprehensive plans of care intended to prevent and treat pressure ulcers. Healthcare facilities that have converted to this mattress have reported: significant reduction in wound incidence rates, desirable wound healing rates, and better patient comfort. This rectangular mattress is recommended for use with the Omega V Angio table, has a neutral gray color and measures 131 in. L x 22 in. W x 2 in T. | |
| 1 | S18341TT | Table Panning Device with 5M Cable<br><br>Table mounted vertical grip for fast and easy table lock release and panning of the Omega Cardiac and Angio tables.<br><br>**Image Display Boom for 4 Monitors- Yale clinical practice will determine final configuration.**<br><br>**Monitors** | |
| 1 | S18391BF | 4 LCD Monitor Suspension with 36 Meter Cable | |
| 1 | S18461EA | Contains two (2) 18 inch Flat Display (LCD) Monitors for Use in the Exam Room Monitor Boom. | |
| 1 | S18381AW | 18" Color LCD In-Room AW Repeater Monitor<br><br>o 18" Color LCD Monitor adapted for In-room Monitor support<br>o Cabling from AW Workstation to Monitor<br>o Signal output from AW to In-Room monitor<br>o Video Splitter providing second signal to Monitor<br><br>**Installation--GE Power Systems UPS--Injector Interface** | |
| 1 | S1876PC | Innova Main Disconnect Panel - UPS Ready<br><br>This main disconnect panel provides emergency shut down, undervoltage protection, overcurrent protection, OSHA lockout tag provisions, and serves as a local disconnect for the GEHC Innova system. It reduces installation time and cost by providing a single-point power connection, eliminating the need to mount and wire a number of individual components, and its standardized design and testing assures high product quality and system reliability. It is UL and cUL listed for compliance with National Electric Code, and it can be either surface or semi-flush mounted.<br><br>Customer is responsible for rigging and arranging for installation with a certified electrician. | |
| 1 | S18751PC | GE Digital Energy 20 KVA UPS for Innova Single Plane Systems | |
| 1 | S18751PS | Innova UPS Interface | |
| 1 | S18081KA | IVUS Ready Kit | |
| 1 | S18051NF | Provis Mark V+ Table Mount Injector Interface | |
| 1 | S18751DP | S18751DP | |
| 1 | S18101SF | Above Grade and Through Bolts | |
| 1 | S18101SM | Vascular Base Plate Assembly | |

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Innova 2100IQ EP Cardiology YNHHS

| Qty | ID | Description | Price |
|---|---|---|---|
| 1 | S18101SP | Installation Template | |
| 1 | S18101SX | Rails and Cable Drapes | |
| 1 | S18111SB | 9 ft. 6 inch Inboard Monitor Bridge | |
| 1 | S18121RA | In Board Rails, 228 inch/579 cm for LCD Monitor Suspensions | |
| 1 | S18121TB | X-ray Digital Detector Coolant Kit | |
| 1 | S18741CB | Innova Group 4-5 Cable | |
| 1 | S18741CD | Innova 3100/4100 Group 1 Cable - Max Length | |
| 1 | S18741CF | Innova Group 2 Cable - Maximum Length | |
| 1 | S18741CG | Bolus Cable Set - 100 FT/30M | |
| 1 | S18741ET | Innova Omega 5 Table Elevator | |
| 1 | S18741TP | Omega Table Baseplate | |
| 1 | S18751CA | Innova Group 3 Cable | |
| 1 | S18751CC | MAC LAB Cable - 70 inches | |
| 1 | S18751PM | Innova Pre-installation Manual | |
| | | **Recommended Accessories** | |
| 1 | E3053LG | Mavig Standard Track-Mounted, 40 cm x 50 cm, 58 cm Column<br><br>The Mavig Portegra2 standard overhead lead acrylic radiation protection systems provide protection for medical personnel while allowing visual contact from practitioner to patient, and with Mavig's patented systems, these shields provide the utmost in safety and convenience. This standard track-mounted system includes a side, frame-mounted 40 x 50 cm, 0.5 mm lead equivalent acrylic shield with MUL protection, a 58 cm Portegra2 standard ceiling column with trolley, and cable spooler. UL and CE marked.<br>Warranty Period- 6 months- Exchange of non-conforming products, which are returned to GE during warranty period<br>Note: Installation, parts, application training and on-site service is the buyer's responsibility | |
| 1 | E3053JB | Mavig Double Pivot, Flexible Lower Body Protector<br><br>Pivotal, flexible shield 65x90 cm (25x35 in.)<br>Easy on upper protective shield 25x65 cm (10x25in.)<br>Includes one set of wall storage holders<br>Most convenient and flexible system<br><br>Warranty Period- 6 months- Exchange of non-conforming products, which are returned to GE during warranty period<br><br>Note: Installation, parts, application training and on-site service is the buyer's responsibility | |
| 1 | E7058A | GE Anti-Fatigue Floor Mat | |

GE Healthcare

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| Qty | ID | Description | Price |
|---|---|---|---|
| | | The GE anti-fatigue floor mat helps reduce body stress and fatigue resulting from standing for long periods, and it is one of the most comfortable, buoyant anti-fatigue floor mats on the market. The mat is durably constructed and sealed to prevent moisture absorption and facilitate cleanup. It is a medium blue marbleized color, weighs 22 lbs. and measures 36 in. W x 60 in. L as 0.5 in. T. This mat is ideal for Cardiology, Angiography, and R&F environments. | |
| | | **Training** | |
| 3 | W0002CV | Two Days Cardiovascular X-ray TiP Onsite Training<br><br>Two Day Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. Days provided consecutively. | |
| | | **TOTAL NET EQUIPMENT SELLING PRICE** | **$922,996.79** |
| | | --- | |
| | | **EQUIPMENT OPTIONS** | |
| | | Training Days- Typically 2 day Blocks- Time required based on System Experience- Typical 4-9 days | |
| 1 | W0002CV | Two Days Cardiovascular X-ray TiP Onsite Training<br><br>Two Day Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. Days provided consecutively. | $3,350.00 |
| 1 | W0001CV | 1 Day Cardiovascular X-ray TiP Onsite Training<br><br>One Day Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. | $1,900.00 |
| | | IVUS Full System for Intervention | |
| 1 | S18181BP | Volcano S5i Imaging System with IVUS - Cardiology<br><br>Includes:<br><br>o Volcano IVUS s5i System<br>o Volcano VH (TM) IVUS | $73,600.00 |

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| Qty | ID | Description | Price |
|---|---|---|---|
| | | The Volcano IVUS s5i system is a fully functional catheter-based ultrasound system with an ultrasound imaging probe at the tip of a catheter that is used to image and measure inside the cardiovascular system. IVUS provides information about the vessel, including vessel/lumen diameter, lesion length, anatomical landmarks, and plaque composition. The s5i system is designed to make IVUS more integrated into the interventionalist lab by the use of modular components that are connected to a remote CPU. The CPU can be located in the control room or equipment closet. Images can be displayed on one or more monitors, including a monitor on the boom.<br><br>o Volcano IVUS System CPU<br>- Compact size and flexible location<br>o IVUS Control Panel<br>- Integrated Keyboard and Mouse<br>- Mount in control room or on table rail<br>o Color LCD Monitor on Desk Stand (19.1 inch Diagonal) for control room<br>o Video output to multiple locations<br>o Video Signal Switch<br>o Patient Interface Module for Catheter designed to hang on bed rail<br>- Always active and ready for catheter connection and operation<br>o Interface cables and documentation<br><br>Includes standard GE one year warranty.<br><br>Volcano IVUS Applications included.<br><br>Volcano VH (TM) IVUS<br><br>The VH (TM) IVUS functionality provides lesion assessment in real-time in the procedure room or control room utilizing advanced spectral analysis. Using the same catheter and processing system, the Volcano VH IVUS functionality provides additional clinical information.<br><br>VH (TM) IVUS Features:<br><br>o Automated border contours - fast, simple image interpretation<br>o Automated lumen and vessel measurements to aid in diagnosis and planning<br>o Colorized tissue map of plaque composition - for complete lesion assessment<br>o Data for VH (TM) IVUS is captured during normal IVUS run<br>o Plaque composed into four categories:<br>- Fibrous<br>- Fibro-fatty<br>- Necrotic Core<br>- Dense Calcium<br><br>**Advanced Software Options** | |
| 1 | S18751SP | InnovaSpin 2D Rotational Angiography Option<br><br>The offset C-arm permits fast spin rotational angiography over a total 200 degrees at variable speed from 20 degrees to 40 degrees per second, with cranial/caudal angulation. Each configurable spin trajectories are available. The acquisition protocol is driven entirely from tableside using the auto-positioning module and test button. | $32,000.00 |

GE Healthcare

# Preliminary Proposal

To:
YALE-NEW HAVEN HOSPITAL
20 YORK ST
New Haven, CT 06504

From:
Andrew M Dinitz
7 Terhune Dr
Westport, CT 06880
(203)395-2480
fax: (203)702-5405

GTWC36.GTW01 Wednesday, March 19, 2008

## Innova 2100IQ EP Cardiology YNHHS

| Qty | ID | Description | Price |
|---|---|---|---|
| 1 | S18751CB | Cardiac Analysis Package on DL Digital System<br><br>The Cardiovascular Analysis Package includes both the Stenosis Analysis Package and the Left Ventricular Analysis Package.<br><br>The Stenosis Analysis Package is an application designed to estimate vessel dimensions and relevant parameters of the arterial Stenosis morphology in X-Ray angiography. The system is capable of automatic detection of vessel edges and display of stenosis severity.<br><br>The Left Ventricular Analysis Package is an expert reporting tool designed to estimate wall motion dynamics of the left ventricle, and to perform Global Ejection Fraction analysis in X-Ray angiography. The system is capable providing Wall Motion and Global Ejection Fraction measurements. Wall Motion is built on the centerline method.<br><br>GEF analysis is calculated using both Simpson's rule method and the Dodge-Sandler area-length method.<br><br>Injector System- Interface included above. | $17,920.00 |
| 1 | E7018JN | Medrad Provis Table Mount Injector w/Remote Keyboard, & Free-Standing Pedestal<br><br>The Medrad Mark V Provis table mount injector has a programmed microprocessor that helps protect against over-volume, over-flow and over-pressure, as well as an exclusive mechanical stop that automatically sets and locks to physically limit injection to selected volume and is unaffected by electrical interruption. There is also a large, bright control panel for easy reading in any lighting situation, and common protocols are stored to save time. Multiple turret configurations offer different volume studies and a wide range of fast and slow loading speeds. This model includes a remote keyboard and free-standing pedestal so that it can be moved around the room for added flexibility. Recommended for use with Angiography and Cardiology systems. | $26,800.00 |

**PRICING PROPOSAL**
General Electric Company is pleased to submit this Pricing Proposal for budgetary purposes only.
This Pricing Proposal will be valid until May 18, 2008, unless otherwise indicated herein.
If you would like to place an order for the equipment listed herein, your GE Sales Representative will arrange for the preparation and submission to you of a formal GE Quotation, including applicable GE Terms and Conditions, Warranties, and Payment Terms, for your consideration.
Only a formal GE Quotation may be used to create a binding order for this equipment.
Upon request, your GE Sales Representative can also provide you with information concerning GE training, lease/finance and service agreement options.

GE Healthcare

Preliminary Proposal

To:
YALE-NEW HAVEN HOSPITAL
20 YORK ST
New Haven, CT 06504

From:
Andrew M Dinitz
7 Terhune Dr
Westport, CT 06880
(203)395-2480
fax: (203)702-5405

GTWC36.GTW01 Wednesday, March 19, 2008

Innova 2100IQ EP Cardiology YNHHS

## Excluded Parts Warning

| ID | Description | Reason | Explaination |
|---|---|---|---|
| S18181BP | Volcano S5i Imaging System with IVUS - Cardiology | Other | |
| S18751SP | InnovaSpin 2D Rotational Angiography Option | Other | |
| S18751CB | Cardiac Analysis Package on DL Digital System | Other | |
| E7018JN | Medrad Mark V ProVis Table Mount Injector, Remote Keyboard, Free Standing Pedestal | Other | |

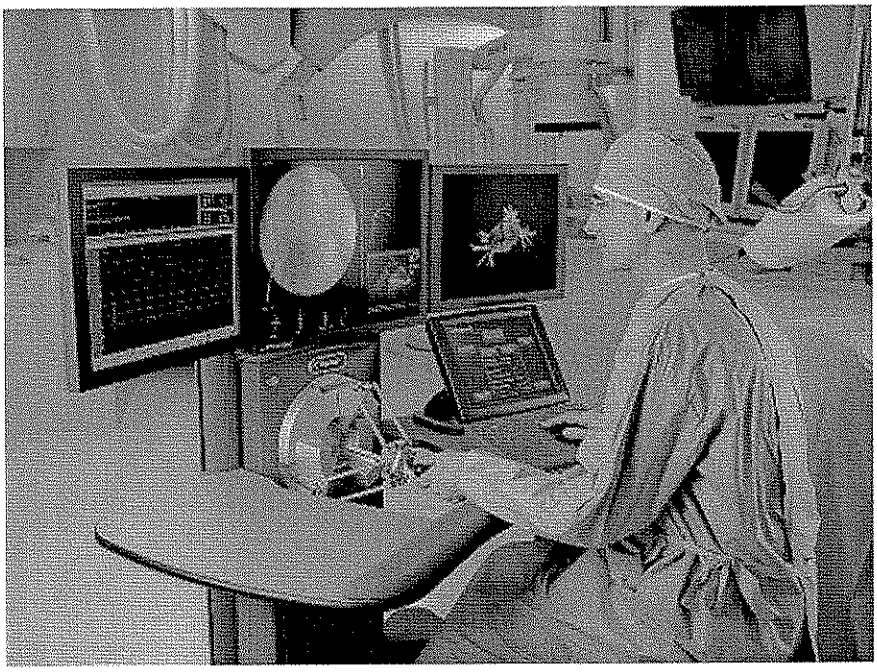
Hansen Medical
380 North Bernando Avenue
Mountain View, CA, 94043

## Introduction

Dear Michael,

At Hansen Medical our mission is to enable a new class of percutaneous procedures by introducing robotic catheter control to interventional technique. The Sensei™ Robotic Catheter System and Artisan™ Control Catheter are designed to provide physicians with more accurate and stable control of the catheter tip. This facilitates positioning of percutaneous catheters in hard to reach locations within the heart. The Sensei system fits seamlessly into existing cath labs and allows the physician to remain seated throughout the procedure, out of the field of direct harmful radiation.

Thank you for your interest in the Sensei Robotic Catheter System!



Regards,

Craig Buck
Hansen Medical
Regional Sales Executive
315-427-2122
650-404-5901

Hansen Medical
380 North Bernardo Avenue
Mountain View, CA, 94043

# Quotation

**Quote To**
Mr Michael Viner
Yale New Haven Health
789 Howard Ave
New Haven, CT, 06519
USA

| Quote ID | Date |
|---|---|
| 0181CB-R02 | 1/14/2008 |

| Description | Rate | Qty | Amount |
|---|---|---|---|
| **Capital** | | | |
| Sensei™ Robotic Catheter System<br>The Sensei™ Robotic Catheter System is intended to facilitate accurate manipulation, placement and positioning of percutaneous catheters into discrete regions of the cardiovascular system. The System includes the following components:<br>• Physician Workstation<br>• Remote Catheter Manipulator (RCM)<br>• Electronics Rack<br>• Sterile Drape Kits, eight count box<br>• System Interconnect Cables<br>• Operator's Manual Package<br>• Adjustable Herman Miller Chair with Hansen Medical logo<br>• Includes the warranty package covering parts, service and labor for 12 months as described in the terms and conditions of the quote.<br>• Includes non-recurring software licensing fee. | $660,000.00 each | 1 | $660,000.00 |

**Total: $660,000.00**

This Quote is valid for 60 Days

## Terms and Conditions

This quote is valid for 60 days

To the extent permitted by law, any typographical, clerical or other error or omission in sales literature, quotation, price list, acceptance of offer, invoice or other documents or information issued by the Company shall be subject to correction without any liability on the part of the Company.

The quoted price excludes any substitute components or optional items.

Hansen Medical
380 North Bernando Avenue
Mountain View, CA, 94043

## Signature Block

Please sign below to commence processing of your order and to acknowledge your agreement to the Terms and Conditions set forth below. There shall be no force or effect to any different or additional terms of any related purchase order, confirmation or similar form even if signed by the parties after the date hereof.

Michael Viner

Signature:

Title:

Date:

Craig Buck

Signature:

Title:

1/14/2008

Jed Palmacci
VP of Sales

Jed Palmacci

Hansen Medical
380 North Bernando Avenue
Mountain View, CA, 94043

## Standard Terms

Terms and Conditions

1. Sale and Purchase. Hansen will use reasonable commercial efforts to sell to Buyer and Buyer will purchase from Hansen the Products in the quantities ordered in accordance with the terms of the above quotation ("Firm Orders") only for Buyer's own internal use and subject to Hansen's then-current lead time requirements. All Firm Orders are subject to written acceptance by Hansen. In order to ensure patient safety, Buyer agrees that it will not use or permit others to use Products with any disposable devices, software or accessories, other than those approved on the Product label or otherwise in writing by Hansen. "Products" are Hansen's products specified above, and any other products Hansen may in its discretion add to this Agreement by express notice to Buyer. In addition to Products, Hansen may make available for purchase certain disposable devices (that are approved by applicable regulatory authority) for use in connection with Products ("Disposables"). Notwithstanding anything else, Disposables are sold (a) for single patient use only (and any re-use is strictly prohibited), (b) "as is" except for conformity to the claimed shelf-life on the packaging, and no indemnity, support or warranty obligations of Hansen will apply with respect thereto. Hansen may in its discretion discontinue or modify any Product upon 60 days notice. Accepted Firm Orders are binding non-cancelable commitments. Non-disposable Products may contain used, reworked or refurbished parts and components (that comply with the terms of this Agreement).

2. Price, Payment and Delivery Terms. Buyer shall pay to Hansen, with respect to each Firm Order, the prices documented in the Hansen quotation relevant to such Firm Order . Unless otherwise set forth in the quotation, Hansen's payment terms are as follows: an initial deposit of 20% of the purchase price for each Product is due upon submission of the purchase order, and the remaining 80% of the purchase price is due upon completion of installation. Unless otherwise agreed, all payments other than the initial deposit are due net thirty (30) days from the date of invoice. However, for orders outside of the United States, Hansen reserves the right at any time, to require Buyer to promptly establish a confirmed irrevocable letter of credit ("ILC") in favor of Hansen issued by a United States bank acceptable to Hansen (the "Bank"), payable in U.S. Dollars in an amount equal to the total price of any requested order. The ILC shall be in a form satisfactory to Hansen and shall provide that Hansen may draw upon it in full upon presentation to the Bank of a certificate of Hansen that it has shipped such Products to Buyer. All Products are delivered Ex Works (Incoterms 2000) Hansen's shipping point. Hansen will use its reasonable commercial efforts to deliver Products within fifteen days of the applicable requested delivery dates. In addition to the price, Buyer will pay all charges, including without limitation transportation charges, insurance premiums, and shall be responsible for all taxes (except Hansen's U.S. income taxes), duties, costs of compliance with export and import controls and regulations, and other governmental assessments. From the Ex Works point, Hansen shall have a purchase money security interest in the Products (and all accessories and replacements thereto and all proceeds thereof) until payment in full by Buyer. Buyer hereby authorizes Hansen to file (and Buyer shall promptly execute, if requested by Hansen) any Uniform Commercial Code financing statements (along with a copy of this Agreement, as necessary) with respect to the Products and/or this Agreement.

3. Warranties. Hansen warrants only to Buyer that the Products, when shipped to Buyer by Hansen, will be free from material defects in materials and workmanship. Such warranty does not apply to units that have been damaged, mishandled, mistreated or used or maintained or stored other than in conformity with such specifications and Hansen's instructions. EXCEPT FOR BODILY INJURY, BUYER'S SOLE AND EXCLUSIVE REMEDY FOR ANY BREACH OF THE FOREGOING WARRANTY SHALL BE THE REPAIR OF, REPLACEMENT OF OR (AT HANSEN'S OPTION OR IF REPAIR OR REPLACEMENT IS IMPRACTICAL) REFUND FOR RETURNED NON-CONFORMING UNITS OF PRODUCT FOR WHICH FULL DOCUMENTATION AND PROOF OF NON-CONFORMITY IS PROVIDED TO HANSEN WITHIN ONE YEAR AFTER THE ORIGINAL NON-CONFORMING UNITS (BUT NOT REPLACEMENTS) ARE INSTALLED BY HANSEN. EXCEPT FOR THE FOREGOING WARRANTIES, HANSEN DOES NOT MAKE (AND HAS NOT AUTHORIZED ANYONE TO MAKE) ANY EXPRESS OR IMPLIED WARRANTY, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR NONINFRINGEMENT. HANSEN HAS NOT AUTHORIZED ANYONE TO MAKE ANY REPRESENTATION OR WARRANTY OTHER THAN AS PROVIDED ABOVE. Hansen's standard warranty services are provided during the hours of 8am to 5pm, Buyer's local time ("Business Hours") during the applicable warranty period. If Buyer desires to purchase services beyond Hansen's standard warranty services or outside of the warranty period, such services are offered under a separate service agreement in accordance with Hansen's standard terms.

4. Indemnification. Hansen shall hold Buyer and its officers, directors, agents and employees harmless from liability resulting from infringement by the Products of any patent or copyright issued as of the date of this Agreement in the country of Product installation, provided Hansen is promptly notified of any and all threats, claims and proceedings related thereto and given reasonable assistance and the opportunity to assume sole control over the defense and all negotiations for a settlement or compromise; Hansen will not be responsible for any settlement it does not approve in writing. The foregoing obligation of Hansen does not apply with respect to Product or portions or components: (i) not supplied by Hansen, (ii) made in whole or in part in accordance to Buyer specifications or requests, (iii) which are modified after shipment, if the alleged infringement relates to such modification, (iv) combined, processed or used with other products, processes or materials where the alleged infringement relates to such combination, process or use, (v) where Buyer continues allegedly infringing activity after being notified thereof or after being informed of modifications that would have avoided the alleged infringement, or (vi) where the infringement is incident to use of the Product but does not result primarily from the Product and its intended application. Buyer will indemnify Hansen and its officers, directors, agents and employees from all damages, settlements, attorneys' fees and expenses: (I) related to a claim of infringement or misappropriation excluded from Hansen's indemnity obligation by the immediately preceding sentence or (II) in connection with Buyer's activities regarding the Products or its failure to effectively pass on Hansen's liability and warranty limitations and disclaimers.

5. Term, Termination, Survival, and Termination Liability. This Agreement shall be effective as of Buyer's execution of a quote governed by these terms and conditions, except that if either party materially breaches any material provision of this Agreement and such breach is not remedied within sixty (60) days (or ten (10) days in the case of non-payment) after receipt by the defaulting party of a notice thereof from the other party,

the non-breaching party may immediately terminate this Agreement. Sections 3 through 9 and 11 shall survive the termination of this Agreement. Any accrued rights of Hansen to payments, remedies for breach, as well as obligations of the parties under Firm Orders shall remain in effect, except that Hansen may in its discretion decide whether to honor (i) portions of Firm Orders with requested delivery dates more than one month after termination, and (ii) in the event of termination by Hansen for Buyer's breach, any Firm Orders. Neither party shall incur any liability whatsoever for any damage, loss or expenses of any kind suffered or incurred by the other (or for any compensation to the other) arising from or incident to any termination of this Agreement by such party which complies with the terms of the Agreement whether or not such party is aware of any such damage, loss or expenses. Expiration is treated the same as termination.

6. Confidentiality and Intellectual Property. All business, technical, financial or other information provided by Hansen to Buyer and designated as confidential or proprietary ("Confidential Information") shall be held in confidence and not disclosed or, except as provided in the next sentence, used by Buyer; this obligation will not apply to information that is generally and freely publicly available through no fault of Buyer, or that Buyer otherwise rightfully obtains from third parties without restriction. Further, Buyer will not remove or obscure any names, designations or notices from any Product.

7. License Rights; Restrictions. Any software incorporated into or provided for use in or with a Product (whether initially, as part of maintenance or support or otherwise) ("Software") is not sold, but rather is licensed on a non-exclusive, non-sublicensable basis, solely for Buyer's internal use in or with that Product strictly in accordance with the documentation and any other use restrictions applicable for that Product. Software shall be deemed Hansen Confidential Information whether or not designated as such. Buyer will not (and will not allow any third party to) modify, reverse engineer (except to the extent applicable law prohibits reverse engineering restrictions), incorporate or use in any other works, create derivatives of, or copy any portion of the Software or Product (except as specifically authorized in documentation provided by Hansen for purposes of installation, support or maintenance), or to use the Software or Product for the benefit of any third party (except patients). If a Product is provided to any unit or agency of the United States Government ("U.S. Government"), the following provisions shall apply: All software and accompanying documentation are deemed to be "commercial computer software" and "commercial computer software documentation," respectively, pursuant to DFAR Section 227.7202 and FAR Section 12.212, as applicable. Any use, modification, reproduction, release, performance, display or disclosure of the software and accompanying documentation by the U.S. Government shall be governed solely by the terms of this Agreement and shall be prohibited except to the extent expressly permitted by the terms herein.

8. Limited Liability. EXCEPT FOR BODILY INJURY, HANSEN WILL NOT BE LIABLE WITH RESPECT TO ANY SUBJECT MATTER OF THIS AGREEMENT UNDER ANY CONTRACT, NEGLIGENCE, STRICT LIABILITY OR OTHER LEGAL OR EQUITABLE THEORY FOR (I) ANY AMOUNTS IN EXCESS IN THE AGGREGATE OF THE AMOUNTS PAID TO HANSEN HEREUNDER DURING THE TWELVE MONTH PERIOD PRIOR TO DATE THE CAUSE OF ACTION AROSE OR (II) ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES, OR (III) COST OF PROCUREMENT OF SUBSTITUTE GOODS, TECHNOLOGY OR SERVICES. HANSEN SHALL HAVE NO LIABILITY FOR ANY FAILURE OR DELAY DUE TO MATTERS BEYOND ITS REASONABLE CONTROL OR FOR ANY ALLOCATION OF PRODUCTS BETWEEN ITS CUSTOMERS IN THE EVENT OF A SHORTAGE.

9. Export Control. Buyer shall comply with all export laws and restrictions and regulations of the Department of Commerce, the United States Department of Treasury Office of Foreign Assets Control ("OFAC"), or other United States or foreign agency or authority, and not export, or allow the export or re-export of any Product in violation of any such restrictions, laws or regulations. Buyer shall obtain and bear all expenses relating to any necessary licenses and/or exemptions with respect to the export from the U.S. of all Products to any location and shall demonstrate to Hansen compliance with all applicable laws and regulations prior to delivery thereof by Hansen.

10. Installation and Training. Subject to Buyer's payment of the applicable fees, Hansen agrees to use reasonable commercial efforts to install the applicable Product at Buyer's site during Business Hours and to provide training at such site in accordance with Hansen's generally applicable policies and practices. If Hansen cannot complete the installation within the requested installation time frame during Business Hours, or if the parties agree to additional training time or consulting work, then Hansen reserves the right to charge Buyer at Hansen's then-current hourly rates (plus expenses) for such services. With respect to the foregoing, Buyer shall, at its expense and in advance of delivery, provide all proper and necessary labor and materials required to prepare the site for such installation. Additionally, the Buyer shall provide free access to the premises of installation and, if necessary, safe and secure space thereon for storage of Products and equipment prior to installation by Hansen. If any special work of any type must be performed in order to comply with requirements of any governmental authority, including procurement of special certificates, permits and approvals, the same shall be performed or procured by Buyer at Buyer's expense. Buyer shall provide a suitable environment for the Products and shall ensure, at its sole cost and expense, that its premises are free of asbestos, hazardous conditions and any concealed dangerous conditions and that all site requirements are met.

11. General. All notices under this Agreement shall be in writing, and shall be deemed given when personally delivered, when sent by confirmed fax, or three days after being sent by prepaid certified or registered U.S. mail to the address of the party to be noticed as set forth herein or such other address as such party last provided to the other by written notice. Buyer shall not have any right or ability to assign, transfer, or sublicense any obligation or benefit under this Agreement and any attempt to do so shall be void, unless authorized in writing by Hansen Medical, Inc. Hansen may assign or subcontract its obligations under this Agreement in whole or in part. The failure of either party to enforce its rights under this Agreement at any time for any period shall not be construed as a waiver of such rights. This Agreement supersedes all proposals, oral or written, all negotiations, conversations, or discussions between or among parties relating to the subject matter of this Agreement and all past dealing or industry custom. No changes or modifications or waivers are to be made to this Agreement unless evidenced in writing and signed for and on behalf of both parties. In the event that any provision of this Agreement shall be determined to be illegal or unenforceable, that provision will be limited or eliminated to the minimum extent necessary so that this Agreement shall otherwise remain in full force and effect and enforceable. This Agreement shall be governed by and construed in accordance with the laws of the State of California (without regard to the conflicts of laws provisions thereof or the UN Convention on the International Sale of Goods). In any action or proceeding to enforce rights under this Agreement, the prevailing party will be entitled to recover costs and attorneys fees.

# APPENDIX II

# STATE OF CONNECTICUT

## Department of Public Health

## 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

May 7, 2008

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

Re: Letter of Intent, Docket Number 08-31144
Yale-New Haven Hospital
Proposal to Replace an Electrophysiology Laboratory
Notice of Letter of Intent

Dear Ms. Ahn,

On April 22, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Yale-New Haven Hospital ("Applicant") to replace an Electrophysiology Laboratory in New Haven, with a capital expenditure of $3,857,448.

A notice to the public regarding OHCA's receipt of a LOI was published in the *New Haven Register* 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

May 7, 2008

Requisition # HCA08-200
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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, May 12, 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 Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

**New Haven Register**
**Docket Number 08-31144**

**Letter of Intent**
**May 7, 2008**

**PLEASE INSERT THE FOLLOWING:**

| | |
|---|---|
| Statute Reference: | 19a-639 |
| Applicant: | Yale-New Haven Hospital |
| Town: | New Haven |
| Docket Number: | 08-31144-LOI |
| Proposal: | Proposal to replace an Electrophysiology Laboratory |
| Capital Expenditure: | $3,857,448 |

The Applicant may file its Certificate of Need application between June 21, 2008 and August 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 ***
**********

TRANSMISSION OK

| | |
|---|---|
| TX/RX NO | 3493 |
| RECIPIENT ADDRESS | 912038658360 |
| DESTINATION ID | |
| ST. TIME | 05/07 08:32 |
| TIME USE | 00'20 |
| PAGES SENT | 2 |
| RESULT | OK |

# STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 7, 2008

Requisition # HCA08-200
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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, May 12, 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 Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

# STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 6, 2008

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

RE: Certificate of Need Application Forms, Docket Number: 08-31144-CON
Yale-New Haven Hospital
Proposal to Replace an Electrophysiology Laboratory

Dear Ms. Ahn:

Enclosed are the application forms for Yale-New Haven Hospital's Certificate of Need ("CON") proposal to Replace an Electrophysiology Laboratory with an associated capital expenditure of $3,857,448. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between June 21, 2008, and August 20, 2008.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The OHCA 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, "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than June 21, 2008, and may be submitted no later than August 20, 2008. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

| | |
|---|---|
| **Docket Number:** | 08-31144-CON |
| **Applicant Name:** | Yale-New Haven Hospital |
| **Contact Person:** | Jean Ahn |
| **Contact Title:** | System Director |
| **Contact Address:** | Yale-New Haven Hospital<br>20 York Street, CB-1007<br>New Haven, CT 06504 |
| **Project Location:** | New Haven |
| **Project Name:** | Proposal to Replace an Electrophysiology Laboratory |
| **Proposal Type:** | Section 19a-639, C.G.S. |
| **Estimated Total Capital Expenditure:** | $3,857,448 |

# HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

# OFFICE OF HEALTH CARE ACCESS

## REQUEST FOR NEW CERTIFICATE OF NEED

## FILING FEE COMPUTATION SCHEDULE

| APPLICANT: _____<br>PROJECT TITLE: _____<br>DATE: _____ | FOR OHCA USE ONLY:<br>DATE INITIAL<br>1. Check logged (Front desk) _____ _____<br>2. Check rec'd (Clerical/Cert.) _____ _____<br>3. Check correct (Superv.) _____ _____<br>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):<br><br>_____ 19a-638.Additional function or service, change of ownership, service termination.<br>**No Fee Required.**<br><br>_____ 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.<br>**Fee Required.**<br><br>_____ 19a-638 and 19a-639.<br>**Fee Required.**<br><br>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.<br><br>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<br><br>4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above <u>OR</u> if both 19a-638 and 19a-639 are checked):<br>a. Base fee: _____<br>b. Additional Fee: (Capital Expenditure Assessment)_____<br>(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)<br>c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____<br>d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B). | $ 1,000.00<br>$_____.00<br><br>$_____.00 |
| **SECTION B TOTAL FEE DUE:** _____ | $_____.00 |

**ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY** (Payable to: Treasurer, State of Connecticut)

## 1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed equipment acquisition 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

Please address the following questions regarding the acquisition of the replacement electrophysiology laboratory:

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

B. Provide the service's primary and secondary service area towns.

C. Provide the rationale for choosing the proposed primary and secondary service area towns.

D. Identify the population being served, including the number of individuals to receive the service. Include demographic information, as appropriate.

E. Provide any service scheduling backlogs in the Hospital's service area.

F. Provide the travel distance from the service area towns to the Hospital.

G. Provide the hours of operation of the existing and proposed replacement laboratories.

H. Please complete the following table to include actual, current fiscal year ("CFY") and projected electrophysiology service volume for the Hospital's existing and proposed electrophysiology labs:

| Number of Procedures | Actual Exam Volume (Last 3 *Completed* FYs) | | | CFY Volume* | Projected Exam Volume (First 3 *Full* Operational FYs)** | | |
|---|---|---|---|---|---|---|---|
| | FY_____ | FY_____ | FY_____ | FY_____ | FY_____ | FY_____ | FY_____ |
| Suite 1 | | | | | | | |
| Suite 2 | | | | | | | |
| Suite 3 | | | | | | | |
| **TOTAL** | | | | | | | |

**Notes:** *Please report the annualized number of procedures, identifying the respective number of months of recorded activity in your response.

**If the first year of operation of the proposed lab is only a partial year, the Hospital must provide the first partial year and then the first three full FYs. **Include all derivations and/ or calculations.**

I. Please provide a table that segregates the number of procedures by the town and zip code of origin for the last completed fiscal year.

J. Provide current operating information as outlined in the following table concerning other existing providers of electrophysiology services in the Hospital's primary service area.

| Service Description [1] | Provider Name & Location | Hours and Days of Operation[2] | Current Utilization[3] |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Notes: [1] Provide a description of the equipment used by the provider, if know.
[2] Specify days of the week and start and end time for each day.
[3] Provide the number of procedures performed by Provider for the most recent 12 month period, if known.

K. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

L. 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.

M. Provide a copy of the needs analysis conducted in relationship to the proposed replacement.

N. Provide copies of any of the following plans, studies or reports related to your proposal:

| | | | |
|---|---|---|---|
| ☐ | Epidemiological studies | ☐ | Market share analysis |
| ☐ | Public information reports | ☐ | Other (Identify) |

☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

## 5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

| | | |
|---|---|---|
| ☐ American College of Cardiology | ☐ National Committee for Quality Assurance | ☐ Public Health Code & Federal Corollary |
| ☐ National Association of Child Bearing Centers | ☐ American College of Obstetricians & Gynecologists | ☐ American College of Surgeons |
| ☐ Report of the Inter-Society Council for Radiation Oncology | ☐ American College of Radiology | ☐ Substance Abuse and Mental Health Services Administration |

☐ Other: Specify _____

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

C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, etc., related to the proposal and a copy of their Curriculum Vitae.

***Note:*** For physicians, please provide a list of hospitals where the physicians have admitting privileges.

D. 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]

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital, its physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, its physicians working at the Hospital and/or any staff related to the proposal.

G. Provide a copy of the following:

☐ A copy of the Quality Assurance plan for electrophysiology services.

☐ A copy of the annual report evaluating the electrophysiology service Quality Assurance plan.

[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.

## 6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

## 7. Miscellaneous

A. Will this proposal result in 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 make 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) Please provide the latest cash equivalent balance as of the date of submission of this application.

iii) Please 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.

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. | |

## 12. 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<br>Source/Entity Name<br>Available Funds | $ _____<br>_____<br>_____ |
| Contributions | $ _____ |
| Funded depreciation | $ _____ |
| Other | $ _____ |

☐ Grant:

| | |
|---|---|
| Amount of grant | $ _____ |
| Funding institution/ entity | _____ |

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

| | |
|---|---|
| Current CHEFA debt | $ _____ |
| CON Proposed debt financing | $ _____ |
| Interest rate | _____ % |
| Monthly payment | $ _____ |
| Term | _____ Years |
| Debt service reserve fund | $ _____ |

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

| | |
|---|---|
| Current CHEFA Leases | $ _____ |
| CON Proposed lease financing | $ _____ |
| Fair market value of leased assets at lease inception | $ _____ |
| Interest rate | _____ % |
| Monthly payment | $ _____ |
| Term | _____ Years |

☐ Other financing alternatives:

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

B. Please provide copies of the following, if applicable:

i. Letter of interest from the lending institution.

ii. Letter of interest from CHEFA.

iii. Amortization schedule (if not level amortization payments).

iv. Lease agreement.

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

A.3. Does the Hospital have Tax Exempt Status? ☐ Yes ☐ No

A.4. Provide a copy of the charity care policy for the Hospital.

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

vi) 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 |