MIDDLESEX
HOSPITAL

ADMINISTRATION

April 22, 2008

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

Dear Commissioner Vogel:

Re: Report 08-31118-DT; Certificate of Need Determination
Middlesex Hospital Suspension of Endoscopy Services at
Shoreline Medical Center in Essex, Connecticut

In response to your letter of March 17, 2008, it has become clear that the gastroenterologists do not intend to provide endoscopy services at the Shoreline Medical Center despite attempts by the Hospital to convince them otherwise.

Therefore, we are submitting the attached Letter of Intent, Form 2030, requesting permanent discontinuance of this service at the Shoreline Medical Center.

If I can answer any questions regarding our decision, please let me know.

Sincerely,

Harry Evert

Harry Evert
Vice President, Operations

HE/rdo
Attachment

28 Crescent Street
Middletown, Connecticut 06457-3650

tel 860 344-6000
fax 860 346-5485

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by 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	Middlesex Hospital	
Doing Business As		
Name of Parent Corporation	Middlesex Health System Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	28 Crescent St. Middletown, CT 06457	
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.	Harry Evert Vice President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	28 Crescent St. Middletown, CT 06457	
Contact Person Telephone Number	(860) 358-6120	
Contact Person Fax Number	(860) 346-5485	

Contact Person e-mail Address	Harry_Evert@midhosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Closure of Shoreline Endoscopy Suite

b. Project Proposal: Close Shoreline Endoscopy Suite

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: _____

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:
Shoreline Medical Center, 260 Westbrook Road, Essex, CT 06426

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

h. Estimated starting date for the project: N/A

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $N/A

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
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	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing.

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☐ Applicant's Equity	☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	
☒ Other *(specify)* *N/A*		

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.

Suite has been available for endoscopy services; however, since the opening of a physician-owned freestanding endoscopy center, physicians have not been using the suite.

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

N/A

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

N/A

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

N/A

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

Middlesex Hospital will continue to have an endoscopy suite at the main hospital.

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

None.

7. Who will be responsible for providing the service?

N/A

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

N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: **Middlesex Hospital**

Project Title: Suspension of Endoscopy Services at the Shoreline Medical Center in Essex, Connecticut

I, **Harry Evert** (Name), **VP, Operations** (Position – CEO or CFO)

of Middlesex Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that **Middlesex Hospital** (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 4/21/08 Date

Subscribed and sworn to before me on April 21, 2008

Melissa M Dorsey
Notary Public/Commissioner of Superior Court

My commission expires: 3-31-09

RECEIVED
2008 APR 25 A 11:32
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 30, 2008

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

Re: Letter of Intent, Docket Number 08-31146
Middlesex Hospital
Termination of Endoscopy Services at Shoreline Medical Center
Notice of Letter of Intent

Dear Mr. Evert:

On April 25, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital ("Applicant") to terminate endoscopy services at Shoreline Medical Center in Essex, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Middletown Press* pursuant to Sections 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 30, 2008

Requisition # HCA08-189
Fax: 347-3380

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

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, May 5, 2008.**

Please provide the following within **30 days of publication:**

- Proof of publication (copy of legal ad acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Laurie Greci or Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:AGF:lmg

c: Sandy Salus, OHCA

The Middletown Press **Letter of Intent**
Docket Number 08-31146 **April 30, 2008**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Middlesex Hospital
Town:	Essex
Docket Number:	08-31146-LOI
Proposal:	Termination of endoscopy services at Shoreline Medical Center
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between June 24, 2008 and August 23, 2008. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3469
RECIPIENT ADDRESS	93473380
DESTINATION ID	
ST. TIME	04/30 12:12
TIME USE	00'38
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

JOURNAL REGISTER COMPANY **PROOF**

Account No: 337940

Ad Number: 2096972

Customer: OFFICE OF HEALTH CARE Contact: KIM MARTONE Phone: 8604187001

Price: 64.03

Size: 1 X 47.00

Class: 1200; LEGALS

Ordered: 2 Times

Notes:

Printed By: CSPENCER 04/30/2008

Dates: 05/01/2008 05/01/2008

Signature of Approval: Date:

Fax

347.3380

LEGAL NOTICE

Statute Reference:
19a-638
Applicant:
Middlesex Hospital
Town:
Essex
Docket Number:
08-31146-LOI
Proposal:
Termination of endoscopy services at Shoreline Medical Center
Capital Expenditure:
$0

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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.

418-7053

Kim -
Thank you
Sam

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 6, 2008

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

RE: Certificate of Need Application Forms, Docket Number 08-31146-CON
Middlesex Hospital
Termination of Endoscopy Services at Shoreline Medical Center

Dear Mr. Evert:

Enclosed are the application forms for Middlesex Hospital's Certificate of Need ("CON") proposal for the termination of endoscopy services at Shoreline Medical Center with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between June 24, 2008, and August 23, 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.**

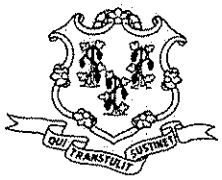
- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding 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 analysts assigned to the CON application are Laurie Greci and Alexis Fedorjaczenko. Please contact /them at (860) 418-7001 if you have 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 24, 2008, and may be submitted no later than August 23, 2008. The Analysts assigned to your application are Laurie Greci and Alexis Fedorjaczenko. They may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31146-CON

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

Project Location: Essex

Project Name: Termination of Endoscopy Services at Shoreline Medical Center

Type proposal: Section 19a-638
Est. Capital Expenditure: $ 0

1. Existing Services

What services are currently offered at the Shoreline Medical Center? Specify which service(s) the Hospital is proposing to terminate at the Shoreline Medical Center.

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Regarding the service termination at the Center, please answer the following:

i) Explain the rationale for this service termination. Identify the process undertaken by the Hospital in making this decision.

ii) Did the Hospital determine there was no or insufficient public need for the continuation of this program? Please explain.

iii) Is the Hospital being reimbursed by payers for these services? If so, did reimbursement levels enter into the determination to terminate?

iv) Did the termination require the vote of the Board of Directors of the Hospital? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed, motion made and carried.

B. Please address the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups, etc.) that were provided at the Shoreline Medical Center ("Center). Identify the hours these services were provided at the Center.

ii) List the service area towns and provide a rationale for choosing the selected towns.

iii) Provide the units of service (i.e. number of procedures) performed at the Center as well as any other Hospital location currently providing

endoscopy procedures for the past three fiscal or calendar years by patient town of origin.

iv) Discuss any scheduling backlogs that existed at the Center.

v) Were there any waiting lists in place at the Center? If so, identify the typical number of patients on the waiting list.

vi) Describe the pattern of referrals that existed with regard to the center's operation.

vii) Provide the following information regarding the impact of the Center's service termination on the patient and provider community. Explain the procedures that the Hospital will take in terminating these services and explain how the Hospital has been able to provide services to those patients that requested the service.

viii) Provide the information as outlined in the following table concerning the existing providers in the service area of the service to be terminated:

Provider Name Street Address Town and Zip Code	**Number of Operating Rooms**				**Estimated Capacity for Proposal**		**Current Utilization[7]**
	Available[1]	**Utilized[2]**	**Not Utilized[3]**	**Equipped for Proposal[4]**	**Minimum[5]**	**Maximum[6]**	
				Total			

[1] Include used, equipped, and shell space.

[2] Include those actually used to perform the proposal's procedures. .

[3] Include those not used and those that are equipped or are only shell space.

[4] Include those rooms that are uniquely equipped to perform the type of procedures included in the proposal.

[5] Minimum number of procedures to be performed in a single operating room for one year. Provide an explanation of the criteria or basis used to estimate the number.

[6] Maximum number of procedures of the type included in the proposal that can optimally be performed in a single operating room(s) in one year. Provide an explanation of the criteria or basis used to estimate the number.

[7] Report the most current 12 month period.

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

- ☐ Epidemiological studies
- ☐ Public information reports
- ☐ Needs assessments
- ☐ Market share analysis
- ☐ Other (Identify)
- ☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

5. Quality Measures

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

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

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

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
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No If you checked "Yes," please provide an explanation.

---

[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.

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 and Revenue, Expense and Volume Projections

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

☐ Corporation (Inc.)
☐ Partnership
☐ Joint Venture
☐ Other (Specify):
☐ Limited Liability Company (LLC)
☐ Professional Corporation (PC)

B. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Hospital and for the Shoreline Medical Center separately based on Gross Patient Revenue and in the following reporting format:

	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

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

i) A summary of revenue, expenses, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **See attached Financial Attachment II.**

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). 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.

8. C (i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

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

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

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

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

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____