71 Haynes Street
Manchester, CT 06040

Phone (860) 533-3414

ECHN

Eastern Connecticut Health Network, Inc.

June 5, 2008

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

Dear Commissioner Vogel:

Re: Letter of Intent
Expansion of Wound Care Services to Include Hyperbaric Oxygen Therapy

Please find enclosed an original and five copies the Letter of Intent for the proposed expansion of the Wound Care program at Manchester Memorial Hospital. We are seeking approval to purchase two hyperbaric oxygen therapy chambers to enhance our existing program and improve patient access to effective treatments for patients with difficult to heal wounds.

If you have any questions regarding this Letter of Intent, please do not hesitate to call me at (860) 533-3429. Please forward all applicable application materials to me for completion. Thank you.

Sincerely,

Dennis P. McConville
Senior Vice President, Strategic and Operational Planning

Enc.

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One
Full Legal Name	Manchester Memorial Hospital
Doing Business As	Manchester Memorial Hospital
Name of Parent Corporation	Eastern Connecticut Health Network, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP
Does the Applicant have Tax Exempt Status?	(Yes) No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Dennis McConville Senior Vice President, Strategic and Operational Planning
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040
Contact Person's Telephone Number	(860) 533-3529
Contact Person's Fax Number	(860) 647-6860
Contact Person's e-mail Address	dmcconvill@echn.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Expansion of ECHN wound care services to include hyperbaric oxygen therapy

b. Project Proposal: Eastern Connecticut Health Network (ECHN) plans to expand the existing wound care program at Manchester Memorial Hospital (MMH) to include hyperbaric oxygen therapy.

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)* Wound Care (hyperbaric oxygen therapy)**

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:

71 Haynes Street, Manchester, Connecticut 06040

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

Response:

The total service area of Manchester Memorial Hospital and ECHN is comprised of the following towns:

Primary Service Area	Secondary Service Area
Andover	Columbia
Ashford	East Hartford
Bolton	Glastonbury
Coventry	Hebron
East Windsor	Mansfield
Ellington	Somers
Manchester	Stafford
South Windsor	Union
Tolland	
Vernon	
Willington	

These are the towns this project is intended to serve.

h. Estimated starting date for the project: **Immediately, upon CON approval. Planned date to begin treating patients with Hyperbaric Oxygen Therapy is November 1, 2008.**

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

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

Response:

Not applicable – The proposal to expand wound care services to include hyperbaric oxygen therapy at Manchester Memorial Hospital does not involve any change in the number of inpatient beds provided at the facility.

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$ 410,000**

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

Major Medical Equipment Purchases*	$ 185,000
Medical Equipment Purchases*	$ 5,000
Non-Medical Equipment Purchases*	$ 2,500
Land/Building Purchases	-
Construction/Renovation	$ 200,000
Other (Non-Construction) Specify: Design costs	$ 17,500
Total Capital Expenditure	**$ 410,000**
Major Medical Equipment – Fair Market Value of Leases Medical	-
Equipment – Fair Market Value of Leases	-
Non-Medical Equipment – Fair Market Value of Leases*	-
Fair Market Value of Space – Capital Leases Only	-
Total Capital Cost	**-**
Total Project Cost	**$ 410,000**
Capitalized Financing Costs (Informational Purpose Only)	$ 43,046

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

Response:

It is anticipated that the following items will be purchased to implement the proposed service:

Major Medical Equipment	Medical Equipment	Non-Medical Equipment
- 2 Hyperbaric Chambers	- Treatment Chair - O_2 Testing Device	- General office equipment - Miscellaneous office supplies

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 ☒ **Not Applicable**

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
Hyperbaric Oxygen Chamber	Perry	Sigma 34 Monoplace	2	$88,000

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

Response:

A copy of the quotation for the Sigma 34 Monoplace Hyperbaric Oxygen Chambers has been included as **Attachment 1**.

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

To be completed by each Applicant

Applicant: Manchester Memorial Hospital and Eastern Connecticut Health Network (ECHN)

Project Title: Expansion of ECHN wound care services to include hyperbaric oxygen therapy

I, Peter J. Karl (Name) President and CEO (Position – CEO or CFO)

of Eastern Connecticut Health Network (Organization Name) 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 Manchester Memorial 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.

RECEIVED
2008 JUN 11 A 11:07
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Peter J Karl
Signature

6-6-08
Date

Subscribed and sworn to before me on June 6, 2008

Carol Freeman
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 4-30-2009

Response to Section IV Project Description:

Eastern Connecticut Health Network (ECHN) currently provides wound care services in their Wound Care Center (Center) located on the ground floor of Manchester Memorial Hospital (MMH). The present program treats patients two to three times per week, and offers dressing changes and topical ointment applications. Treatment in the Center is provided by registered nurses.

ECHN is proposing to expand the Wound Care program to operate five days per week and will be moving to a more comprehensive, physician-based program able to offer surgical debridement and hyperbaric oxygen therapy, in addition to the services currently provided by the existing program. Most hospitals that offer an organized wound care program have moved to this comprehensive physician model, making it the standard of care for treating patients with difficult to heal wounds. Under the physician-based model, patients have experienced better outcomes and improved healing. Utilization of hyperbaric oxygen therapy is now also considered the standard in treating this patient population as adherence to the recommended regime also improves patient outcomes.

Patients served by the existing program originate from the service area towns noted in Section II above. Individuals requiring treatment in the Wound Program are predominantly diabetic patients and patients with difficult to heal wounds, either secondary to diabetes or to some other condition. Hyperbaric oxygen therapy will be judiciously provided to a subset of these patients with difficult to heal wounds.

Under the current model, MMH is unable to provide the surgical debridement and oxygen therapy that facilitates the healing of wounds, speeds recovery time and improves patient outcomes. With the services the Center is presently able to provide, patients often wait several weeks for treatment. There are no other comprehensive providers of wound care services in the proposed service area. The closest facilities that offer this service are in Hartford (Hartford Hospital) and New London (Lawrence and Memorial). Successful outcomes for the treatment of difficult to heal wounds are dependent on adherence to the defined treatment schedule. Expansion of the program at MMH will significantly improve patient accessibility to comprehensive wound care services and better enable patients to comply with the recommended treatment regime. The improved outcomes experienced by patients better able to access these services and comply with their treatment will have an overall positive impact on the health care delivery system of the State.

As is currently the case, MMH will be responsible for providing this service to their patients.

The primary payer of this service as currently provided at MMH is Medicare (nearly 70%). ECHN does not anticipate a change in payer mix as a result of this proposal.

PERRY BAROMEDICAL CORPORATION
3660 Interstate Parkway
Riviera Beach, FL 33404

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

ATTACHMENT 1

PERRY SIGMA 34 MONOPLACE QUOTATION

Prepared For: **National Healing Corporation**
6400 Congress Ave, Suite 2200
Boca Raton, FL 33487

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
Attn: Phillip Candito, Director of Business Development
Planning Department
860-533-2970
pcandito@echn.org

***** Please note that prices quoted are only valid if the Hospital is contracted with National Healing Corporation for program management.**

Quotation Date:	2/20/2008
Quotation Num:	S34-1928
Quotation Valid:	1 year
Prepared By:	AHD

PART NO.	SIGMA 34 MONOPLACE HYPERBARIC CHAMBER	Qty	List Price	Total Price
D-903160	**Sigma 34 Monoplace Hyperbaric Chamber**	2	$129,900.00	$259,800.00
	LESS 32.256% PREFERRED CUSTOMER DISCOUNT		$41,900.00	$83,800.00
			$88,000.00	$176,000.00
	The Sigma 34 has a larger 34" diameter clear acrylic cylinder. This larger diameter allows the patient's upper torso to be elevated up to 25 degrees for added comfort and for increased compliance.			
	(In accordance with Technical/Building Service Specs TECH-34-902703,Rev E)			
	Each Chamber Includes:			
D-902537	Wide Hydraulic Adjustable-Height Patient Transfer Gurney with Stretcher and Mattress Hydraulic height-adjustment makes patient transfer easier. Wide mattress cushion is extra thick for maximum comfort. Includes handrail assembly.	2	Included	Included
	(Right Hand Door Configuration is Standard. Alternate Configuration Available If Specified on Purchase Order)			

PART NO.	ACCESSORIES FOR PERRY SIGMA 34	Qty	List Price	Total Price
B-902679	Perry IV Penetrator and Plug Assembly Provides the through-hull interface for intravenous drug/fluid delivery.	2	$175.00	Included
D-902637	Assembly Patient Monitoring Cabling Allows connection of electrical monitoring cables between the patient and an external monitor. The penetrator comes complete with a set of mating end-connectors which can be adapted for use with various brands of monitors.		$1,946.34	
F `981	Perry Patient Air Break Mask Assembly Provides the means to supply Medical Air to the patient for short-term air breathing. Includes demand valve, penetrator fittings, internal & external hose, and two disposable masks.	2	$898.00	Included
C-3400	Chamber cover	2	$300.00	Included

PERRY BAROMEDICAL CORPORATION
3660 Interstate Parkway
Riviera Beach, FL 33404

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

QUOTATION NO. S34-1928

B-903475	Sigma 34 Tool Kit Includes Tool Box (1); ohmmeter and extension with small clamps (1); screwdriver 4 in 1 Allen key set (small) (1); Adjustable wrench 6", adjustable wrench 12" (1 wrench each); brass brush (1); lip seal (1) B-902488		$354.16	
B-903096	Wedge Cushion		$295.92	
B-901433	Cable Assembly and penetrator for Transcutaneous Monitor Provides the connection path from tcpO2 monitor to chamber and chamber to patient monitoring cable. The penetrator is specially constructed to accept the standard monitor extension cables.	2	$1,797.18	Included
D-902537	Add'l Hydraulic Transfer Gurney With Stretcher and Mattress		$9,400.00	
	Patient Entertainment System			
D-903529	20"LCD Flat Panel Video w/ DVD Player Tie Rod universal mounting bracket and all cables/ adapters with installation instructions		$3,200.00	
i /136	Air/O2 Select Manifold Enables user to quickly, easily switch the chamber pressurization gas supply between air and oxygen.		$3,042.82	
B-902704	BIBS (Built-in Breathing System) Allows the user to pressurize the chamber with air and deliver oxygen or air through a head tent or mask system.		$6,830.00	

PART NO.	OPTIONAL ITEMS FOR PATIENT CARE	Qty	List Price	Total Price
P-10046A	Hyperbaric Ventilator		$13,800.00	
B-902888	Ventilator Bracket Assembly		$92.00	

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3660 Interstate Parkway
Riviera Beach, FL 33404

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

QUOTATION NO. S34-1928

INSTALLATION AND TRAINING	Qty	List Price	Total Price
System Installation and Start-up Including: Operator and Maintenance Training One Operation and Maintenance Manual All Required Installation Fittings and Equipment (Final installation pricing may vary in accordance with system location)			$3,800.00

Based on ground floor location and adequate and unrestricted pathway from dock to room location.

The SIGMA 34 is designed, manufactured, tested and installed in accordance with the current regulations of the FDA, ASME PVHO-1, and NFPA. The customer is responsible for meeting local and state regulations regarding the installation and operation of the system.

Customer is responsible for ensuring the facility meets Technical / Building Services Specification TECH-34-902703, Revision E

FREIGHT AND DELIVERY	Qty	List Price	Total Price
Delivery FOB Riviera Beach, Florida Delivery charges to be paid by customer Allow 2-3 Months For Delivery After Receipt Of Purchase Order			$3,500.00

(Final freight and delivery pricing may vary in accordance with system location)

WARRANTY

One Year Warranty Is Standard
Limited Parts and Labor

PAYMENT TERMS

30% Down Payment Due With Purchase Order
60% Due 30 Days After Date Of P.O. Or Prior to Delivery (whichever comes first)
10% Due Upon Installation

Perry and Eastern Connecticut Health Network agree that the title in any hyperbaric medical equipment ordered and shipped pursuant to this agreement will remain with Perry until the entire purchase price for equipment has been received by Perry.

(Buyer shall pay all sales and use taxes attributable to the sale)

TOTAL	**$183,300.00**

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 23, 2008

Dennis McConville
Vice President, Strategic and Operational Planning
Manchester Memorial Hospital
71 Haynes Street
Manchester, CT 06040

Re: Letter of Intent, Docket Number 08-31185
Manchester Memorial Hospital
Expansion of its Existing Wound Care Services to include Hyperbaric Oxygen Therapy
Notice of Letter of Intent

Dear Mr. McConville:

On June 11, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Manchester Memorial Hospital ("Applicant") for the expansion of its existing Wound Care Services to include Hyperbaric Oxygen Therapy in Manchester, with a capital expenditure of $410,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* pursuant to Section 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

June 23, 2008

Requisition # HCA08-226
Email: Legals@JournalInquirer.com

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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 **Saturday, June 28, 2008.**

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

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

If there are any questions regarding this legal notice, please contact Diane Duran or Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:DD:PF:lmg

c: Sandy Salus, OHCA

Journal Inquirer
Docket Number 08-31185

Letter of Intent
June 23, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Manchester Memorial Hospital
Town:	Manchester
Docket Number:	08-31185-LOI
Proposal:	Expansion of its existing Wound Care Services to include Hyperbaric Oxygen Therapy
Capital Expenditure:	$410,000

The Applicant may file its Certificate of Need application between August 10, 2008 and October 9, 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.

Greer, Leslie

From: Treiss, Carolyn
Sent: Wednesday, June 25, 2008 1:30 PM
To: Greer, Leslie; Martone, Kim
Cc: Durdy, Barbara
Subject: RE: Approval of Newspaper Notice

Leslie,
You may send out the notice for LOI-31185 as well.
Carolyn

Carolyn M. Treiss, JD, MSW
Chief of Staff

Office of Health Care Access
State of Connecticut
410 Capitol Avenue
3rd Floor, MS # 13HCA
Hartford, CT 06134-0308
(860) 418-7024

From: Greer, Leslie
Sent: Wednesday, June 25, 2008 1:25 PM
To: Treiss, Carolyn
Subject: FW: Approval of Newspaper Notice

From: Duran, Diane
Sent: Wednesday, June 25, 2008 12:02 PM
To: Martone, Kim; Greer, Leslie
Cc: Fiducia, Paolo
Subject: RE: Approval of Newspaper Notice

The LOI for DN: 08-31185 was received by OHCA on June 11, 2008.

Diane Duran

From: Huber, Jack
Sent: Wednesday, June 25, 2008 11:51 AM
To: Martone, Kim; Greer, Leslie
Cc: Duran, Diane
Subject: FW: Approval of Newspaper Notice

Dear All - the LOI for DN: 08-31187 was received by OHCA on June 13, 2008. Jack

---

From: Martone, Kim

Sent: Wednesday, June 25, 2008 11:42 AM
To: Fiducia, Paolo; Duran, Diane; Huber, Jack
Subject: FW: Approval of Newspaper Notice

From: Greer, Leslie
Sent: Wednesday, June 25, 2008 8:59 AM
To: Martone, Kim
Subject: FW: Approval of Newspaper Notice

Kim,
Can you please let me know the time frame on these LOI's?

From: Treiss, Carolyn
Sent: Tuesday, June 24, 2008 4:50 PM
To: Greer, Leslie
Subject: RE: Approval of Newspaper Notice

Leslie,
Sorry but another question – can you tell me when these came into the agency and when the deadline for getting it published is? Then I can decide if they can wait until after 7/1.
Thanks.
Carolyn

Carolyn M. Treiss, JD, MSW
Chief of Staff

Office of Health Care Access
State of Connecticut
410 Capitol Avenue
3rd Floor, MS # 13HCA
Hartford, CT 06134-0308
(860) 418-7024

From: Greer, Leslie
Sent: Tuesday, June 24, 2008 12:10 PM
To: Treiss, Carolyn
Subject: Approval of Newspaper Notice

Carolyn,
I have the following newspaper notices that require your approval:

Docket	Newspaper	Analyst
08-31185-LOI	Journal Inquirer	Paolo/Diane
08-31187-LOI	New Haven Register	Diane/Jack

Please let me know if you require further information.

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: legals@journalinquirer.com
Sent: Thursday, June 26, 2008 12:25 PM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31185 Revised

Good Morning Leslie,

Your legal is set for the 28th and the cost is $133.79.

Thanks and have a good day
Sandy
Classified Dept.

---- Original Message ----
From: Leslie.Greer@ct.gov
To: legals@JournalInquirer.com
Subject: Legal Ad 08-31185 Revised
Date: Wed, 25 Jun 2008 14:44:29 -0400

>Legal Ad,
>
Attached is a revised public notice that was emailed on 6/25/08.
>Please
>feel free to contact me if you have any questions.
>
>
>
>Leslie M. Greer
>
>Office of Health Care Access
>
>State of Connecticut
>
>410 Capitol Avenue
>
>Hartford, CT 06134
>
>Phone: (860) 418-7001
>
>Fax: (860) 418-7053
>
>Website: www.ct.gov/ohca <http://www.ct.gov/ohca>
>

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 23, 2008

Dennis McConville
Manchester Memorial Hospital
Senior VP, Strategic and Operational Planning
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application Forms, Docket Number 08-31185-CON
Manchester Memorial Hospital
Expansion of its existing Wound Care Services to include Hyberbaric Oxygen Therapy Services

Dear Mr. McConville:

Enclosed are the application forms for Manchester Memorial Hospital's Certificate of Need ("CON") proposal for the expansion of its existing Wound Care Services to include Hyberbaric Oxygen Therapy Services with an associated capital expenditure of $410,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 10, 2008, and October 9, 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, prefiled 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 analyst assigned to the CON application is Diane Duran. Please contact her at (860) 418-7001 if you have questions.

Sincerely,

Kim Martone

Kimberly Martone
Certificate of Need Supervisor

Enclosures

KM:dd

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 August 10, 2008 and may be submitted no later than October 9, 2008. The Analyst assigned to your application is Diane Duran, who may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	08-31185-CON
Applicant(s) Name:	Manchester Memorial Hospital
Contact Person:	Dennis McConville
Contact Title:	Senior VP, Strategic and Operational Planning
Contact Address:	71 Haynes Street Manchester, CT 06040
Project Location:	Manchester
Project Name:	Expansion of its existing Wound Care Services to include Hyberbaric Oxygen Therapy Services
Type of proposal:	Sections 19a-638 C.G.S.
Est. Capital Expenditure:	$410,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

A. Explain in detail how Manchester Memorial Hospital determined need for this proposal and in your service area.

B. Explain in detail how it was determined there was a need for the number of chambers and the treatment capacity.

C. Provide copies of needs assessments and market share analyses performed to support the need for the proposal. If there are none, explain why no such assessments or analyses were undertaken by the Applicant.

D. Please chart and describe the various steps involved in proposed integration.

E. Provide the following information:

i) List the service area towns for the proposed service. Provide a rationale for choosing the selected towns.

ii) The units of service for the past three fiscal years and the current fiscal year-to-date for the wound care program.

iii) Describe the population to be served, including the number of diabetic individuals to receive the proposed service as in the following table. Include demographic information as appropriate.

Population with Diabetes	

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

A. Explain in detail how Manchester Memorial Hospital determined need for this proposal and in your service area.

B. Explain in detail how it was determined there was a need for the number of chambers and the treatment capacity.

C. Provide copies of needs assessments and market share analyses performed to support the need for the proposal. If there are none, explain why no such assessments or analyses were undertaken by the Applicants.

D. Please chart and describe the various steps involved in proposed integration.

E. Provide the following information:

i) List the service area towns for the proposed service. Provide a rationale for choosing the selected towns.

ii) The units of service for the past three fiscal years and the current fiscal year-to-date for the wound care program.

iii) Describe the population to be served, including the number of diabetic individuals to receive the proposed service as in the following table. Include demographic information as appropriate.

Population with Diabetes	

Diabetic Population with Chronic Wounds	
Diabetic Population requiring HBOT	

iv) Scheduling backlogs in service area.
v) Travel distance from the proposed site to service area towns.
vi) Hours of operation of existing and the proposed service.

F. Provide the units of service projected for the first three years of operation of the proposed service. **Include all assumptions used in the derivation/calculation of your projections.**

G. Provide the information as outlined in the following table concerning the existing providers' in the Applicant's service area:

Name and Location of Provider	**Similar Services Provided? (Y/N)**	**Affiliated Physicians**

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

I. 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.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

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

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-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society 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, 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.

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 a copy of the related Quality Assurance plan.

F. Provide a copy of the following (as applicable):

☐ Protocols for service (new service only)
☐ Patient Selection Criteria/Intake form

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 new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

[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.

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

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

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction/Renovation 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 information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

D. 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			

E. Explain how the proposed new construction or renovations will affect the delivery of patient care.

11. Capital Equipment Lease/ Purchase

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

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

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

12. Type of Financing

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

☐ Applicant's equity:

Source and amount:

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

☐ Grant:

Amount of grant	$_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ 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. Amortization schedule (if not level amortization payments),
   iii. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current and the payer mix for the **proposed service only, based on Gross Patient Revenue** in the following reporting format:

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

B. Do the Applicants have Tax Exempt Status? ☐ Yes ☐ No

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

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

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Please complete CON 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.