NORWALK HOSPITAL

FACSIMILE TRANSMITTAL SHEET

TO: HONORABLE CRISTINE A. VOGEL

FROM: GEOFF COLE

DATE: 07-11-08

FAX NUMBER: 860-418-7053

TOTAL NO. OF PAGES INCLUDING COVER: 11

PHONE NUMBER:

SENDER'S REFERENCE NUMBER:

RE: NORWALK HOSPITAL FACILITY MASTER PLAN

YOUR REFERENCE NUMBER:

☐ URGENT X FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

Notes/Comments:

DEAR COMMISSIONER VOGEL

PLS. FIND ATTACHED LETTER FROM GEOFF COLE, ALONG WITH LOI REGARDING NH FACILITY MASTER PLAN.

PLS. FEEL FREE TO CONTACT EITHER MYSELF OR GEOFF IF YOU HAVE ANY QUESTIONS.

THANK YOU.

GAYLE McGRATH
ASSISTANT TO GEOFF COLE
203-852-2482

34 MAPLE STREET
NORWALK, CT 06850
203-852-2211
FAX: 852-1553

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	Norwalk Hospital Association	
Doing Business As	Norwalk Hospital	
Name of Parent Corporation	Norwalk Health Services Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	34 Maple Street Norwalk, CT 06856	
Identify Applicant Status: P for Profit or NP for Nonprofit	Non-profit	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Lisa Brady VP, Planning and Business Development	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	34 Maple Street Norwalk, CT 06856	

Contact Person Telephone Number	203-852-3402	
Contact Person Fax Number	203-852-1553	
Contact Person e-mail Address	John.Pierro@norwalkhealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

- Project Title: Norwalk Hospital Master Facility Plan
- Project Proposal:

  Norwalk Hospital proposes to renovate and restructure its main campus by demolishing several old buildings, modernizing the Main Pavilion, which houses the majority of inpatient beds, to bring it up to building code standards and consolidating outpatient services in a new outpatient pavilion.

- 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)* undertake renovations to inpatient units

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)* consolidate outpatient services in a new outpatient pavilion

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cine-angiography 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: _____

- 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

- 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:

34 Maple Street, Norwalk, CT 06856

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

This project is intended to serve Norwalk Hospital's historical primary service area. This is defined as the towns of Norwalk, New Canaan, Weston, Westport and Wilton.

h. Estimated starting date for the project: Summer/Fall 2009

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
N/A				

This is not applicable because this project does not involve any change in the number of staffed or licensed beds.

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $150,000,000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$ 12,523,437
Non-Medical Equipment Purchases*	$ 10,054,263
Land/Building Purchases	
Construction/Renovation	$117,318,912
Other (Non-Construction) Specify: Relocation Lease	
Total Capital Expenditure	$139,896,612
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	$139,896,612
Total Project Cost	$149,966,612
Capitalized Financing Costs (Informational Purpose Only)	$9,500,000

* 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.
Not applicable. The project does not include any major medical/imaging equipment.

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

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

SECTION IV. PROJECT DESCRIPTION

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

Please see Project Summary which is included as Attachment 1.

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.

   Norwalk Hospital is an acute care general hospital that offers a full range of medical and surgical services. The specific patient services that are impacted by the proposal are inpatient services, ambulatory surgery and gastroenterology procedures, cardiac and vascular services, wound care, oncology, adult and pediatric clinics, women's center, physical therapy, occupational therapy, audiology, and sleep laboratory.

   Please see attached DPH license which is included as Attachment 2.

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

   Norwalk Hospital is not seeking any change in license as part of this project. All of the services that are impacted are currently provided by Norwalk Hospital. Please see Attachment 1.

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

   Norwalk Hospital will continue to serve the population in its primary service area.

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

   This proposal is designed to improve delivery of both inpatient and outpatient clinical services by renovating the aging infrastructure of our campus, and centralizing these services to best serve our patients. It includes a consolidation of outpatient services into a new building, which will create effective and efficient delivery of services and improve access for our patients.

Another important component of this proposal is to consolidate inpatient services in the Main Pavilion and provide for medical provider conference areas for patients and families. This is consistent with the Hospital's focus on patient centered care. Physical plant deficiencies in the Main Pavilion will be corrected by updating the electrical and plumbing systems to bring them into compliance with current standards and by constructing new storage areas so that equipment will no longer be stored on the floors.
Please see Attachment 1.

Finally, the project will also include the expansion of the garage by incrementally adding 100-200 spaces to resolve the parking constraints that exist at the Hospital.

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

   Norwalk Hospital is the only acute care general hospital in the proposed geographic area.

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

   The proposal will enhance the quality of health care delivery in the region by renovating the Main Pavilion, bringing the Main Pavilion into compliance with the latest building code, and by consolidating outpatient services into an easily accessible Outpatient Pavilion. These renovations and consolidations of service will improve the overall quality, accessibility and efficiency of health care delivery. Please see Attachment 1.

7. Who will be responsible for providing the service?

   The Norwalk Hospital currently provides these services and will continue to do so. Please see Attachment 1.

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

   The current payers mix for Norwalk Hospital based on net revenue is: Medicare – 40%, Medicaid – 5%, Medical Assistance – 1%, non-government – 53% and uninsured – 1%. The payer mix is not anticipated to change when the proposed project becomes operational.

Attachment 1: Project Summary

Norwalk Hospital (NH) is an acute care general hospital that offers a full range of medical and surgical services. The Hospital is licensed for 328 beds and 38 bassinets. The majority of the inpatient beds are located in the Main Pavilion. The 7 available pediatric beds and 18 available psychiatric beds are located in the Community Pavilion. Norwalk Hospital also offers a full range of outpatient services including ambulatory surgery and gastroenterology procedures, cardiac and vascular services, wound care, oncology, adult and pediatric clinics, women's center, physical therapy, occupational therapy, audiology, and sleep laboratory. These services are dispersed throughout the Hospital's campus. This project is known as the Master Facility Plan ("MFP") and is the result of eight years of planning activity by the Hospital and its Board. The project is projected to take 3 years to complete and is designed to address the issues that are related to the hospital's commitment to patient-centered care, delivered through demonstrated best practice. The plan provides a detailed inventory and assessment of current and future space requirements for the Hospital. The plan was developed by Cannon Design of Boston, Massachusetts.

This project summary is divided into the following sections: Overview of Physical Plant, Outpatient Services and Inpatient Services. It is projected that both outpatient and inpatient sections of the MFP will be implemented concurrently.

Overview of the Physical Environment

The existing Norwalk Hospital campus is contained within six primary buildings ranging in age and floor plate configuration. Major building projects began in 1918 and continued through 1992, with ongoing renovations. The Hospital's physical plant is approximately 50 years old on average and is the oldest in southwestern Connecticut. The existing physical plant has significant infrastructure components nearing the end of their useful life. The physical plant is not compliant with current building code requirements and is in need of updates to the electrical and plumbing systems. Lack of storage space for equipment is also an issue that has been identified by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

Our plan is around the sequenced decommissioning/ demolition of the Community, Tracey and Bedford Pavilions, creation of a new ambulatory building and the upgrade of the Main Pavilion. This recommendation is based on the analysis and realization of the inefficient floor plate configurations, restrictive structural grid, inefficient building maintenance costs and continual aging engineering infrastructure. The modernization costs for these respective buildings have been estimated to be $60 million alone and would not allow for centralization of services or improved access.

Outpatient Services

The majority of outpatient services provided by the Hospital will be consolidated into the newly constructed Outpatient Pavilion. The Outpatient Pavilion will contain approximately 100,000 – 125,000 square feet. The outpatient services are currently located in several locations throughout the Hospital's campus which results in patient access issues and inefficiencies in the delivery of care. In addition, several clinical services such as ambulatory surgery and gastroenterology procedures and oncology have experienced growth over the past few years and do not have the physical space to meet this growth in demand for services.

Currently, inpatient surgery and ambulatory surgery utilize the same operating suite. In FY 2007, 7,200 of the approximately 10,800 surgical procedures performed at the Hospital were done as ambulatory procedures. The project would result in the development of a dedicated ambulatory surgery center located in the Outpatient Pavilion. The ambulatory surgery suite would consist of 8 rooms with shell space for 4 additional rooms that would come on line as needed. The existing 10 room inpatient surgical suite would be reduced to an 8 room suite, with 2 rooms taken off line. The establishment of dedicated operating rooms will result in better outcomes and a better utilization of the operating rooms. The Hospital has also experienced a significant growth in the number of gastroenterology procedures that are performed, and the creation of a gastroenterology procedures suite in the Outpatient Pavilion will allow the Hospital to accommodate these additional procedures. In FY 2007, 10,400 gastroenterology procedures were performed in the NH gastroenterology lab, which is designed to support a maximum of 8,000 procedures.

The current oncology program is experiencing space constraints, and this project will allow the components of the program to be located at one site in the new outpatient pavilion. In addition, the Hospital is proposing to construct a vault in anticipation of future replacement of the linear accelerator.

The Hospital has recently received authorization from OHCA for a 128 slice CT scanner (DN: 07-30942) and 1:5 Tesla MRI, and is not requesting any additional imaging equipment as part of this CON application. It should be noted that the imaging equipment is located adjacent to the proposed Outpatient Pavilion, and will not require extensive relocation as part of this proposed MFP.

Other outpatient programs such as the women's clinic, children's clinic and sleep laboratory will be relocated to the Outpatient Pavilion. Ancillary services such as a spa and wellness center will also be located in the building. These ancillary services are part of the Hospital's focus on patient centered care.

The outpatient plans include the renovation and expansion of Emergency Department services. This renovation will solve the issues of inadequately sized rooms, physical plant concerns and create space for an urgent care program.

Finally, a parking garage containing 100-200 spaces will be constructed to address accessibility concerns. The construction of the new Outpatient Pavilion and garage will require the demolition of the Community Pavilion, Tracey Pavilion and Bedford Pavilion.

Inpatient Services

All inpatient beds will be consolidated into the Main Pavilion through the relocation of existing pediatric and psychiatric units from the Community Pavilion. In keeping with its patient centered care focus, the Hospital is proposing to renovate the inpatient care area including the interior wall covering and trims and the building exterior. Space will be made available on the floors for family members to stay with the patient. Meeting space for patient and family consultation with physicians will also be developed.

The existing Inpatient Tower is approximately 33 years old. There are several infrastructure issues that will be remedied by this project. First, the Hospital is proposing to construct 1,000 square feet of storage space on floors 6, 7, 8 and 9. Currently there is insufficient space for the storage of medical equipment. The equipment is stored on the floors. Several patient rooms have been taken off line and are used to store some of this equipment. The electrical system and the plumbing system in the

Inpatient Tower will also be improved. This proposal will allow the Hospital to update these systems and produce and distribute energy much more efficiently.

AFFIDAVIT

To be completed by each Applicant

Applicant: The Norwalk Hospital Association

Project Title: Norwalk Hospital Master Facility Plan

I, Geoffrey Cole, CEO of the Norwalk Hospital Association 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 Norwalk 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.

Geoffrey F. Cole 7/10/08

Signature Date

RECEIVED
2008 JUL 11 P 2:28
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on 7/10/08

Janet L. Johnson

Notary Public/Commissioner of Superior Court

My commission expires: 5/31/2012

JANET L. JOHNSON
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2012

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 14, 2008

Lisa Brady
Vice President, Planning & Business
Norwalk Hospital
34 Maple Street
Norwalk, CT 06856

Re: Letter of Intent; Docket Number: 08-31205
Norwalk Hospital
Master Facility Proposal including ED Expansion, Creation of a Freestanding On-Campus O/P Surgical Service, Consolidation of O/P Services in a New Ambulatory Services Pavilion, and Modernization of the Hospital's Main Pavilion

Dear Ms. Brady:

On July 11, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Norwalk Hospital ("Applicant") for the Master Facility Proposal including ED Expansion, Creation of a Freestanding On-Campus O/P Surgical Service, Consolidation of O/P Services in a New Ambulatory Services Pavilion, and Modernization of the Hospital's Main Pavilion project at Norwalk Hospital, at a total capital expenditure of $139,896,612.

A notice to the public regarding OHCA's receipt of a LOI was published by *The Hour Publishing Company* 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

July 14, 2008

Requisition # HCA08-009
Email: OBIT@The Hour.com
Attention: David

The Hour Publishing Company
P.O. Box 790
Norwalk, CT 06852-0790

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 **Friday, July 18, 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

Norwalk Hospital
Docket Number: 08-31205

Letter of Intent
July 14, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Norwalk Hospital
Town:	Norwalk
Docket Number:	08-31205-LOI
Proposal:	Master Facility Proposal including ED Expansion, Creation of a Freestanding On-Campus O/P Surgical Service, Consolidation of O/P Services in a New Ambulatory Services Pavilion, and Modernization of the Hospital's Main Pavilion
Capital Expenditure:	$139,896,612

The Applicant may file its Certificate of Need application between September 9, 2008 and November 8, 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

Sent: Monday, July 14, 2008 11:20 AM

----IMA2886e88.487b/pop.state.ct.us
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.
Unless the delivery fails, this will be the only delivery notification.

----IMA2886e88.487b/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;obit@THEHOUR.COM
Action: relayed
Status: 2.0.0

----IMA2886e88.487b/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-9.23) id AE8306EC; Mon, 14 Jul 2008 11:19:31 -0400
Received: from 159.247.77.55 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Mon, 14 Jul 2008 11:27:35 -0400
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
X-MimeOLE: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: Legal Ad 08-31205-LOI
Date: Mon, 14 Jul 2008 11:19:04 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7D7FD@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 08-31205-LOI
Thread-Index: AcjlxPQGp9MlPjrvS+GeS3Q5zqmNDw==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: obit@THEHOUR.COM
X-WSS-ID: 6465AFEC24K2410538-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C8E5C4.F3EE2933"

----IMA2886e88.487b/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 14, 2008

Lisa Brady
Chief Operating Officer
Norwalk Hospital
34 Maple Street
Norwalk, CT 06856

RE: Certificate of Need Application Forms; Docket Number: 08-31205-CON
Norwalk Hospital's Master Facility Proposal including ED Expansion, Creation of a Frestanding On-Campus O/P Surgical Service, Consolidation of O/P Services in a New Ambulatory Services Pavilion, and Modernization of the Hospital's Main Pavilion

Dear Ms Brady:

Enclosed are the application forms for Norwalk Hospital's Certificate of Need ("CON") proposal for its Master Facility Plan with an associated capital expenditure of $139,896,612. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between September 9, 2008, and November 8, 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 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

Enclosure

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: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above <u>OR</u> if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE:_____	$_____.00

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

13. B (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 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. 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				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project a response of "Not Applicable" may be considered an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than September 9, 2008, and may be submitted no later than November 8, 2008. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached directly at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number:	08-31205-CON
Applicant Name:	Norwalk Hospital
Contact Person:	Ms. Lisa Brady
Contact Title:	Vice-President Planning and Business
Contact Address:	Norwalk Hospital 34 Maple Street Norwalk, CT 06856
Project Location:	Norwalk
Project Name:	A Master Facility Proposal including ED Expansion, Creation of Freestanding On-Campus O/P Surgical Service, Consolidation of O/P Services in a New Ambulatory Servives Pavilion, and Modernization of the Hospital's Main Pavilion
Proposal Type:	Section 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$139,896,612

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposal will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

A. Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

B. Provide the excerpt from the minutes of the Hospital Board of Director's meeting that verifies the Board voted favorably to proceed with the proposed building project.

C. Describe the efforts the Hospital made in seeking community input for the proposed building project.

D. Briefly describe how the proposal reflects the community input received.

4. Clear Public Need

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

B. With the exception of surgical services, which will be addressed in Section 15 of the CON application form, provide the following information for each service/program affected by the proposal:

a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
c) The unit of service for the past three fiscal years by service area town.
d) Describe the population being served. Include demographic information, as appropriate.

e) Scheduling backlogs for the affected services/programs in the service areas.
f) Travel distance from the Hospital to service area towns.
g) Hours of operation of each affected service/program.

ii) Identify the existing Hospital providers of the affected services/programs in your service area.

iii) Provide the information as outlined in the following table concerning the existing providers in the Hospital's PSA and SSA for each affected service/program less surgical services:

Description of Service	Provider Name and Location	Hours and Days of Operation	Current Utilization

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

v) With the exception of surgical services, please provide the units of service projected for the first three years of operation of the services/programs affected by the proposal. **Include the derivation/calculation for each service/program.**

C. 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.

D. Please provide a copy of the needs assessment completed for the proposed project.

E. Please provide excerpts of the Hospital's Strategic Plan relating to the project.

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

☐ Market share analysis ☐ Epidemiological studies

☐ Public information reports ☐ Parking Studies

G. Please provide an itemization of the Hospital's current and proposed staffed and licensed bed configuration by service in the following format:

Current and Proposed Staffed and Licensed Hospital Beds

General Services	**Current Staffed Beds**	**Proposed Staffed Beds**	**Current Licensed Beds**	**Proposed Licensed Beds**
Medical				
Surgical				
Intensive Care Unit				
Cardiac Care Unit				
Exempt Psychiatric				
Exempt Rehabilitation				
Specialty Services				
Maternity				
Newborn				
Oncology				
Total Bed Count				

H. Please provide an itemization in the number of Emergency Department treatment beds by service (i.e. general, trauma, urgent, psychiatric etc.) and by existing and proposed treatment beds in similar format to the above referenced table.

I. Please provide an itemization in the number of private and semi-private patient rooms at the Hospital, by floor and service (i.e. med-surg, CCU, etc.) and by existing and proposed beds in similar format to the above referenced table.

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 Hospital plans to meet the each of the guidelines checked off above.

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

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]

[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.

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:

☐ Excerpts of the Hospital's Quality Assurance Plan (QAP) relating to the project.

☐ The latest Annual Evaluation Report of the QAP Committee.

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 makes your proposal unique?

☐ Yes ☐ No

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

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

8. Financial Information

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

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

ii) Provide the latest cash equivalent balance as of the date of submission of this application.

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

iv) Does the Hospital have Tax Exempt Status? ☐ Yes ☐ No

v) Copies of all bond resolutions which are currently outstanding.

vi) Copies of all indenture and loan agreements which are currently outstanding.

vii) Copies of all line of credit agreements which are currently outstanding.

viii) Copies of any correspondence to and from creditors that placed any additional financial requirements or restrictions on the Hospital, the Norwalk Hospital Association or any of the Association's affiliates.

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 project illustrating the changes that will take place for each department affected by the proposal.

B. Provide a table illustrating the current and anticipated location(s) with associated square footage for each department affected by the proposal. To the degree possible, the table should be itemized by newly constructed and renovated space.

C. Provide all schematic drawings of the existing and proposed floor plans related to the project. One set of the schematics should be a legible, full-scale rendition.

D. Provide an existing and a proposed plot plan of the Hospital, showing all areas affected by the project.

E. Provide an itemization of newly constructed and renovated space 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			

F. Explain how the proposed building project will affect the delivery of patient care.

G. Provide a timetable chart identifying the various phases of the building project and the anticipated time in months to initiate and complete each major stage of the proposal.

11. Capital Equipment Lease/ Purchase

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

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

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

12. 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. Letter of interest from CHEFA,

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

iv. Lease agreement.

14. 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.

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

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

ii) Please provide three years of projection of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. Please complete Financial Attachment II included in the forms package**.

iii) List the assumptions utilized in developing the projections **(e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). Please Note*: Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.***

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

v) Describe how this proposal is cost effective.

15. Surgical Services and Facilities:

A. Please provide the **inpatient procedure volumes** performed in the Hospital's operating room suites (i.e. existing ten (10) operating rooms) for fiscal years ("FYs") 2005, 2006, and 2007. For FY 2008, provide year-to-date ("YTD") volumes and their annualized equivalent.

Description	Town	FY 2005	FY 2006	FY 2007	YTD 2008*
Service Area					
All Other					
Total I/P					

Note: * Please identify the number of months of data reported for YTD 2008.

B. Please provide the **outpatient procedure volumes** performed in the Hospital's operating room suites for fiscal years FYs 2005, 2006, and 2007. For FY 2008, provide year-to-date volumes and their annualized equivalent.

Description	Town	FY 2005	FY 2006	FY 2007	YTD 2008*
Service Area					
All Other					
Total O/P					

Note: * Please identify the number of months of data reported for YTD 2008.

C. Categorize the **inpatient surgical procedures** (i.e. general, ortho, eye, ob-gyn, etc.) performed in the Hospital's operating room suites during the past three fiscal years and report the total minutes required to perform the procedures in each category using the format in the table below. Provide the same data for year-to-date 2008 annualized information.

Inpatient Procedure Category	FY 2005		FY 2006		FY 2007	
	No. of Procedures	Total Minutes	No. of Procedures	Total Minutes	No. of Procedures	Total Minutes

D. Categorize the **outpatient surgical procedures** (i.e. general, ortho, eye, ob-gyn, etc.) performed in the Hospital's operating room suites during the past three fiscal years and report the total minutes required to perform the procedures in each category using the format in the table below. Provide the same data for year-to-date 2008 annualized information.

Outpatient Procedure Category	FY 2005		FY 2006		FY 2007	
	No. of Procedures	Total Minutes	No. of Procedures	Total Minutes	No. of Procedures	Total Minutes

E. Using the total number of **inpatient surgical procedures** performed and the total number of minutes as reported in Questions A and C above, report the operating room utilization using the following format:

Inpatient Surgical Utilization	**FY 2005**	**FY 2006**	**FY 2007**
Total number of procedures performed			
Annual increase in procedures performed	-	%	%
Number of operating rooms			
Average annual number of procedures per room			
Total number of procedure hours			
Number of hours available per year			
Percent of Total Hours Utilized	%	%	%

F. Using the total number of **outpatient surgical procedures** performed and the total number of minutes as reported in Questions B and D above, report the operating room utilization using the following format:

Outpatient Surgical Utilization	**FY 2005**	**FY 2006**	**FY 2007**
Total number of procedures performed			
Annual increase in procedures performed	-	%	%
Number of operating rooms			
Average annual number of procedures per room			
Total number of procedure hours			
Number of hours available per year			
Percent of Total Hours Utilized	%	%	%

G. Provide the projected number of **inpatient surgical procedures** by service line to be performed during the first three fiscal years (FY 2013, FY 2014, and FY 2015) after project completion, i.e., utilizing eight (8) operating rooms. Use the format provided in Question A above. Present this same information itemized by town.

H. Provide the projected number of **outpatient surgical procedures** by service line to be performed during the first three fiscal years (FY 2013, FY 2014, and FY 2015) after project completion, i.e., utilizing eight (8) operating rooms. Use the format provided in Question A above. Present this same information itemized by town.

I. Categorize the projected number of **inpatient surgical procedures** to be performed with the proposal and report the total number of minutes that will be required to perform the procedures with the proposal using the format provided in Question C above.

J. Categorize the projected number of **outpatient surgical procedures** to be performed with the proposal and report the total number of minutes that will be required to perform the procedures with the proposal using the format provided in Question D above.

K. Using the information reported for the projected number of **inpatient surgical procedures** and the total number of minutes required to perform the projected procedures, report the **projected inpatient operating room utilization** using the following format:

Inpatient Surgical Utilization	**FY 2013**	**FY 2014**	**FY 2015**
Total number of procedures to be performed			
Annual projected increase in procedures to be performed	-	%	%
Number of operating rooms	8	8	8
Average annual number of procedures per room			
Total number of projected procedure hours			
Number of hours projected available per year			
Percent of Total Hours Utilized	%	%	%

L. Using the information reported for the projected number of **outpatient surgical procedures** and the total number of minutes required to perform the projected procedures, report the **projected inpatient operating room utilization** using the following format:

Outpatient Surgical Utilization	**FY 2013**	**FY 2014**	**FY 2015**
Total number of procedures to be performed			
Annual projected increase in procedures to be performed	-	%	%
Number of operating rooms	8	8	8
Average annual number of procedures per room			
Total number of projected procedure hours			
Number of hours projected available per year			
Percent of Total Hours Utilized	%	%	%

M. With respect to all outpatient/ambulatory surgical facilities operating in the Hospital's service area, please complete the following table:

Provider Name	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 surgeries.
[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 surgeries included in the proposal.
[5] Minimum number of surgeries 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 surgeries 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.

N. Referring to the definitions[2] given below, check each level of anesthesia being used or proposed for use:

☐ Minimal Sedation ☐ Moderate Sedation/Analgesia ("Conscious Sedation")

☐ Deep Sedation/Analgesia ☐ General Anesthesia

Minimal Sedation is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesis ("Conscious Sedation") describes a medically controlled state of depressed consciousness that allows protective reflexes to be maintained. The patient retains the ability to independently maintain his or her airway and to respond purposefully to verbal commands and/or tactile stimulation. Moderate Sedation and Analgesia is a state that allows patients to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully

[2] Source: American Society of Anesthesiologists, October 1999.

to verbal command and tactile stimulation. Those patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree than encompassed by sedation/analgesia.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

O. List the anesthetic and/or sedating drugs currently used by the Facility. List the drug's common chemical name and/or brand name.

_____

_____

_____

P. List the monitoring equipment currently available at the Facility.

_____

_____

_____

Q. List the emergency resuscitative equipment currently available at the Facility.

_____

_____

_____

R. Attach a copy of the Facility's Conscious Sedation Protocol and/or Anesthesia Protocol as amended to date.

Greer, Leslie

From: obit Classified [obit@thehour.com]
Sent: Monday, July 14, 2008 4:37 PM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31205-LOI

$115.84 for 7/18

Thanks!

David

-----Original Message-----
From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Mon 7/14/2008 11:19 AM
To: obit Classified
Subject: Legal Ad 08-31205-LOI

David,

Please run the attached public notice in your newspaper no later than Friday, July 18, 2008. Please notify me that you have received this request.

Thank you,

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>