MIDDLESEX
HOSPITAL

ADMINISTRATION

October 31, 2008

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

Dear Commissioner Vogel:

Re: Acquisition of an Imaged-Guided Radiation Therapy Treatment System

Pleased find enclosed the original and six (6) copies of Middlesex Hospital's Letter of Intent to acquire an Imaged-Guided Radiation Therapy Treatment System

Thank you very much for your consideration of the enclosed application.

Please call me if you have any questions or concerns.

Very truly yours,

Harry Evert
Vice President, Administration

HE/rdo
Enclosure

28 Crescent Street
Middletown, Connecticut 06457-3650

tel 860 344-6000
fax 860 346-5485

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	**Middlesex Hospital**	
Doing Business As		
Name of Parent Corporation	**Middlesex Health System Inc.**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**28 Crescent St. Middletown, CT 06457**	
Identify Applicant Status: P for Profit or NP for Nonprofit	**NP** ☐	
Does the Applicant have Tax Exempt Status?	Yes √ No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	**Harry Evert Vice President**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**28 Crescent St. Middletown, CT. 06457**	
Contact Person Telephone Number	**(860) 358-6120**	
Contact Person Fax Number	**(860) 346-5485**	
Contact Person e-mail Address	**Harry_Evert@midhosp.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Acquisition of an Imaged-Guided Radiation Therapy Treatment System at Middlesex Hospital**

b. Project Proposal: _____

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☒ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☒ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

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

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

☒ Yes ☐ No

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

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

☐ Reduction ☐ Change in Ownership/Control

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

☒ Yes ☐ No

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

☒ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☒ Major medical equipment

☐ Change in ownership or control

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

Middlesex Hospital, 536 Saybrook Road, Middletown, CT 06457

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

The Middlesex Hospital primary service area includes the Connecticut cities and towns of Middletown, Middlefield, Cromwell, Durham, Haddam, Killingworth, Portland, East Hampton, East Haddam, Marlborough, Colchester, Chester, Deep River, Essex, Old Saybrook, Westbrook, Clinton and Madison.

h. Estimated starting date for the project: **July 2009**

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

Not Applicable

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$5,226,899**

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

Major Medical Equipment Purchases*	**$3,999,999**
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation **(Vault to accommodate the new unit)**	**$ 1,076,900**
Other (Non-Construction) Specify: **Owner's Contingency**	**$ 150,000**
Total Capital Expenditure	**$ 5,226,899**
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	**$ 5,226,899**
Total Project Cost	**$ 5,226,899**
Capitalized Financing Costs (Informational Purpose Only)	

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

* **The only major medical equipment to be acquired is an image-guided radiation therapy treatment system.**

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
Image-guided radiation therapy treatment system	**Varian**	**Novalis Tx System with Rapid Arc**	**1**	**$3,999,999**

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment. **Copies of the vendor's quotation pages with pricing information are enclosed on pages 8 & 9.**

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: __ **Middlesex Hospital** _____

Project Title: __ **Acquisition of an Imaged-Guided Radiation Therapy Treatment System at Middlesex Hospital** _____

I, **Susan Martin** (Name), **Vice President of Finance/CFO** (Position – CEO or CFO)

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

Susan Martin
Signature

10/30/08
Date

Subscribed and sworn to before me on October 30, 2008

Abby Ann Cole
Notary Public/~~Commissioner of Superior Court~~

ABBY ANN COLE
NOTARY PUBLIC
MY COMMISSION EXPIRES JAN. 31, 2010

My commission expires: _____

RECEIVED
2008 NOV -3 P 12:00
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

SECTION IV. PROJECT DESCRIPTION

The Applicant, Middlesex Hospital, currently provides radiation therapy treatment services under the hospital's General Hospital License (license # 0069) from the State of Connecticut Department of Public Health. The Hospital provides these services today with a Varian Clinac treatment system which was installed when the Hospital's Cancer Center facility, located at 536 Saybrook Road in Middletown, Connecticut, was opened in 2003. The Hospital is proposing to expand its radiation therapy treatment capacity by acquiring a new state-of-the art imaged-guided radiation therapy treatment system to augment the current treatment unit. The addition of this new treatment system will require an addition to the Cancer Center facility in order to add a second vault to accommodate a new unit.

The current treatment system at the Middlesex Hospital is capable of providing intensity modulated radiation therapy ("IMRT") treatments in addition to more traditional 3-D conformal radiation therapy treatments. The utilization of IMRT in treating cancer patients has been increasing significantly in recent years. IMRT treatment technology allows for the delivery of higher doses of radiation to the tumor while sparing the surrounding normal tissue. The state-of-the art for providing the highest quality IMRT treatments today includes the use of image-guided technology to augment the treatment machine's intensity modulated treatment capability. Image-guided radiation therapy ("IGRT") can both better localize the extent of tumor before the radiation is delivered and then deliver the optimal dose of radiation precisely to the localized tumor to minimize the exposure of normal tissue to radiation. The current treatment system at the Hospital does not have this image-guided technology. With the increasing demand for image-guided IMRT treatments, this current system is no longer state of the art for many of the cases being treated today. In addition, given the age and extended use of the current treatment system; unscheduled "down-time" has been increasing resulting in insufficient capacity on some days meet schedule patient demand.

Total radiation therapy treatments at the Middlesex Hospital increased 10% between FY04 and FY07 (from 8,200 to nearly 9,000) and the Hospital's single treatment unit is now operating very close to its maximum practical capacity. The Hospital's radiation therapy service schedules patients for treatments nine and one-half hours per day, five days a week. This is considered to be close to the maximum scheduling capacity of a radiation therapy service. Therefore, the current unit's maximum practical capacity, assuming ten hours per day of operations, is approximately 9,500 treatments per year.

The Middlesex Hospital provides radiation therapy services to patients from the hospital's primary service area, which includes the Connecticut cities and towns of Middletown, Middlefield, Cromwell, Durham, Haddam, Killingworth, Portland, East Hampton, East Haddam, Marlborough, Colchester, Chester, Deep River, Essex, Old Saybrook, Westbrook, Clinton and Madison. The residents of this service area are the target population for both the current and proposed service and no other radiation therapy service providers are located in this primary service area. The demand for radiation therapy treatments in this target population is projected to continue to grow significantly over the next decade. Total cancer incidence and new radiation therapy patient demand in the primary service area is projected to increase by 30% over the next decade due to growth and aging of the population. Without adding treatment capacity with the proposed second radiation therapy treatment unit, Middlesex Hospital will not be able to meet the cancer care needs of these service area patients in the future.

This proposed radiation therapy capacity expansion project does not represent a significant change in the Hospital's clinical services, its relationship with payers, or the population it serves. This project is necessary to enable the Hospital to continue to provide state-of-the-art radiation therapy treatments to its patients and to meet the significant growth in the demand for treatments projected from its service area population in the near-term future. As such this proposal will should have a beneficial impact on the patients served by Middlesex Hospital and the overall health care delivery system in the State of Connecticut.

VARIAN medical systems

Quotation

RXV20070802-001L

BrainLAB

Page: 1

Quotation For:

Linda Jo Spencer
Middlesex Hospital
Purchasing
28 Crescent Street
Middletown, CT 06457
(860) 344 - 6605 FAX: (860) 344 - 6009

Please address inquiries and replies to:

Richard VanSaun
Varian Medical Systems
100 Walnut Ave.
Suite 201
Clark, NJ 07066
(410) 638 - 6800 FAX: (410) 638 - 6811

Your Reference:	*Quotation Firm Until:* October 3, 2008
FOB Point: 02 FOB DESTINATION	*Shipping Allocation:* 09/25/2009
Payment Terms: See Terms and Conditions	

Customer acknowledges that it is entering into two separate contracts for products purchased hereunder. Varian Terms and Conditions of Sale 1652 VTX and 1580 AD apply for products manufactured by Varian. BrainLAB Terms and Conditions of Sale 1652 BTX apply for products manufactured by BrainLAB.

Novalis Tx Quotation

Novalis Tx System

Middlesex Hospital	Varian Medical Systems (for itself and on behalf of BrainLab)
Quotation Total of: USD $3,659,638 Accepted by:	Submitted by:
Signature: _____	Signature: _____
Name: _____	Name: Richard VanSaun
Title: _____	Title: District Manager
Date: _____	Date: September 30, 2008

For this purchase, we designate ____NOVATION____ as our Institution's Primary Group Purchasing Organization Affiliation. Any change will be indicated below:

☐ AmeriNet	☐ Aptium	☐ BJC	☐ Broadlane
☐ CHW	☐ Consorta/HPG	☐ KP Select	☐ Magnet
☐ Matrix	☐ MedAssets	☐ Novation	☐ Premier
☐ ROI	☐ USO	☐ VA Gov	☐ None

VARIAN
medical systems

Quotation

RXV20080915-001B Page: 1

Quotation For:

Linda Jo Spencer
Middlesex Hospital
Purchasing
28 Crescent Street
Middletown, CT 06457 USA
(860) 344 - 6605 FAX: (860) 344 - 6009

Please address inquiries and replies to:

Richard VanSaun
Varian Medical Systems
100 Walnut Ave.
Suite 201
Clark, NJ 07066 USA
(410) 638 - 6800 FAX: (410) 638 - 6811

Your Reference:	*Quotation Firm Until:* November 14, 2008
FOB Point: 02 FOB DESTINATION	*Shipping Allocation:* 120 DAYS ARO
Payment Terms: See Terms and Conditions	Varian Terms and Conditions of Sale 1652S Attached

RapidArc

Middlesex Hospital

Quotation Total of: USD $340,161 Accepted by:

Signature: _____

Name: _____

Title: _____

Date: _____

For this purchase, we designate ____NOVATION____ as our Institution's Primary Group Purchasing Organization affiliation. Any change will be indicated below:

☐ AmeriNet ☐ Aptium ☐ BJC ☐ Broadlane
☐ CHW ☐ Consorta/HPG ☐ KP Select ☐ Magnet
☐ Matrix ☐ MedAssets ☐ Novation ☐ Premier
☐ ROI ☐ USO ☐ VA Gov ☐ None

Varian Medical Systems

Submitted by:

_____
(Signature)

Name: Richard VanSaun

Title: District Manager

Date: September 15, 2008

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2008

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

Re: Letter of Intent; Docket Number: 08-31262
Middlesex Hospital
Acquisition of an Image-Guided Radiation Therapy Treatment System at Middlesex Hospital

Dear Mr. Evert,

On November 3, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Middlesex Hospital ("Applicant") for the acquisition of an Image-Guided Radiation Therapy Treatment System at Middlesex Hospital in Middletown, with a capital expenditure of $5,226,899.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Middletown Press* pursuant to Section 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Barbara Durdy
Director of Operations

BD:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2008

Requisition # HCA09-062
Fax: 347-3380

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

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, November 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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara Durdy
Director of Operations

Attachment

BD:AGF:lmg

c: Sandy Salus, OHCA

The Middletown Press
Docket Number 08-31262

Letter of Intent
November 14, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Middlesex Hospital
Town:	Middletown
Docket Number:	08-31262-LOI
Proposal:	Acquisition of an Image-Guided Radiation Therapy Treatment System at Middlesex Hospital
Total Capital Expenditure:	$5,226,899

The Applicant may file its Certificate of Need application between January 2, 2009 and March 3, 2009. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

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

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

TRANSMISSION OK

TX/RX NO	4311
RECIPIENT ADDRESS	93473380
DESTINATION ID	
ST. TIME	11/14 17:16
TIME USE	00'46
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2008

Requisition # HCA09-062
Fax: 347-3380

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

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, November 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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara Durdy

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 18, 2008

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

Re: Certificate of Need Application Forms; Docket Number: 08-31262
Middlesex Hospital
Acquisition of an Image-Guided Radiation Therapy Treatment System

Dear Mr. Evert,

Enclosed are the application forms for Middlesex Hospital's Certificate of Need ("CON") proposal for the Acquisition of an Image-Guided Radiation Therapy Treatment System with an associated capital expenditure of $5,226,899. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between January 2, 2009, and March 3, 2009.

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

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and five (5) hard copies of the submission, each 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 Alexis Fedorjaczenko. She may be reached at (860) 418-7067, if you have any questions.

Sincerely,

Kimberly Martone (agf)

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 2, 2009, and may be submitted no later than March 3, 2009. The Analyst assigned to your application is Alexis Fedorjaczenko; she may be reached at the Office of Health Care Access at (860) 418-7067.

Docket Number:	08-31262-CON
Applicant's Name:	Middlesex Hospital
Contact Person: **Contact Title:**	Harry Evert Vice President
Contact Address:	28 Crescent Street Middletown, CT 06457
Project Location:	Middletown
Project Name:	Acquisition of an Image-Guided Radiation Therapy Treatment System at Middlesex Hospital
Proposal Type:	Section 19a-639, C.G.S.
Est. Capital Expenditure:	$5,226,899

1. Expansion of Existing or New Service

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

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

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

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in Middletown.

B. Provide the following service area information:

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

ii) Describe the population to be served.

iii) Scheduling backlogs in service area.

iv) Travel distance from the proposed site to service area towns.

v) Hours of operation of the Hospital's existing service and the proposed service to be provided.

vi) Provide the following information concerning existing providers:

a) Identify the existing providers of the proposed service in your service area using the following format:

Legal Name of Provider Street Address	List the Services	Names of Affiliated Physicians

Town and Zip Code	Provided	

b) Provide the information as outlined in the following table concerning the existing providers' current operations:

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

[1] Provide a description of the equipment used by the Provider, if known.
[2] Specify days of the week and start and end time for each day.
[3] Volume performed on specified equipment used by the Provider for the most recent 12 month period, if known.

c) What will be the effect of your proposal on each of the listed existing providers (i.e. patient volume, quality of care, etc.)?

C. Report the following information and provide all derivations, calculations, and supporting detail.

i) The units of service for the past three fiscal years and the current fiscal year-to-date by service area town for radiation therapy.

ii) The units of service projected for the first three years of operation of the proposed service by service area town. Include separate projections for the existing treatment system (Varian Clinac) and the proposed image guided radiation therapy treatment system.

iii) How capacity is determined on each unit.

D. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural	☐ Transportation
☐ Geographic	☐ Economic
☐ None	☐ Other (Identify) _____

If you checked other than "None" of the above, please provide an explanation.

E. Provide copies of any epidemiological, public information or other similar studies related to your proposal. If there are none, please explain why none are available for submission.

F. 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.

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

Note: Above referenced acronyms are defined below. [1]

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

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

7. Miscellaneous

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

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

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

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

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.
ii) The DPH licensure category you are seeking.
iii) If not applicable, please explain why.

---

[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.

8. Financial Information

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

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

B. 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.

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 Information

A. Provide a detailed description of the any construction or renovations including the related gross square feet that will be required as a result of the proposal.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide a breakdown of the new construction/renovation costs.

D. Explain how the proposal will affect the delivery of patient care for existing patients.

E. Provide the following information regarding the schedule for the proposal:

Purchase Date	
DPH Licensure Date	
Commencement of Operations Date	

11. 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.

12. Revenue, Expense and Volume Projections

A. 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 Gross Patient Revenue in the following reporting format:

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

*Includes managed care activity.

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

C. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

D. 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 for the Hospital and for the Hospital System. **See attached, Financial Attachments IA and IB.** *Note: The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

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

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

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

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

vi) Describe how this proposal is cost effective.

Middlesex Hospital

12. D (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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

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

Middlesex Hospital

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

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
FY	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

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, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ $ 1,000.00 b. Additional Fee: (Capital Expenditure Assessment)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ $_____.00 d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

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