Robert E. Smanik, FACHE
President and CEO

DAY KIMBALL HOSPITAL
320 Pomfret Street Putnam, Connecticut 06260 860-928-6541 www.daykimball.org

March 12, 2009

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

Dear Commissioner Vogel:

Please find enclosed Day Kimball Hospital's Letter of Intent in regard to provide OB/GYN services at its existing Dow Road location in Plainfield.

Should you have any questions regarding this information, please do not hesitate to contact me at 860-928-6541 x2218.

Sincerely,

Robert E. Smanik, FACHE
President & CEO

enclosure

cc: Julie Drouin, CFO
Christine Vallee, VP, Physician Services

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	Day Kimball Healthcare, Inc.	
Doing Business As	Day Kimball Hospital	
Name of Parent Corporation	Day Kimball Healthcare, Inc. d/b/a Day Kimball Hospital	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	320 Pomfret Street Putnam, CT 06260	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	**Yes X** No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Robert Smanik, FACHE President & CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	320 Pomfret Street Putnam, CT 06260	
Contact Person Telephone Number	860.928.6541	
Contact Person Fax Number	860.963.6341	

Contact Person e-mail Address	rsmanik@daykimball.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: OB/GYN Professional Services

b. Project Proposal: OB/GYN Professional Services in Plainfield, Connecticut.

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)* OB/GYN Services

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:

31 Dow Road, Plainfield, Connecticut 06374

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

This project is intended to serve towns comprising the Hospital's existing service area, including: Brooklyn, Canterbury, Chaplin, Griswold, Hampton, Killingly, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Voluntown and Woodstock.

h. Estimated starting date for the project: June 1, 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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 87,000.00

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	$87,000.00
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	$87,000.00
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	$87,000.00
Capitalized Financing Costs (Informational Purpose Only)	

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

Medical Equipment Purchases will include: Novasure/Essure, Limited Ultrasound Machine, and exam tables.

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. **N/A**

☐ 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 **N/A**

   ☐ 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). **N/A**

d. Major Medical and/or Imaging Equipment Acquisition: **N/A**

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

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

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.

Day Kimball Hospital ("DKH") is a tax-exempt, not-for-profit acute care general hospital located in Putnam, Connecticut. Currently, DKH provides the following inpatient services: ICU/Tele; Maternal Child Health; Med/Surg; Pediatrics; Hospice; OR; PACU; Physical Medicine; Psychiatry; Respiratory; Pharmacy; Sleep Lab and IV therapy. DKH also provides the following outpatient services: Emergency Department/Prompt Care; Ambulatory Surgery; OR; Rehabilitation; Behavioral Health; DI-MRI, CT, PET Scan, Ultrasound and X-Ray; Homecare/Hospice; Homemakers; Primary Care; Pediatrics; OB/GYN; Pulmonology; Oncology and Diabetes. Specific to this proposal, DKH already provides outpatient adult primary care services in Plainfield and OB/GYN services in multiple locations.

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

In accordance with CON Determination Report 02-J2, DKH was authorized to provide OB/GYN services at locations in Dayville and Putnam. DKH proposes to also provide OB/GYN services at its existing Dow Road location in Plainfield. No additional DPH licensure categories are being sought.

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

The current population served by DKH's provision of OB/GYN services includes patients located within DKH's service area. The target population to be served by this proposal will be the same.

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

Currently, DKH is serving towns which are part of federally designated Medically Underserved Populations (MUPs). According to the Federal Health Resources Services Administration MUPs are categorized, in part, as having too few primary care providers. Specifically, the towns of Griswold, Voluntown, Killingly, Plainfield and Sterling are designated MUPs. These towns are all part of the Hospital's service area. Accordingly, there is a need for the expansion of medical services. Such need can be reduced upon implementation of DKH's proposal to expand its provision of OB/GYN services in Plainfield.

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

The following OB/GYN physician/physician practices exist in the proposed geographic service area:

- **Women's Health Center of Putnam**
- **David L Yeager, M.D. (located in Putnam)**
- **Day Kimball Hospital Ob/Gyn Centers (located in Putnam and Dayville)**

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

It is not anticipated that this proposal will cause any adverse impact on the health care delivery system in the State. Instead, patients in DKH's service area will enjoy increased access to needed OB/GYN services.

7. Who will be responsible for providing the service?

DKH's Physician Practices Department will provide the services.

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

Currently DKH participates with the following third party payors: Anthem BC/BS of CT; CIGNA; CIPA, EBPA; Health Net; Medicaid; Medicare; United Healthcare; Oxford; AETNA, Community Health Network; Connecticare; First Health; Preferred One/Wellcare; Great West; Multiplan; and Pioneer. DKH does not anticipate any changes to the participating payor list for this proposal.

AFFIDAVIT

To be completed by each Applicant

Applicant: Day Kimball Hospital

Project Title: OB/GYN Professional Services

I, Robert Smanik, FACHE, President and CEO
(Name) (Position – CEO or CFO)

of Day Kimball 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 Day Kimball 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.
(Facility Name)

Signature 3-12-09
Date

Subscribed and sworn to before me on March 12, 2009

Nancy L. White
Notary Public/Commissioner of Superior Court

My commission expires: 6-30-10

Nancy L. White
NOTARY PUBLIC
State of Connecticut
My Commission Expires
June 30, 2010

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

Robert Smanik, FACHE
President and Chief Executive Officer
Day Kimball Hospital
320 Pomfret Street
Putnam, CT 06260

Re: Letter of Intent, Docket Number: 09-31330
Day Kimball Hospital
Proposal to add OB/GYN Services to its Existing Outpatient Center in Plainfield
Notice of Letter of Intent

Dear Mr. Smanik:

On March 16, 2009 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Day Kimball Hospital ("Applicant") for the proposal to add OB/GYN services to its existing Outpatient Center in Plainfield, with a capital expenditure of $87,000.

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

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

Requisition # HCA09-119
Email: ndouglas@norwich@gannett.com

Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

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, March 24, 2009.**

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

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

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

The Norwich Bulletin
Docket Number: 09-31330

Letter of Intent
March 20, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Day Kimball Hospital
Town:	Plainfield
Docket Number:	09-31330-LOI
Proposal:	Proposal to add OB/GYN services to its existing Outpatient Center in Plainfield
Capital Expenditure:	$87,000

The Applicant may file its Certificate of Need application between May 15, 2009 and July 14, 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

Greer, Leslie

Sent: Friday, March 20, 2009 1:37 PM

----IMAd68d429.49c3/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.

----IMAd68d429.49c3/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;ndouglas@norwichbulletin.com
Action: relayed
Status: 2.0.0

----IMAd68d429.49c3/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-10.02) id A42806F0; Fri, 20 Mar 2009 13:36:40 -0400
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Fri, 20 Mar 2009 13:46:01 -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: FW: Legal Ad 09-31330
Date: Fri, 20 Mar 2009 13:35:36 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD4DA@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31330
Thread-Index: AcmpgGzK4KKZnfriTvqIUoWOULqEXQAAEPjw
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: ndouglas@norwichbulletin.com
X-WSS-ID: 65DD09D330S5772293-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C9A982.47A2B63F"

----IMAd68d429.49c3/pop.state.ct.us--

Greer, Leslie

From: Douglas, Nancy [ndouglas@norwichbulletin.com]
Sent: Friday, March 20, 2009 2:07 PM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31330

Hi, You are all set for this legal to run March 24,
If you could make a note of my correct email below.....just want to make sure to get future emails from you – thanks

Nancy C. Douglas
Classified Adv
Phone 860-889-3363
Fax 860-887-1949
email ndouglas@norwichbulletin.com

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Friday, March 20, 2009 1:36 PM
To: Douglas, Nancy
Subject: FW: Legal Ad 09-31330

Legal Ad,
Please run the attached public notice in your newspaper by March 24, 2009. Please notify me when this has been completed.

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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 19, 2009

via fax and e-mail

Robert Smanik, FACHE
President and Chief Executive Officer
Day Kimball Hospital
320 Pomfret Street
Putnam, CT 06260

RE: Certificate of Need Application Forms, Docket Number 09-31330-CON
Day Kimball Hospital
Proposal to add Ob/Gyn Services to the Outpatient Center in Plainfield

Dear Mr. Smanik:

Enclosed are the application forms for Day Kimball Hospital's Certificate of Need ("CON") proposal for the proposal to add Ob/Gyn Services to the Hospital's existing Outpatient Center in Plainfield, with an associated capital expenditure of $87,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between May 15, 2009, and July 14, 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 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 application and supporting documents in MS Word format.
- Submit completed financial attachments, and other data as appropriate, in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please contact her at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Director of Operations

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 May 15, 2009, and may be submitted no later than July 14, 2009. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31330-CON

Applicant Name: Day Kimball Hospital
Contact Person: Robert Smanik FACHE
Contact Title: President and Chief Executive Officer
Day Kimball Hospital
Contact Address: 320 Pomfret Street
Putnam, CT 06260

Project Location: Plainfield

Project Name: Day Kimball Hospital proposes to add obstetrics and gynecological services to its existing Outpatient Center in Plainfield

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $87,000

1. List the services that are currently offered at the Hospital's Outpatient Center at 31 Dow Road, Plainfield ("Plainfield OP Center").

2. List the proposed services to be added to the Plainfield OP center.

3. List the service area towns for the proposed services. Provide a rationale for choosing the listed towns.

4. Explain how it was determined there was a need for the proposal in your service area. Provide specific evidence of the need, including, but not limited to, incidence and prevalence of conditions to be treated, the demand for the service and the Hospital's market share of the service area.

5. Describe the population whose health needs are not currently being met with the current services available. Identify how and where these individuals are currently receiving care. Include demographic information, as appropriate.

6. Describe the population to be served, including the number of individuals to receive care through the proposed service. Include demographic Information as appropriate

7. Report the units of service by town and then by service type, provided by the Hospital for:
    a. the past three fiscal years; and
    b. the current fiscal year-to-date.

8. Report the units of service projects for the proposal. Explain how the project units of service were determined. Provide supporting calculations and documentation as appropriate. Provide the units of service projected for:
    a. The first fiscal year encompassing the year in which the proposed service begins operations; and
    b. The following three full fiscal years of operations.

9. Identify the existing providers of the proposed service in the service area towns and provide the information as outlined in the following table:

Legal Name of Provider, Street Address, Town and Zip Code	**Services Provided**	**Names of Affiliated Physicians**

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

11. Report any scheduling backlogs in service area.

12. What are the travel distances Plainfield OP Center to each of the proposed service area towns?

13. Report the current hours of operation of the Plainfield OP Center and the hours that the proposed services will be available.

14. 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.

15. Provide copies of needs assessments and market share analyses performed to support the clear public need for the proposal and to support the proposed units of service. If there are none, explain why no such assessments or analyses were undertaken by the Hospital.

16. 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:		

17. Describe in detail how the Hospital plans to meet the each of the guidelines checked off above.

18. 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, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

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

19. 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]

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

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for proposed service
- ☐ Patient Selection Criteria/Intake form

21. What is the type of ownership that will offer the proposed services: (Please check off all that apply.)

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

22. 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.

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

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

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

26. Identify the entity that will be billing for the proposed service.

---

[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.

27. 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 equipment.
** Provide a current vendor quote for each piece of equipment.

28. 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 (specify):	$

☐ Other financing:

Amount	$
Source (specify):	

29. Provide a copy of the lease agreement, if applicable.

30. Payer Mix Projection:

Provide the current payer mix for the proposed services currently offered by the Hospital and the projected payer mix with the CON proposal 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				
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

*Include managed care activity.

31. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

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

a. A summary of the Plainfield Outpatient Center's revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment Ia.**

A summary of the Hospital's revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment Ib.**

Note: The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

b. Provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer.
See attached, Financial Attachment II.

c. All assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense percentage 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.

d. 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.

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

35. Describe how this proposal is cost effective.

36. Provide the charity care policy for the proposed services.

37. State Health Plan (No questions at this time.)

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

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

39. Will your proposal remedy any of the following barriers to access?

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

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

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

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

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

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

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

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

43. Provide the following licensing information:
    a. If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.
    b. The DPH licensure category you are seeking.
    c. If not applicable, please explain why.

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: _____

33. a. 1. Provide one year of actual results and three years of projections for the Plainfield Outpatient Center's 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										
***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. proposal.

33. a.2. Provide one year of actual results and three years of projections for Day Kimball Hospital's revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

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

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

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

Type of Service Description
Type of Unit Description:
# of Months in Operation

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

****
*** TX REPORT ***
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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: ROBERT SMANIK, FACHE

FAX: (860) 963-6341

AGENCY: DAY KIMBALL HOSPITAL

FROM: LAURIE GRECI

DATE: 3/20/09 **TIME:**

NUMBER OF PAGES: 16
(including transmittal sheet

Comments: Docket 09-31330-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***