HARTFORD HOSPITAL

80 Seymour Street
P.O. Box 5037
Hartford, CT 06102-5037
860/545-5000

March 17, 2009

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

RE: Letter of Intent

Dear Commissioner Vogel,

I have enclosed an original and six copies of a Letter of Intent for a forthcoming Certificate-of-Need application regarding our plans to establish an endovascular surgical operating room. We look forward to submitting our project application to you, and we request from your office the necessary application forms.

Please feel free to contact me if you have any questions about this matter. Thank you.

Sincerely,

J. Kevin Kinsella
Vice President

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	Hartford Hospital	
Doing Business As		
Name of Parent Corporation	Hartford HealthCare Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Seymour Street P.O. Box 5037 Hartford, Ct 06102-5037	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
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.	J. Kevin Kinsella Vice President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	80 Seymour Street P.O. Box 5037 Hartford, Ct 06102-5037	
Contact Person Telephone Number	860-545-4155	
Contact Person Fax Number	860-545-4193	
Contact Person e-mail Address	Kkinsel@harthosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Establish Endovascular Surgical Operating Room

Project Proposal: The project consists of the installation of imaging equipment, and the associated renovations to an existing operating room, in order to accommodate endovascular surgery. The project is designed to improve intraoperative vascular imaging for minimally invasive vascular surgical procedures.

b. 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: _____

c. 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

d. 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:

80 Seymour Street, Hartford, CT 06102

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

Response: This project will not change the municipalities, primarily within the Hospital's primary and secondary service areas, served by the Hospital at present. The municipalities within these primary and secondary service areas include the following:

Primary Service Area:

Avon	Hartford	Simsbury
Bloomfield	Manchester	South Windsor
Bolton	New Britain	West Hartford
East Hartford	Newington	Wethersfield
Farmington	Rocky Hill	Windsor
Glastonbury		

Secondary Service Area:

Andover	Enfield	Portland
Barkhamsted	Franklin	Preston
Berlin	Granby	Salem
Bozrah	Haddam	Somers
Bristol	Hartland	Southington
Burlington	Harwinton	Stafford
Canton	Hebron	Suffield
Colchester	Lebanon	Tolland
Columbia	Mansfield	Torrington
Coventry	Marlborough	Union
Cromwell	Meriden	Vernon
East Granby	Middlefield	Wallingford
East Haddam	Middletown	Winchester
East Hampton	New Hartford	Windham
East Windsor	Norwich	Windsor Locks
Ellington	Plainville	

h. Estimated starting date for the project: November 16, 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				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $2,989,000

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

Major Medical Equipment Purchases*	$1,650,000
Medical Equipment Purchases*	$ 89,000
Non-Medical Equipment Purchases*	$ 20,000
Land/Building Purchases	
Construction/Renovation	$1,205,000
Other (Non-Construction) Specify: furniture and furnishings	$ 25,000
Total Capital Expenditure	**$2,989,000**
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**$2,989,000**
Total Project Cost	**$2,989,000**
Capitalized Financing Costs (Informational Purpose Only)	$ 0

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.
Response: Major medical equipment consists of a Siemens Artis Zeego c-arm system. Medical equipment includes an additional set of monitors, an injector and a two-monitor PACS Setup. Non-medical equipment consists of fixed storage cabinets.

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

Response: Not applicable

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

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

☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).
Response: Questions # 1 and # 2 are not applicable.

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
C-Arm System	Siemens	Artis Zeego	1	$1,650,000

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.

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?

Project Description

This is a proposal for the acquisition and installation of vascular imaging (angiography) equipment in an existing Hartford Hospital operation room on the fourth floor of the CORE Building. The discipline of vascular surgery is undergoing a dramatic shift – more and more procedures are being performed using radiologic, image-guided, catheter-based technology, which is performed in conjunction with open operative surgical techniques. These hybrid endovascular/surgical procedures are less invasive and associated with more rapid patient recovery. The installation of that equipment and the associated renovations to the room will make it more suitable for vascular surgical procedures that are currently being performed in the Hospital's cardiac catheterization laboratory on the second floor of the High Building. This new equipment will provide improved imaging quality, and will allow for the incorporation of other imaging modalities such as 3D reconstructions and intravascular ultrasound exams. These new techniques are most safely performed in an operating room environment with full digital imaging capabilities. Current portable equipment available for use in the operating room provides insufficient anatomic image resolution to perform the most advanced procedures. Hartford Hospital has pioneered the development of advanced endovascular procedures such as aortic stent grafting for the treatment of abdominal aortic aneurysm. The Hartford Hospital medical staff includes several individuals who possess the advanced skill set required to perform these complex cases.

With regard to the numbered questions, our responses appear below.

1. List the types of services that are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.
   Response: Hartford Hospital provides such endovascular surgical procedures as aortic stent grafting for aneurismal disease as well as stent grafting for aneurysms of the iliac, popliteal and other visceral arteries. In addition to aneurysms, the Hartford Hospital endovascular surgeons use minimally invasive techniques to treat occlusive disease to the peripheral circulation as well as performing catheter based procedures to treat diseases of the visceral arteries including the renal and mesenteric circulation.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.
   Response: While the same services are being proposed in a new setting, and no new patient population will be treated, the new equipment in the operating room will allow greater complexity of endovascular interventions. Newer vascular devices require installation in an operating room setting and need the enhanced imaging capabilities of fixed digital fluoroscopic equipment. The portable equipment lacks the required resolution of the newer procedures. Because these procedures are currently being performed at the Hospital, no new licensure categories are being sought as part of this proposal.

3. Identify the current population served and the target population to be served.
   Response: The current population consists mainly of patients with peripheral vascular disease (PVD). This project would not change that patient population. The new approaches to PVD have resulted in a dramatic increase in patient safety. Patients with PVD have many co-morbid conditions and are at high risk for complications, especially cardiac problems. The diminished invasiveness of the minimally invasive, catheter-based endovascular procedures has been associated with fewer peri-operative deaths and complications and shorter hospital length of stay.

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

Response: At present, there is not one place where the entire breadth of endovascular surgery procedures can be provided, and this room will provide such a place. These procedures include endovascular aneurysm repair, and treatment of occlusive disease of the peripheral arterial tree. In addition to that unmet need, this project is based on the continuing need to assure the delivery of the highest quality services to the Hospital's patients.

5. Are there any similar existing service providers in the proposed geographic area?
   Response: Although other hospitals in the region provide endovascular services for PVD, there are no state-of-the-art endovascular operating rooms with high-quality, fixed digital imaging equipment in the state of Connecticut.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   Response: This proposal will ensure that vascular surgery patients in Connecticut can be treated with minimally invasive techniques in an operating room environment, by surgeons who have access to the most efficient, state-of-the-art imaging equipment available.

7. Who will be responsible for providing the service?
   Response: Hartford Hospital and the surgeons of Connecticut Surgical Group will continue to 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?
   Response: Hartford Hospital's existing payers, which would not be changed by this proposal, include Medicare, Medicaid, Anthem Blue Cross, Aetna, and Connecticare.

AFFIDAVIT

To be completed by each Applicant

Applicant: Hartford Hospital

Project Title: Establish Endovascular Surgical Operating Room

I, Thomas Marchozzi, (Name) Chief Financial Officer (Position – CEO or CFO)

of Hartford 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 Hartford Hospital complies with the appropriate and (Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486

and/or 4-181 of the Connecticut General Statutes.

Signature 3/12/09 Date

Subscribed and sworn to before me on March 12, 2009

Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2012

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 31, 2009

J. Kevin Kinsella
Vice President
Hartford Hospital
80 Seymour Street
Hartford, CT 06102-0729

Re: Letter of Intent, Docket Number 09-31340
Hartford Hospital
Proposal to Establish an Endovascular Surgical Operating Room and Acquire and Operate a C-Arm Angiography System

Dear Mr. Kinsella ,

On March 23, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hartford Hospital ("Applicant") for the proposal to establish an Endovascular Surgical Operating Room and acquire and operate a C-Arm Angiography System in Hartford, at a total capital expenditure of $2,989,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hartford Courant* 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
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 31, 2009

Requisition # HCA09-126
Email: Publicnotices@courant.com

Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, April 4, 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 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

Hartford Courant
Docket Number 09-31340

Letter of Intent
March 31, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Hartford Hospital
Town:	Hartford
Docket Number:	08-31340-LOI
Proposal:	Proposal to Establish an Endovascular Surgical Operating Room and Acquire and Operate a C-Arm Angiography System
Capital Expenditure:	$2,989,000

The Applicant may file its Certificate of Need application between May 22, 2009 and July 21, 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: Tuesday, March 31, 2009 11:57 AM

----IMAef83d46.49d2/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.

----IMAef83d46.49d2/pop.state.ct.us
Content-Type: message/delivery-status

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

----IMAef83d46.49d2/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 AD440780; Tue, 31 Mar 2009 11:56:52 -0400
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Tue, 31 Mar 2009 12:06:07 -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 09-31340
Date: Tue, 31 Mar 2009 11:54:59 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD52F@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31340
Thread-Index: AcmyGQu30mwsgwPOSH2zG5VM5U931w==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: publicnotices@courant.com
X-WSS-ID: 65CCE0E42CC329124-06-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C9B219.0BABA37F"

----IMAef83d46.49d2/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 1, 2009

J. Kevin Kinsella, Vice President
Hartford Hospital
80 Seymour St.
Hartford, CT 06102-0729

RE: Certificate of Need Application Forms; Docket Number: 09-31340-CON
Hartford Hospital
Proposal to Establish an Endovascular Surgical Operating Room and
Acquire and Operate a C-Arm Angiography System

Dear Mr. Kinsella:

Enclosed are the application forms for Hartford Hospital's Certificate of Need ("CON") proposal seeking to establish an endovascular surgical operating room and acquire and operate a C-arm angiography system at a total capital expenditure of $2,989,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between May 22, 2009, and July 21, 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 four (4) 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 contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Director of Operations

Enclosure

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 an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than May 22, 2009, and may be submitted no later than July 21, 2009. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number:	09-31340-CON
Applicant Name:	Hartford Hospital
Contact Person:	Kevin Kinsella
Contact Title:	Vice President
Contact Address:	Hartford Hospital 80 Seymour St. Hartford, CT 06102 0729
Project Location:	Hartford
Project Name:	Proposal to Acquire and Operate a C-Arm Angiography System and Establish an Endovascular Surgical Operating Room
Proposal Type:	Section 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$2,989,000

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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ 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)

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

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 is a need to acquire a new C-arm angiography system.

B. Has the Hospital conducted a need assessment for the proposed system? If so, please provide a copy of the assessment. If a need assessment has not been conducted, explain why this is the case.

C. With respect to existing mobile or fixed C-arm systems, please identify the dates of acquisition, current age and condition of each system and the reason for Hospital acquisition.

D. Provide a list of the primary and secondary service area towns for the proposed service.

E. Provide a rationale for choosing the selected towns.

F. Describe the population to be served by the proposed fixed C-arm system in an operating room setting (i.e. conditions, diseases, etc.).

G. Are there any scheduling backlogs in the proposed service area for services provided by the operating room C-arm system?

H. Provide the travel distance from the Hospital to service area towns.

I. Provide the weekly hours of operation of existing C-arm systems and the proposed operating room C-arm system.

J. Please provide the C-arm system's actual procedure volume by system and the projected procedure volume by system as presented in the following format:

	Actual Procedures Volume (Last 3 Completed FYs)			CFY Volume*	Projected Procedures Volume (First 3 Full Operational FYs)**		
	FY____	FY____	FY____	FY____	FY____	FY____	FY____
Mobile System						-	-
Other Systems							
Fixed System	-	-	-	-			
Total Procedures							

Notes:*Please report the annualized number of procedures for the current fiscal year, identifying the respective number of months of recorded activity in your response.
**If the first year of operation of the proposed system is only a partial year, the Hospital must provide the first partial year and then the first three full FYs. Include all derivations and/or calculations.

K. Provide the service volume in procedures for the first three years of operation of the proposed system *by disease type*. **Include all assumptions used in the derivation/calculation of your projections.**

L. Provide the information as outlined in the following table concerning the existing providers' current operations within the Applicant's primary and secondary service area:

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

[1] If proposal concerns imaging equipment, 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] Number of procedures performed on specified system by Provider for the most recent 12 month period, if known.

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

N. 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.

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

☐ Epidemiological studies ☐ Public information reports

☐ Market share analysis ☐ Other (Identify) _____

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

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology
☐ National Committee for Quality Assurance
☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers
☐ American College of Obstetricians & Gynecologists
☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology
☐ American College of Radiology
☐ Substance Abuse Society 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 Applicant'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
- ☐ 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 related sections of the Quality Assurance plan to the proposal and the corresponding sections of the latest annual evaluation report of the Hospital's Quality Assurance 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
- ☐ 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 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.

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[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. Does the Hospital have Tax Exempt Status? ☐ Yes ☐ No

C. 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 CON 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)	$
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.

11. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

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

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

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

E. Provide the following information regarding the building schedule for the project:

Commencement Date	
Completion Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

For capital equipment purchase/lease, address 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.

13. 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.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

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

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

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

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

vi) Describe how the proposal is cost effective.

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.

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

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*** TX REPORT ***
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TRANSMISSION OK

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PAGES SENT	16
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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: J. KEVIN KINSELLA

FAX: (860) 545-4193

AGENCY: HARTFORD HOSPITAL

FROM: JACK HUBER

DATE: 4-1-2009 **Time:** ~3:00 pm

NUMBER OF PAGES: 16
(including transmittal sheet)

Comments: Transmitted: CON Materials for Endovascular Surgical Operating Room & C-Arm Equipment Acquisition Proposal

PLEASE PHONE Jack A. Huber at (860) 418-7034
IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Wednesday, April 01, 2009 12:17 PM
To: Greer, Leslie
Subject: RE: statewide 4/3 - Legal Ad 09-31340

Leslie,
This notice is all set for tomorrow for a total of $210.58. Ad# 2284647

NOTICE

Statute Reference: 19a-639
Applicant: Hartford Hospital
Town: Hartford
Docket Number: 08-31340-LOI
Proposal: Proposal to Establish an Endovascular Surgical Operating Room and Acquire and Operate a C-Arm Angiography System
Capital Expenditure: $2,989,000

The Applicant may file its Certificate of Need application between May 22, 2009 and July 21, 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.

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Tuesday, March 31, 2009 11:55 AM
To: publicnotices@courant.com
Subject: statewide 4/3 - Legal Ad 09-31340

Legal Ad,
Please post the attached public notice in your newspaper by April 4, 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