SHIPMAN & GOODWIN LLP
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

August 28, 2009

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

Re: Letter of Intent For Affiliation of Central Connecticut Health Alliance with Hartford HealthCare Corporation

Dear Commissioner Vogel:

On behalf of the applicants in the above referenced matter, enclosed please find a completed Letter of Intent regarding the affiliation of Central Connecticut Health Alliance ("CCHA") with Hartford HealthCare Corporation ("HHCC"). In the forthcoming Certificate of Need, CCHA, the parent organization of the Hospital of Central Connecticut, and HHCC, the parent corporation of Hartford Hospital, MidState Hospital, Windham Hospital and Natchaug Hospital, will request the Office of Health Care Access's approval for HHCC to become the sole corporate member of CCHA. This proposal does not involve the addition or termination of services, or a change in the service areas of either applicant.

Thank you in advance for your assistance and prompt attention to this matter. If you have any further questions about the matter, please do not hesitate to contact me.

Sincerely,

Joan W. Feldman

Enc.

Cc: Claudio Capone
Kevin Kinsella

1215971v1

SHIPMAN & GOODWIN LLP.
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

August 28, 2009

HAND DELIVERY
The Honorable Cristine Vogel
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: AFFILIATION OF CENTRAL CONNECTICUT HEALTH ALLIANCE WITH HARTFORD HEALTHCARE CORPORATION

Dear Commissioner Vogel:

Enclosed please find the Notice of Appearance form regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Enclosure

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER RE: Affiliation of Central Connecticut Health Alliance with Hartford HealthCare Corporation	: : : :	August 28, 2009

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of the applicants in the above referenced matter.

Respectfully Submitted,

Central Connecticut Health Alliance and Hartford HealthCare Corporation

By: 

Joan W. Feldman
jfeldman@goodwin.com
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5311
Its Attorney

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	Central Connecticut Health Alliance, Inc.	Hartford HealthCare Corporation
Doing Business As	Central Connecticut Health Alliance	Hartford HealthCare Corporation
Name of Parent Corporation	Central Connecticut Health Alliance	Hartford HealthCare Corporation
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	100 Grand Street New Britain, CT 06052	80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	NP
Does the Applicant have Tax Exempt Status?	Yes	Yes
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Claudio Capone Director, Strategic Business Planning	Kevin Kinsella Vice President
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	100 Grand Street New Britain, CT 06050	80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037
Contact Person Telephone Number	860.224.5279	860.545.4155
Contact Person Fax Number	860.224.5740	860.545.3600
Contact Person e-mail Address	ccapone@thocc.org	kkinsel@harthosp.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Affiliation of Central Connecticut Health Alliance ("CCHA") with Hartford HealthCare Corporation ("HHCC")

b. Project Proposal: HHCC will become the sole corporate member of CCHA

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:

100 Grand Street, New Britain, CT 06050

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

There will be no limitation in the towns serviced by the CCHA system. It will continue to serve residents of Berlin, New Britain, Plainville, Southington, Bristol, Burlington, Cheshire, Cromwell, Farmington, Meriden, Newington and West Hartford, as well as the residents of other towns who seek services at CCHA.

h. Estimated starting date for the project: Upon approval by OHCA, CCHA will file an amended and restated Certificate of Incorporation with HHCC as its sole corporate member.

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: $ 0

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$0**
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	**$0**
Total Project Cost	**$0**
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating 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
N/A				

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)* N/A

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.

SEE ATTACHMENT A

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: Central Connecticut Health Alliance

Project Title: Affiliation of Central Connecticut Health Alliance with Hartford HealthCare Corporation

I, Laurence A. Tanner (Name), President and CEO (Position – CEO or CFO)

of Central Connecticut Health Alliance 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 Central Connecticut Health Alliance (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.

Signature

8/28/09
Date

Subscribed and sworn to before me on August 28, 2009

Joyce M. Hawrylik
Notary Public/Commissioner of Superior Court

JOYCE M. HAWRYLIK
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2009

My commission expires:

AFFIDAVIT

To be completed by each Applicant

Applicant: Hartford HealthCare Corporation

Project Title: Affiliation of Central Connecticut Health Alliance with Hartford HealthCare Corporation

I, Elliot Joseph (Name), President and CEO (Position – CEO or CFO)

of Hartford HealthCare Corporation 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 HealthCare Corporation (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.

Elliot Joseph
Signature

8/26/09
Date

Subscribed and sworn to before me on August 26, 2009

Diana Nino
Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2012

ATTACHMENT A

Project Description

CCHA, the parent organization of the Hospital of Central Connecticut, and HHCC, the parent corporation of Hartford Hospital, MidState Hospital, Windham Hospital and Natchaug Hospital, are requesting OHCA's approval for HHCC to become the sole corporate member of CCHA. The Proposal does not involve the addition or termination of services, or a change in the service areas of either Applicant. Rather, the Proposal concerns the affiliation of two health care systems for the purpose of improving services, containing costs, and sustaining their viability in what has become an increasingly demanding economic and regulatory environment. The following summary describes the historical relationship between the Applicants, the demands they currently face, and the objectives for the proposed affiliation:

Historical Relationship. Over the past several decades, the Hospital of Central Connecticut and Hartford Hospital have collaborated on several projects to address the health care needs of the community and find solutions to regional health care problems. For example, Hartford Hospital currently provides cardiac surgery backup for the Hospital of Central Connecticut's primary angioplasty program, and the hospitals jointly employ several ob/gyns, have partnered on genetic research, and share a commitment and spirit of collaboration on graduate education issues. The success of these programs is due, in part, to the positive working relationship between the past and present leadership of the two hospitals and a shared commitment to the delivery of quality health care. Given this shared commitment and compatible operating cultures, both CCHA and HHCC are confident that the proposed affiliation will yield enormous benefits for their respective communities.

Demands Currently Faced. While all hospitals face challenges in this complex economic and regulatory environment, CCHA and HHCC both recognize the following:

1. Consumers are rightfully demanding more for less, or more specifically, demonstrated value through higher quality at lower costs;

2. The physical plant and infrastructure of both hospitals are aging and will require significant capital investment;

3. Clinical technologies are advancing at a rapid pace and also require significant capital investment;

4. Information technology is evolving rapidly and will require significant capital investment;

5. Health care reform on a national level is impending and unquestionably will require more cost-effective delivery systems;

6. There is an increasing demand to service the uninsured and underinsured without additional funding;

7. Nurse and physician recruitment to the region has become more challenging and expensive; and

8. Greater operating efficiencies will be essential as the economic and regulatory environment becomes more complex.

Objectives for Proposed Affiliation. The proposed affiliation is focused on creating a strong and organized integrated health care delivery system capable of delivering high quality and coordinated care for the benefit of the communities served by the Applicants, while containing costs to the maximum extent possible. The Applicants, as stated, share a mutual commitment to offer expanded geographic coverage, a full continuum of care, strong local primary and secondary care services, the highest standards of clinical care, enhanced patient access, including for underserved populations, and the most advanced technologies. The proposed affiliation will further enhance the Applicants' abilities to support their missions, identity and respective community roles. Through integration and planning to meet the changing needs of the region, including responsible decision making and appropriate sharing of services, resources and technologies, the Applicants expect to achieve certain economies of scale that will benefit the communities they serve. Further direct benefits, to name a few, will include additional opportunities for clinical research, teaching, implementation of quality initiatives, including shared best practices, volume purchasing, consolidation of certain administrative services, opportunities for sharing of expensive technologies, spreading of risk, recruitment of world-class medical talent and the ability to effectively share executive management expertise across systems.

Supplemental Information:

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.**

   CCHA is not proposing any changes in the licensed services provided by the Hospital of Central Connecticut and its affiliates in this application.

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

   See Project Description above. No change in the licensed services offered by CCHA is proposed in this application. No new DPH licensure categories are being sought.

3. **Identify the current population served and who is the target population to be served.**

CCHA currently serves approximately 420,000 residents from the following towns: New Britain, Berlin, Newington, Southington, Farmington, Burlington, Bristol, Cromwell, West Hartford, Meriden and Cheshire. The target population will remain the same with this proposal, although the combined system anticipates serving residents of a broader area.

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

   See Project Description above. The Applicants believe that the proposed affiliation will allow for the continued sustainability of CCHA and its affiliates as well as introduce the benefits from HHCC's access to capital, technology, quality initiatives and operating efficiencies.

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

   The residents of the service area are also served by numerous other hospitals.

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

   This Proposal will improve the delivery of health care in central Connecticut as a result of improving CCHA's access to technology, capital, operating efficiencies, and standards of care. The anticipated effect of this Proposal on the health care delivery system in the State is consequently only positive.

7. **Who will be responsible for providing the service?**

   The responsibility for providing all services will remain unchanged.

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

   This Proposal will not have an effect on the current payers. CCHA and HHCC contracts with all major payers including Medicare and Medicaid and will continue to do so in the interest of assuring access to care for all within the community.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 11, 2009

via fax and email only

Claudio Capone
Director, Strategic Business Planning
Central Connecticut Health Alliance
100 Grand Street
New Britain, CT 06052

Kevin Kinsella
Vice President
Hartford Healthcare Corporation
80 Seymour Street
P.O. Box 5037
Hartford, CT 06102

RE: Certificate of Need Application Forms, Docket Number 09-31441-CON
Central Connecticut Health Alliance and Hartford Healthcare Corporation
Affiliation of Central Connecticut Health Alliance and Hartford Healthcare Corporation

Dear Mr. Capone and Mr. Kinsella:

Enclosed are the application forms for Central Connecticut Health Alliance and Hartford Healthcare Corporation's Certificate of Need ("CON") proposal for the affiliation of Central Connecticut Health Alliance and Hartford Healthcare Corporation with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between ***October 27, 2009, and December 26, 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 documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analysts assigned to the CON application are Ronald Ciesones and Steven W. Lazarus. Please contact them at (860) 418-7001 if you have questions.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Enclosures

HO:rc

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: _____

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: _____

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 ***October 27, 2009, and may be submitted no later than December 26, 2009***. The Analysts assigned to your application are Ronald Ciesones and Steven Lazarus and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31441-CON	
Applicants Name:	Central CT Health Alliance	Hartford HealhtCare Corporation
Contact Person:	Claudio Capone	Kevin Kinsella
Contact Title:	Director, Strategic Business Planning	Vice President
Contact Address:	100 Grand Street New Britain, CT 06050	80 Seymour Street P.O. Box 5037 Hartford, CT 06102
Project Location:	New Britain, CT	
Project Name:	Affiliation of Central Connecticut Health Alliance with Hartford Healthcare Corporation	
Type proposal:	Section 19a-638, C.G.S.	
Est. Capital Expenditure:	$ 0	

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.

e. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.

f. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

g. List all existing providers (name, address, services provided) of the services involved in this proposal in the towns served by the facility changing ownership or control, and in nearby towns.

h. Describe the effect of this proposal on existing providers.

i. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:

   i. Legal chart of corporate or entity structure including all affiliates.
   ii. List of owners and the % ownership and shares of each.

j. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

2. **Actual and Projected Volume**

a. Provide volumes for the most recently completed FY by town.

b. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for the facility/services changing ownership or control.

Table 1: Historical, Current, and Projected Volume

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Service***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service separately and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

3. **Quality Measures**

a. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

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

4. Organizational and Financial Information

a. Identify the Applicants' ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Do the Applicants have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicants and indicate any additional licensure categories being sought in relation to the proposal.

d. Please explain what will happen to Central Connecticut Health Alliance's license after the proposed affiliation/merger.

e. Financial Statements

i) If the Applicant is a Connecticut hospital: 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 hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii) If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

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 (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

g. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Patient Population Projections

a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for each Applicant.

Table 3: Patient Population Mix

	Current FY **	Year 1 FY **	Year 2 FY **	Year 3 FY **
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

6. Financial Attachments I

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

c. Provide the assumptions utilized in developing **Financial Attachments I** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Identify the entity that will be billing for the proposed service(s).

e. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

g. Describe how this proposal is cost effective.

h. Describe detail, cost savings that will result as a direct result of the proposed affiliation/merger for each of the Applicant involved. Provide specific examples and supporting documentation.

7. Other Review Criteria

a. Describe the proposal's relationship to each of the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

Financial Attachment I

Hartford HealthCare Corporation

Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

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

Financial Attachment I

Central Connecticut Health Alliance

Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

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

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

TRANSMISSION OK

TX/RX NO	0586
RECIPIENT ADDRESS	92245740
DESTINATION ID	
ST. TIME	09/11 11:34
TIME USE	02'43
PAGES SENT	13
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: CLAUDIO CAPONE

FAX: (860) 224-5740

AGENCY: CENTRAL CONNECTICUT HEALTH ALLIANCE, INC.

FROM: STEVEN LAZARUS

DATE: 9/11/09 **TIME:**

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Docket 09-31441 CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

TRANSMISSION OK

TX/RX NO	0588
RECIPIENT ADDRESS	95454193
DESTINATION ID	
ST. TIME	09/11 12:02
TIME USE	01'51
PAGES SENT	13
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KEVIN KINSELLA

FAX: (860) 545-4193

AGENCY: HARTFORD HEALTHCARE CORPORATION

FROM: STEVEN LAZARUS

DATE: 9/11/09 **TIME:**

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Docket 09-31441 CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 11, 2009

Claudia Capone
Director , Strategic Business Planning
Central Connecticut Health Alliance, Inc.
100 Grand Street
New Britain, CT 06052

Kevin Kinsella
Vice President
Hartford HealthCare Corporation
80 Seymour Street, P.O. Box 5037
Hartford, CT 06102-5037

Re: Letter of Intent, Docket Number 09-31441
Central Connecticut Health Alliance and Hartford HealthCare Corporation
Affiliation of Central Connecticut Health Alliance and Hartford HealthCare Corporation

Dear Gentlemen,

On August 28, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Central Connecticut Health Alliance and Hartford HealthCare Corporation ("Applicants") for the affiliation of Central Connecticut Health Alliance and Hartford HealthCare Corporation in Hartford, with no capital expenditure.

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

September 11, 2009

Requisition # HCA010-017
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 **Tuesday, September 15, 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 Steven Lazarus or Ronald Ciesones at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:RC:lmg

c: Marie Dempsey, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Central Connecticut Health Alliance & Hartford HealthCare Corporation
Town:	Hartford
Docket Number:	09-31441-LOI
Proposal:	Affiliation of Central Connecticut Health Alliance and Hartford HealthCare Corporation
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between October 27, 2009 and December 26, 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, September 11, 2009 4:13 PM
To: Undisclosed recipients

----IMA5acaf54.4aaa/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.

----IMA5acaf54.4aaa/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

----IMA5acaf54.4aaa/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 AF520A00; Fri, 11 Sep 2009 16:13:06 -0400
Received: from [159.247.77.53] by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.3.2)); Fri, 11 Sep 2009 16:09:42 -0400
X-Server-Uuid: 89BF447C-F78F-4C06-BC72-B858FE7D13AC
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 09-31441
Date: Fri, 11 Sep 2009 16:08:24 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD9E7@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach:
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31441
Thread-Index: AcozG54cSiGyLTMGQPGq6QHmL46anA==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: publicnotices@courant.com
X-WSS-ID: 66B4710C40W620286-04-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01CA331B.9E459D04"

----IMA5acaf54.4aaa/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 11, 2009

Requisition # HCA010-018
Fax: 225-2611

The Herald
One Herald Square
New Britain, CT 06050

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, September 15, 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 Steven Lazarus or Ronald Ciesones at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:RC:lmg

c: Marie Dempsey, OHCA

The Herald
Docket Number 09-31441

Letter of Intent
September 11, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Central Connecticut Health Alliance and Hartford HealthCare Corporation
Town:	Hartford
Docket Number:	09-31441-LOI
Proposal:	Affiliation of Central Connecticut Health Alliance and Hartford HealthCare Corporation
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between October 27, 2009 and December 26, 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.

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

TRANSMISSION OK

TX/RX NO	0611
RECIPIENT ADDRESS	92252611
DESTINATION ID	
ST. TIME	09/11 16:18
TIME USE	00'44
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 11, 2009

Requisition # HCA010-018
Fax: 225-2611

The Herald
One Herald Square
New Britain, CT 06050

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, September 15, 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 Steven Lazarus or Ronald Ciesones at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone