HARTFORD HOSPITAL
Great Doctors Are Just The Beginning

80 SEYMOUR STREET
P.O. BOX 5037
HARTFORD, CT 06102-5037
860/545-5000

RECEIVED
2006 JUN 16 PM 2:41
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

16 June 2006

The Honorable Cristine 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 a completed Letter of Intent for a forthcoming Certificate-of-Need application for our proposal to acquire a linear accelerator and a simulator and the establishment of a satellite radiation oncology center to serve Hartford Hospital's patients in the Farmington Valley. 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 us if you have any questions about this matter. Thank you.

Sincerely,

J. Bryan Simmons
Vice President for Planning
and Facilities Development

JBS/km

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

RECEIVED
2006 JUN 16 PM 3:31
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form 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 there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Hartford Hospital	
Doing Business As		
Name of Parent Corporation	Hartford Health Care Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	J. Bryan Simmons, Vice President for Planning and Facilities Development	
Contact person's street mailing address	80 Seymour Street Hartford, CT 06102-5037	
Contact person's phone #, fax # and e-mail address	860 / 545-2232 phone 860 / 545-3600 fax bsimmon@harthosp.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Radiation Oncology Center.

b. Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☐ Replacement ☒ Additional (F, S, Fnc)

☒ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than $ 1,000,000

☒ Equipment Acquisition greater than $ 400,000

☒ New ☐ Replacement ☐ Major Medical

☐ Imaging ☒ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address): The proposal would be located within the Town of Avon. The specific street address has not been finalized, but will be in time for the submission of the CON application.

d. List all the municipalities this project is intended to serve. The Center's Primary Service Area will consist of the towns of Avon, Bristol, Burlington, Canton, Farmington, Harwinton, New Britain, Plainville, Plymouth and Simsbury. The Secondary Service Area will consist of Barkhamsted, Bloomfield, East Granby, Granby, Hartford, Hartland, New Hartford, Southington, Torrington, West Hartford, Windsor, Windsor Locks, Winchester and Wolcott.

e. Estimated starting date for the project: 15 July 2008 is the projected start date for the provision of care for patients.

f. Type of project: **13** **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ 3,314,562

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$
Medical Equipment (Purchase)	$ 2,630,781
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	$ 683,781
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$ 3,314,562**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$ 3,314,562**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Linear Accelerator		TBD	1	$ 2,205,634
Simulator		TBD	1	$ 100,000

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

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

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☒ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that _____ 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 Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Project Description:

This is a proposal to meet the increasing need and demand for Hartford Hospital's radiation oncology services, and to improve accessibility to these services, by establishing a satellite radiation oncology center to serve Hartford Hospital's patients in the Farmington Valley. The project involves the acquisition of a linear accelerator and a simulator required for state-of-the-art radiation oncology services, and the installation of this equipment within leased facility space in the Town of Avon.

By means of further explanation, Hartford Hospital's Radiation Oncology Department has experienced growth in its patient care visits over the past several years. The department utilizes three linear accelerators, and the average annual utilization of each is approximately 7,000 patient visits per accelerator. This exceeds the generally accepted 6,000 patient visit standard for linear accelerator capacity. Thus, apart from future growth in the patient population and growth in the number of needed patient treatments, there is a need for additional linear accelerator capacity to accommodate present patient care demand. In addition, information from both the National Cancer Institute and the American Cancer Society suggests that, due to the aging of the population, the total number of patients who will develop cancer annually will double over the next twenty years. It is quite clear, given the Hospital's historic growth rate of three to four percent per year, that a fourth linear accelerator is now needed for Hartford Hospital's present and projected patient visits.

With regard to the best location for this additional unit, the Hospital has noted the trend toward the distribution of radiation oncology facilities to communities in which patients reside, in the interest of improving patient care access. Hartford Hospital and physicians with the Hospital currently manage two such centers in Connecticut: one in Enfield and one in Manchester, through the Northeast Regional Radiation Oncology Network (NRRON); and this initiative has been successful in improving access to technology and expertise for the patient population that suffers from cancer from eastern and northern Connecticut.

There is a similar opportunity to improve access for the patient population residing in the Farmington Valley that seeks care at Hartford Hospital. The growth of population in towns northwest of Hartford and increasing difficulty with traffic over the highways into Hartford have impeded access for Hartford Hospital radiation oncology outpatients.

Thus, the combination of four factors, 1) a large and growing population in need of cancer care that historically has traveled to Hartford, 2) the capacity limitations inherent to the existing three linear accelerators on the Hospital's main campus and the need to expand capacity to meet the needs of the population, 3) the ability, demonstrated by the NRRON project, to successfully improve access to a population in need, by distributing radiation oncology services to facilities within the communities in which the population resides, and 4) the increasing difficulties with access resulting from population growth and associated traffic congestion, all suggest that Hartford Hospital should locate its fourth linear accelerator in the Farmington Valley. The forthcoming CON application therefore involves the proposed development of a radiation oncology facility in Avon.

Hartford Hospital has been a leader in the provision of care for cancer patients over the last several decades. The Hospital was the first to provide megavoltage radiation therapy in the

state in 1955 with the establishment of a cobalt treatment facility. The Hospital one of the first to have a geographic multidisciplinary cancer center when, in 1975, it completed the Heublein Center, featuring two linear accelerators and the physical adjacency of Medical Oncology and Radiation Oncology. The Helen & Harry Gray Cancer Center was completed in 1990, including the addition of a third linear accelerator and the expansion of space for both Medical and Radiation Oncology and the establishment of space for Gynecologic Oncology, Psycho-Oncology, Nutritional Services, Pastoral Care Services, Social Services, and other support services for patients. Over the years, the Hospital has pioneered the development of new technologies within the region, including Intensity Modulated Radiation Therapy, High Dose Rate Brachytherapy, and many other modalities. In addition, we have actively participated in Cancer Clinical Research Trials related to prevention, early detection, treatment, support, and quality of life.

This proposal thus represents a continuation of a distinguished history of providing exemplary care, addressing the growing needs for treatment of the population, and doing so in a manner that will improve accessibility and therefore quality.

Responses to numbered questions:

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
   Response: Currently, radiation therapy services are provided at the Hospital's main campus. These services would continue there as well as in the proposed new location in Avon.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
   Response: The same types of radiation therapy services currently offered in Hartford are being proposed for this location. No new license would be sought since the services are already being provided in Hartford.

3. Who is the current population served and who is the target population to be served?
   Response: The current population consists of cancer patients from the towns listed in our response to Question # II d, as does the target population. These patients would normally receive their care at our main campus in Hartford, but the proposed facility will provide them with more proximal access to that care.

4. Identify any unmet need and how this project will fulfill that need.
   Response: The unmet need upon which this project is based on existing and projected limitations in the capacity of existing facilities and equipment at Hartford Hospital and the need to improve access to cancer care services in the Farmington Valley, as discussed at length above. This project would address both issues by expanding capacity in a location that is nearer to the population that requires care.

5. Are there any similar existing service providers in the proposed geographic area?
   Response: Other hospitals, in addition to Hartford Hospital, provide Radiation Therapy services, including New Britain General Hospital, John Dempsey Hospital, and St. Francis Hospital and Medical Center.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?
   Response: This proposal is anticipated to improve the health care delivery system in the State by assuring that there is sufficient radiation oncology capacity in the future to treat Hartford Hospital patients who need this care, and also by improving access to the population in need by locating services in closer proximity to their homes.

7. Who will be responsible for providing the service?
   Response: Hartford Hospital will continue to be responsible for providing facility and technical components of the radiation oncology services, and Hartford Hospital's Radiation Oncologists will provide professional services.

8. Who are the payers of this service?
   Response: There will be no change in payers of service due to the replacement of this equipment. The Hospital's current payers include Medicare, Medicaid, Anthem Blue Cross, Aetna, and Connecticare.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 20, 2006

J. Bryan Simmons
Vice President for Planning and Facilities Development
Hartford Hospital
80 Seymour Street
Hartford, CT 06102-5037

RE: Certificate of Need Application Forms; Docket Number: 06-30769-CON
Hartford Hospital
Establish a Satellite Radiation Oncology Center in Avon

Dear Mr. Simmons:

Enclosed are the application forms for Hartford Hospital's Certificate of Need ("CON") proposal for the establishment of a satellite radiation oncology center in Avon with an associated capital expenditure of $3,314,562. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes, the CON application may be filed between August 15, 2006, and October 14, 2006.

When submitting your CON application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The OHCA analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053

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, an answer of "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 15, 2006, and may be submitted no later than October 14, 2006. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access directly by dialing (860) 418-7034.

Docket Number:	06-30769-CON
Applicant Name:	Hartford Hospital
Contact Person:	J. Bryan Simmons
Contact Title:	Vice President, Planning and Facilities Development
Contact Address:	Hartford Hospital 80 Seymour Street Hartford, CT 06102 5037
Project Location:	Avon
Project Name:	Establish a Satellite Radiation Oncology Center in Avon
Proposal Type:	Sections 19a-638 and 19a-639, C.G.S.
Estimated Capital Expenditure:	$3,314,562

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 for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **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 exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	$_____.00
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE:_____	$_____.00

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

1. Expansion of Existing or New Service

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

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

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

i) Provide the following information:

a) Primary and secondary service area towns for Avon and Hartford service sites.

b) The unit of service (i.e. radiation treatments, simulations etc.) for the past three fiscal years by service area town.

c) The population to be served by the proposed satellite including the number of individuals to receive the proposed services. Include demographic information, as appropriate.

d) Scheduling backlogs for radiation therapy services in the primary and secondary service areas.

e) Travel distance from proposed site in Avon to service area towns.

f) Hours of operation of the existing Hartford site.

g) Hours of operation of the proposed Avon site.

ii) Identify the existing providers of the radiation oncology services in your service area.

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

iv) Provide the units of service projected for the first three years of operation of the proposed Avon center and the existing Hartford service site. **Include the derivation/calculation.**

B. 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.

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

- ☐ Epidemiological studies
- ☐ Needs assessments
- ☐ Public information reports
- ☐ Market share analysis
- ☐ Other (Identify) _____
- ☐ None: *explain* why no reports, studies or market share analysis was 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 Society Abuse and Mental Health Services Administration

☐Other: Specify _____

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

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

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

D. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH

☐ JCAHO

☐ Fire Marshall Report

☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC

☐ AAAASF

☐ Other: _____

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

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital, its physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, its physicians working at the Hospital and/or any staff related to the proposal.

G. Provide a copy of the following:

☐ A copy of the related Quality Assurance plan; and

☐ The latest approved Report regarding the services annual Quality Assurance Evaluation.

6. Improvements to Productivity and Containment of Costs

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

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in any change to your teaching or research responsibilities?

☐ Yes ☐ No

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

[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.

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. Please provide a copy of the State of Connecticut, Department of Public Health license currently held.

8. Financial Information

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

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

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

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

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

B. Provide all schematic drawings related to the project that are available, 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 Cost			

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

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

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

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	____ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
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. Land/ Building Purchase

If the CON involves any land/building purchase, please answer all of the following that apply:

Please submit a copy of the Real Estate Property Appraisal.	$_____
What is the useful life of the building?	____ Years
Please submit a schedule of depreciation for the purchased building as an attachment.	

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

13. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	_____
CON Proposed debt financing	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years
Debt service reserve fund	_____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	_____
CON Proposed lease financing	_____
Fair market value of leased assets at lease inception	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

14. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
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. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. 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 refer to the enclosed financial attachment.** 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) 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.).

iii) 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.

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

v) Describe how this proposal is cost effective.

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

Total Hospital Health System: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

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

The Hartford Courant.

A TRIBUNE PUBLISHING COMPANY

RECEIVED
2006 JUL -3 AM 10: 18
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Affidavit of Publication

State of Connecticut

Monday, June 26, 2006

County of Hartford

I, Joy Shroyer, do solemnly swear that I am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.

On dates as follows: 06/24/2006

In the amount of $144.83
ST OF CT OFFICE OF HLTH.ACC HCA07-004
700309
Full Run

LEGAL NOTICE

Statute Reference: 19a-638 & 19a-639
Applicant: Hartford Hospital
Town: Avon
Docket Number: 06-30769-LOI
Proposal: Establish a Satellite Oncology Center in Avon
Total Capital Expenditure: $3,314,562

The Applicant may file its Certificate of Need application between August 15, 2006 and October 14, 2006. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308, Hartford, CT 06134-0308.

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

Financial Operations Assistant
Joy Shroyer

Subscribed and sworn to before me on June 26, 2006

Notary Public

LISA CARDINI
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2011

*36 mo. leases w/$3724 RSX/$3835 TSX/$5684 MDX/$ quisition fee). Limit 10K miles per year (except RSX which is 12K). Lease plus tax,reg. & convey.fee (includes 1st mo. pymt, se grams are subject to credit approval. All Offers expire 6/30/06.

Acura ora of Milford

75 Albany Tpke. • Rte 4 Post Rd. • Exit 39B Off I-95 • Milford

860-693-6981 or 4333 or 800-272-2872

Land Connecticut

ELLINGTON
Lots for Sale in Beautiful Wooded Subdivision. **For Info Call Laurie at 860-742-2223**
****

FARMINGTON - Open Sun. 12-4 ATTN BLDRS! New Bldg lot(s)/ 7.5 ac w/Farmington Valley Views. **Wendy White 967-2058. Coldwell Banker 674-0300**

HADDAM - MUST SEE!
4.1 Acre Secluded Lot. Horse Country, 1.5 miles from Route 9. $170k
(860)345-2044

HEBRON & VICINITY
[redacted]

Land Out of State

MA-Colrain
27 acre woodlot. Abuts snowmobile and mountain biking trails. Hunters, sportsmen and wildlife lovers take note. Not buildable under current zoning. Owner Financing. $45,000 **Cersosimo Industries, Inc. Wayne**
802/257-7076

NC-BEUFORT
GRAND OPENING
NC Deep Waterfront!
New upscale gated waterfront community in prime yet secluded coastal location right off scenic Hwy 17 w/easy I-95 access. Enjoy full service marina w/boat slips & boat ramp along w/white sand beach! Paved roads, water, sewer, more. Excellent financing. Must see!
Call now 1-800-733-5501 x1556

Real Estate Services

BURLINGTON
DISCOVER BURLINGTON
High atop Hartford County.
PARTNERS
REALTY GROUP, LTD
1-800-824-8598
or 675-4855

$ CASH $
We Buy Houses, Land & Apts
860-302-8467

"CAZ" BUYS HOUSES & APTS. Fast Cash! Foreclosure Help! Get "Caz" Live! Call 860-490-3996

Complete Commercial Mortgage Services
All types of programs & financing options including **Loans w/ No Prepay Penalty/ 30-yr fixed. We know the CT Market. Also:** Many properties

Don't
or re
forma
share
write
missi
20580
forma

Disne
shares
Call (8

MEXICO
FOR S
sleeps
beach
year
Gardel
$4,700

Camp
bersh
Inclu
transf

[redacted]

ing this Order or Notice office, immediately [illegible] receipt, in the: Hartf[illegible]nt a newspaper h[illegible]ulation in the tow[illegible]ord, CT.
Hon. [illegible]enberg
[illegible]udge
[illegible]/06

[illegible] to Counsel: [illegible] inability to pay fo[illegible], the court will provide [illegible]or you at court expense. [illegible] such request should be [illegible]ade immediately at the court office where your hearing is to be held.

SIMSBURY

TOWN OF SIMSBURY PUBLIC HEARING NOTICE

The Board of Selectmen will hold a public hearing on June 30th at 8:00 a.m. in the Main Meeting Room of the Simsbury Town Offices. The purpose of the hearing is to receive public comment concerning programs to be submitted to the Department of Revenue Services for funding through the Neighborhood Assistance Act. This public hearing is required by C.G.S. 12-632.

HARTFORD

CITY OF HARTFORD REQUEST FOR PROPOSAL

Interested in **providing preschool state-funded services to Hartford three and four year olds?**
Contact the **Mayor's Office for Young Children at (860) 543-8528."**

BARKHAMSTED

NOTICE TO TAXPAYERS TOWN OF BARKHAMSTED
Notice is hereby given to the taxpayers of the Town of Barkhamsted, Connecticut that the first installment of property taxes on the Grand List of October 1, 2005 in excess of $100.00 will become due and payable in two installments; the first on July 1, 2006 and the second on January 1, 2007. If the first installment is not paid on or before August 1, 2006, the tax becomes delinquent. Taxes in the amount of $100.00 or less and motor vehicles taxes also become due

LEGAL NOTICE

Statute Reference:
19a-638 & 19a-639
Applicant: Hartford Hospital
Town: Avon
Docket Number: 06-30769-LOI
Proposal: Establish a Satellite Oncology Center in Avon
Total Capital Expenditure: $3,314,562

The Applicant may file its Certificate of Need application between August 15, 2006 and October 14, 2006. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308, Hartford, CT 06134-0308.

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

STATE OF CONNEC[illegible]
SUPERIOR CO[illegible]
JUVENILE MA[illegible]
ORDER OF [illegible]
NOTICE TO [illegible] Doe
[illegible]arts [illegible]wn
[illegible] been filed seekin[illegible]
Ter[illegible] of parental rights of the above named in minor child(ren).
The petition, whereby the court's decision can effect your parental rights, if any, regarding minor child(ren) will be heard on: 6/30/06 at 2:00 p.m. at 920 Broad Street, Hartford, CT 06106.

Set-Aside 1.27 Final Clean-Up

Only contractors that have been pr[illegible] of Hartford MBE/MWBE Set-Aside Prog[illegible] submit bids for the Set-Aside Bid Packag[illegible]

2. Plans and Specifications are now [illegible] viewed at the following locations:

[illegible]G Industries, Inc. **Greater Hartfor[illegible]**
[illegible] Room 140 Wo[illegible]
[illegible]all Street
To[illegible]ngton, CT 06790
(860) 489-9261

Dodge Plan Room 101
101 Corporate Place
Rocky Hill, CT 06067
(203) 783-8800

Reed Construction Data
Attention: Production
30 Technology Parkway
Suite 500
Norcross, GA 30092

Business Resource C[illegible]
Attention: Kim Haw[illegible]
140 Woodland Street, 3[illegible]
Hartford, CT

3. Bidders may purchase bid docum[illegible] **Co.** at the following location: **650 Fra[illegible] 06114 Tel: 860-296-2500; Fax: 860-947[illegible]** Joseph Merritt & Company and order pl[illegible] **refundable** fee of $175.00 per set plus [illegible] shall be made payable to Joseph Merrit[illegible]

Bidders will be held accountable fo[illegible] documents made available and will no[illegible] sibilities for requirements indicated in [illegible] purchased. Plans are also availabl[illegible] planwell@merrittgraphics.com.

4. A pre-bid meeting will be held [illegible] Kinsella Community School, 65 VanBlo[illegible] 06106 at 1:00 p.m. on July 6, 2006. Im[illegible] pre-bid meeting, a site walk-through [illegible] pre-bid meeting/site walk-thru are n[illegible] ested bidde[illegible]e strongly encourage[illegible] bid meeti[illegible]d the site walk-thru.

5. [illegible] project is being performed [illegible]ement form of construction. Wi[illegible] [illegible]onstruction Manager is the repr[illegible] [illegible] Owner shall approve the award of [illegible] [illegible]rade Contractor's contract shall be [illegible] Manager.

6. The Owner, City of Hartford, has [illegible] dustries to serve as the Construction M[illegible]

7. No oral, telephone or electronic [illegible] ered. All bids shall stand available for [illegible] of ninety (90) days from the date propo[illegible]

8. No bid shall be accepted from a[illegible] is in arrears to the Owner upon debt, o[illegible] faulter as surety or otherwise upon obl[illegible]

9. The Hartford School Building C[illegible] reserves the right to reject any or all [illegible] sons therefor, including without limi[illegible] any or all nonconforming, non-respo[illegible] conditional bids and to reject the bid [illegible] struction Manager believes that it [illegible] interest of the Owner or the project t[illegible]

[illegible]ehicle listings,
[illegible]ar for you.