The Charlotte Hungerford Hospital

October 16, 2006

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

Reference: **CON Letter of Intent**
Replacement of CT Scanner

Dear Ms. Vogel:

Enclosed please find Advanced Medical Imaging, LLC's request for replacement of their CT Scanner.

Should you have any questions or require further information, please contact me at (860) 496-6611, or via e-mail at jcapobianco@hungerford.org.

Sincerely,

John J. Capobianco
Vice President, Patient Care Services
and Administration

Enclosure

540 Litchfield Street
P.O. Box 988
Torrington, CT 06790-0988
(860) 496-6666
www.charlottesweb.hungerford.org

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 an Applicant, 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	Torrington Radiologists, PC	The Charlotte Hungerford Hospital
Doing Business As	Advanced Medical Imaging of Northwest Connecticut, LLC	Advanced Medical Imaging of Northwest Connecticut, LLC
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	57 Commercial Boulevard, Torrington, CT 06790	540 Litchfield Street, Torrington, CT 06790
What is the Applicant's Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	(Yes) No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Gary Griffin, MD, Manager	John Capobianco, Vice President, Patient Care Services and Administration
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	57 Commercial Boulevard, Torrington, CT 06790	540 Litchfield Street, Torrington, CT 06790

Contact Person's Telephone Number	860-489-7314	860-496-6611
Contact Person's Fax Number	860-489-7213	860-482-8627
Contact Person's e-mail Address	Gary.griffin@hungerford.org	jcapobianco@hungerford.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of CT Scanner

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 $ 3,000,000

✔ Equipment Acquisition

☐ New ✔ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

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

220 Kennedy Drive, Torrington, CT 06790

d. List each town this project is intended to serve: Barkhamsted, Colebrook, Cornwall, Goshen, Harwinton, Litchfield, Morris, New Hartford, Norfolk, Thomaston, Torrington and Winchester

e. Estimated starting date for the project: January 1, 2007

f. Type of project: 20
(Fill in the appropriate number(s) from page 7 of this Form)

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

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $557,007

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	$528,203
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$ 15,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	
Major 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	**$543,203**
Total Project Cost	**$543,203**
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

✔ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CT Scanner	Philips	Brilliance CT 6	1	$528,203

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

d. 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

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 are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and who is 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: Advanced Medical Imaging

Project Title: Replacement of CT Scanner

I, Daniel J. McIntyre (Name), President and Executive Director (Position – CEO or CFO)

of The Charlotte Hungerford 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 Advanced Medical Imaging (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.

Daniel J. McIntyre
Signature

10/16/06
Date

Subscribed and sworn to before me on 10/16/06

Annamarie Corrado
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 4/30/2011

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. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

We are planning to upgrade our current Philips Aura CT Scanner, installed in 2001. Pleases see Letter of Determination 01-H2 with a new Philips Brilliance 6 Slice CT. Our current scanner is reaching the end of its useful life and, therefore, needs to be replaced.

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.**
   Currently offer CT, Ultrasound, Plain Film Radiography and MRI services. We do not hold a DPH license.

2. **List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.**
   We propose to replace a current single slice CT with a multi-slice. There will be no impact on licensure. This new 6 slice unit will have the capability to perform CT simulation and radiation planning for patients who are being treated at an adjacent building at approximately half the cost.

3. **Identify the current population served and who is the target population to be served.**
   There will be no change in population served.

4. **Identify any unmet need and describe how this project will fulfill that need.**
   Since this is a replacement scanner, it is not intended to fulfill an unmet need but rather continue our services.

5. **Are there any similar existing service providers in the proposed geographic area?**
   The Charlotte Hungerford Hospital operates a CT scanner on the main Hospital campus.

6. **Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.**
   The scanner will allow continued access to CT services on an outpatient basis.

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

(continued)

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

Current payor mix for CT is:

	% of Total Charges
Blue Cross	27%
Commercial	2%
HMO	20%
Medicare	46%
Other	0%
Self Pay	1%
Work Comp	1%
Welfare	3%
Grand Total:	**100%**