STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 14, 2004

David A. Whitehead
Vice President, Planning
The William W. Backus Hospital
326 Washington Street
Norwich, CT 06360

Re: Letter of Intent, Docket Number 04-30281-LOI
The William W. Backus Hospital
Acquisition of Radiology Services from Women's Care Medical Center
Notice of Letter of Intent Publication

Dear Mr. Whitehead:

On April 8, 2004, the Office of Health Care Access ("OHCA") received a Certificate of Need Determination request that was subsequently deemed to be a Letter of Intent ("LOI") to file a Certificate of Need application from The William W. Backus Hospital ("Hospital") to acquire radiology services from the Women's Care Medical Center in Groton, at an estimated total capital cost of $539,294.

A notice to the public regarding OHCA's receipt of the Hospital's LOI will be published in *The Day* of New London pursuant to Section 19a-638 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17. Enclosed for your information is a copy of the notice to the public that is to be published.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Enclosure

SCE:HO:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 14, 2004

Requisition # HCA04-206
Fax #: (860) 442-5443

The Day Publishing Company
47 Eugene O'Neill Drive
Box 1231
New London, CT 06320

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 Friday, April 16, 2004.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:HO:bko

c: Robin Russo, OHCA

The Day Publishing Company **Letter of Intent**
Docket Number 04-30281 **April 14, 2004**

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-638 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant:	The William W. Backus Hospital
Town:	Groton
Docket Number:	04-30281
Proposal:	Acquisition of Radiology Services from Women's Care Medical Center
Total Capital Cost:	$539,294

The Applicant may file its Certificate of Need application between June 7, 2004 and August 6, 2004. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
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 may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

Confirmation Report – Memory Send

Time : Apr-14-2004 10:46
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	083
Date	:	Apr-14 10:45
To	:	918604425443
Document pages	:	002
Start time	:	Apr-14 10:45
End time	:	Apr-14 10:46
Pages sent	:	002
Status	:	OK

Job number : 083 *** SEND SUCCESSFUL ***

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 14, 2004

Requisition # HCA04-206
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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:HO:bko

c: Robin Russo, OHCA

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
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Fax: (860) 418-7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 14, 2004

David A. Whitehead
Vice President, Planning
The William W. Backus Hospital
326 Washington Street
Norwich, CT 06360

RE: Letter of Intent, Docket Number 04-30281-LOI
The William W. Backus Hospital
Acquisition of Radiology Services from Women's Care Medical Center
Certificate of Need Application Forms

Dear Mr. Whitehead:

Enclosed are the application forms for The William W. Backus Hospital's Certificate of Need ("CON") proposal to acquire radiology services from the Women's Care Medical Center in Groton, at an estimated total capital cost of $539,294.

According to the parameters stated in Section 19a-638 of the Connecticut General Statutes as amended by Public Act 03-17, the CON application may be filed between June 7, 2004 and August 6, 2004. The analyst assigned to the CON application is Harold Oberg. Please feel free to contact him at (860) 418-7001, if you have any questions.

Sincerely,

Susan Cole

Susan Cole
Certificate of Need Supervisor

Enclosure

FICE OF HEALTH CARE ACCES

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 including 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)

w:\cert\conforms\confeenew

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

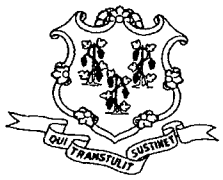
_____ _____
Signature Date

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 will be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than June 7, 2004 and may be submitted no later than August 6, 2004. The Analyst assigned to your application is Harold M. Oberg and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	04-30281-CON
Applicant Name:	The William W. Backus Hospital
Contact Person: **Contact Person Title:**	David A. Whitehead Vice President, Planning
Contact Address:	The William W. Backus Hospital 326 Washington Street Norwich, CT 06360
Project Location:	Groton
Project Name:	Acquisition of Radiology Services from Women's Care Medical Center
Type of Proposal:	Section 19a-638 of the Connecticut General Statutes for New or Additional Services
Total Capital Cost:	$539,294

1. Expansion of Existing Services or New Services

What services are currently offered at your facility that the proposed expansion or new services 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 related to the proposed services
   b) If existing facility/services, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/services, the population to be served, including the number of individuals to receive the proposed services. Include demographic Information, as appropriate.
   d) Hours of operation of existing/proposed services

ii) Identify the existing providers of the proposed services in the service area. What will be the effect of the proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iii) Provide the units of service projected for the first three years of operation for each of the proposed services. Include the derivation/calculation of the projected units of service.

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) _____

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-Society Council for Radiation Oncology ☐ American College of Radiology ☐ Substance Abuse and Mental Health Services Administration

☐ Other: Specify _____

B. Provide a brief summary of how the Applicant plans to meet the guidelines related to this proposal.

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

Note: For physicians, please provide a list of hospitals where the 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 (for new out-of-state providers, only)
- ☐ AAAHC
- ☐ AAAASF
- ☐ Other: _____

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

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

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new services only)
- ☐ Patient Selection Criteria/Intake form

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 new technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new teaching or research responsibilities or a change to existing 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 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. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

8. Acquisitions and Changes in Ownership

A. Provide a copy of any written agreement or memorandum of understanding related to the proposal.

9. 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) If the Applicant is a hospital, provide the cash equivalent balance at the date of submission of this application.

iii) If the Applicant is a hospital, provide a copy of the most recently completed internal monthly financial statements.

iv) The name of the entity that will be billing for the proposed services.

10. Major Cost Components/Total Capital Expenditure

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

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

* Provide an itemized list of all medical and imaging equipment.

11. Construction Information

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

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

C. Explain how the proposed construction/renovations will affect the delivery of patient care.

D. Provide the following information regarding the schedule for construction/renovations:

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

12. Capital Equipment Lease/Purchase

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

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	____ Years
3.	Please submit a schedule of depreciation for the acquired equipment 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	$ _____
Amount of total debt	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing:

Capital or operating	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

B. Please provide copies of the following, if applicable:
   i. Lease agreement for any equipment or space to be leased.

14. Revenue, Expense and Volume Projections

A. 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)				
TriCare (CHAMPUS)				
Total Government Payers				
Commercial Insurers*				
Self-Pay				
Workers Compensation				
Total Non-Government Payers				
Uncompensated Care				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

B. Provide the following for the financial projections:

i) A summary of revenue, expense and volume statistics, with the CON project, without the CON project and incremental to the CON project. **See attached.**

ii) The assumptions utilized in developing the projections (e.g., FTE's, volume statistics, other expenses, revenue and expense % increases, project implementation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the CON proposal.

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
Govt. Gross Revenue	$	$	$	$	$	$	$	$	$	$
Non-Govt. Gross Revenue										
Total Gross Patient Revenue	$	$	$	$	$	$	$	$	$	$
Less: Uncompensated Care	$	$	$	$	$	$	$	$	$	$
Less: Other Deductions										
Total Net Patient Revenue	$	$	$	$	$	$	$	$	$	$
Plus: Other Operating Revenue										
Revenue from Operations	$	$	$	$	$	$	$	$	$	$
Salaries and Fringe Benefits	$	$	$	$	$	$	$	$	$	$
Professional Services										
Supplies and Drugs										
Lease Expense										
Depreciation/Amortization										
Interest Expense										
Other Operating Expense										
Total Operating Expense	$	$	$	$	$	$	$	$	$	$
Gain/(Loss) from Operations	$	$	$	$	$	$	$	$	$	$
Plus: Non-Operating Revenue										
Revenue Over/(Under) Expense	$	$	$	$	$	$	$	$	$	$
Number of Full Time Equivalent Employees:										
*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.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 13, 2004

David A. Whitehead
Vice President, Planning
The William W. Backus Hospital
326 Washington Street
Norwich, CT 06360

Re: Certificate of Need Determination, Report Number 04-30281-DTR
The William W. Backus Hospital
Acquisition of Radiology Services from Women's Care Medical Center in Groton

Dear Mr. Whitehead:

On April 8, 2004, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") Determination request regarding the proposal of The William W. Backus Hospital ("Hospital") to acquire radiology services from the Women's Care Medical Center in Groton. OHCA has reviewed the information contained in your request and makes the following findings:

1. The William W. Backus Hospital is an acute care general hospital located at 326 Washington Street in Norwich, Connecticut.

2. OHCA's Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2002 states that the Hospital primarily serves the residents of Bozrah, Canterbury, Colchester, Franklin, Griswold, Lisbon, Montville, Norwich, Plainfield, Preston, Salem, Sprague, Sterling and Voluntown.

3. The Hospital plans to purchase the existing radiology services currently provided by the Women's Care Medical Center located at 85 Poheganut Drive in Groton, Connecticut from Dr. Caryn Nesbitt.

4. These radiology services include ultrasound, bone densitometry, mammography and radiography and will be provided as Hospital services at the current location.

5. The patient population to be served by the Hospital will be consistent with the patient population that has been served by the Women's Care Medical Center.

6. Radiology services will be provided through Radiology Associates under a contractual agreement with the Hospital.

7. The total capital expenditure for the medical and/or imaging equipment to be acquired by the Hospital is $170,094.

8. The total capital cost associated with the Hospital's proposal is $539,294.

9. The planned acquisition will be funded through the use of the Hospital's operating funds.

10. The payers for the radiology services are anticipated to be representative of Dr. Nesbitt's current radiology practice's payer mix.

11. The estimated starting date for the proposal is June 1, 2004.

Based on the above findings, the Hospital's proposal would establish new or additional Hospital radiology services at 85 Poheganut Drive in Groton. Therefore, OHCA has determined that the proposal of The William W. Backus Hospital to acquire the existing radiology services currently provided by the Women's Care Medical Center located at 85 Poheganut Drive in Groton from Dr. Caryn Nesbitt will require CON authorization from OHCA pursuant to Section 19a-638 of the Connecticut General Statutes.

OHCA considers your CON Determination filing of April 8, 2004 to be your Letter of Intent for the CON proposal. The CON application forms specific to this proposal will be sent to you under separate cover. The Hospital may file its completed CON application with OHCA between June 7, 2004 and August 6, 2004.

If you have any questions concerning this letter, please contact Harold M. Oberg, Principal Health Care Analyst, at OHCA at (860) 418-7001.

Sincerely,

Cristine A. Vogel
Commissioner

cc: Rose McLellan, Licensing Examination Assistant, DHSR, DPH

CAV: ho

The William W. Backus Hospital

RECEIVED

2004 APR -8 PM 12:44

CONNECTICUT OFFICE OF HEALTH CARE ACCESS

April 5, 2004

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

RE: CON Determination Form 2020

Dear Commissioner Vogel,

Enclosed please find three executed copies of a CON Determination form seeking a Determination as to whether The William W. Backus Hospital may acquire the radiology service from Women's Care Medical Center located at 85 Poheganut Drive, Groton, CT, without a Certificate of Need.

If you have any questions, please contact me.

Sincerely,

David A. Whitehead
Vice President, Planning

326 Washington Street • Norwich, Connecticut • 06360 • Tel: (860) 889-8331 • Fax: (860) 823-6329

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted 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. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	The William W. Backus Hospital	
Doing Business As	The William W. Backus Hospital	
Name of Parent Corporation	Backus Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	326 Washington Street Norwich, CT 06360	
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	
Name of Contact person, including title	David Whitehead, VP – Planning	
Contact person's street mailing address	326 Washington Street Norwich, CT 06360	
Contact person's phone, fax and e-mail address	860-889-8331 860-892-2728 dwhitehead@wwbh.org	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:
Acquisition of radiology service from Women's Care Medical Center

b. Location of proposal (Town including street address):
85 Poheganut Drive, Groton, CT

c. List all the municipalities this project is intended to serve:
Bozrah, Canterbury, Colchester, East Lyme, Gales Ferry, Griswold, Groton, Lisbon, Ledyard, Mystic, New London, Niantic, North Stonington, Norwich, Oakdale, Old Lyme, Pawcatuck, Plainfield, Preston, Quaker Hill, Salem, Stonington, Uncasville, Voluntown, Waterford

d. Estimated starting date for the project:
June 1, 2004

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☑	☑	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):_____			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure/Cost: $555,707

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	$244,000
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	170,094
Non-Medical Equipment (Purchase)	47,200
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$461,294**
Fair Market Value of Leased Equipment	78,000

Total Capital Cost	**$539,294**

Major Medical and/or imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
See attachment A.				

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

☑ Operating Funds ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROPOSAL 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. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

See attachment B.

SECTION V. AFFIDAVIT

Applicant: The William W. Backus Hospital

Project Title: Acquisition of radiology services from Women's Care Medical Center

I, Daniel E. Lohr, Chief Financial Officer
(Name) (Position – CEO or CFO)

of The William W. Backus Hospital being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that The William W. Backus Hospital complies with the appropriate
(Facility Name)

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 E Lohr
Signature

4/5/04
Date

Subscribed and sworn to before me on April 5, 2004

Wanda B. Herrick
Notary Public/Commissioner of Superior Court

My commission expires: WANDA B. HERRICK
NOTARY PUBLIC
MY COMMISSION EXPIRES FEB. 28, 2005

Form 2020
Revised 7/02

Attachment A

The William W. Backus Hospital
Acquisition of radiology services from the Women's Care Medical Center
CON Determination

Major medical and/or imaging equipment acquisition:

Equipment Type	Name	Model	# of Units	Cost per Unit
Ultrasound	Ultramark 9 HDI	UM9HDI	1	$28,500
Bone densitometer	Norland XP series	Eclipse	1	$30,000
X-ray	Unimatic 325	3487	1	$22,500
Computed Radiography	AGFA	ADC Solo Digitizer	1	$48,264
	AGFA	QS Server	1	$40,830

Attachment B

The William W. Backus Hospital
Acquisition of Radiology Services from the Women's Care Medical Center
CON Determination

It is our intention to purchase the existing radiology services currently provided through the Women's Care Medical Center located at 85 Poheganut Drive in Groton, CT from Dr. Caryn Nesbitt. These services, Ultrasound, bone densitometry, mammography and radiography will be performed as hospital services within the same location.

The population served will be consistent with the population served through the Women's Care Medical Center (please see Section II. c.).

Radiology services will be provided through Radiology Associates under contract agreement with the Hospital.

Payers of this service are anticipated to be representative of the current practices payer mix: Medicare, Medicaid, Blue Cross/Blue Shield, Healthnet, CIGNA, Connecticare and Tricare.