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 19a639 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	Prospect Diagnostic Imaging, LLC	
Doing Business As	Prospect Diagnostic Imaging, LLC	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	166 Waterbury Road Route 69 Prospect, CT 06712	
What is the Applicant's Status: P for Profit or NP for Nonprofit	Profit	
Does the Applicant have Tax Exempt Status?	No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Paul Masotto Executive Director NVRA/CRN	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	385 Main Street South Building #1 Union Square Southbury, CT 06488	
Contact Person's Telephone Number	203 267-3340 Ext 1101	
Contact Person's Fax Number	203 267-3342	
Contact Person's e-mail Address	pmasotto@stmh.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **Imaging Equipment Replacement and Upgrade: MRI 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: **166 Waterbury Road, Route 69, Prospect, CT 06712**

d. List each town this project is intended to serve: **Greater Waterbury service area including Cheshire, Naugatuck, Oakville, Prospect, Waterbury, Watertown, and Wolcott.**

e. Estimated starting date for the project: **January 2008**

f. Type of project: **19 and 34**
(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 or (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$1,506,896**

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	$1,256,896
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$250,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,506,896**
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	**$1,506,896**
Total Project Cost	**$1,506,896**
Capitalized Financing Costs (Informational Purpose Only)	$

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

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 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
Open MRI Scanner	**GE**	**OPEN SPEED**	**1**	**$1,256,896**

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

Response:
A copy of the vendor quote will be submitted as part of the CON application.

c. 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: **Prospect Diagnostic Imaging, LLC**

Project Title: **Imaging Equipment Replacement and Upgrade: MRI Scanner**

RECEIVED
2007 JUN 18 AM 11:44
OFFICE OF HEALTH CARE ACCESS

I, Robert Gumbardo, M.D., President
(Name) (Position – CEO or CFO)

of Naugatuck Valley Radiological Associates, P.C. 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 Prospect Diagnostic Imaging, LLC complies with the
(Facility Name)

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

6/15/07
Date

Subscribed and sworn to before me on June 15, 2007

Notary Public/Commissioner of Superior Court

DEBORAH E. SHUPENIS
NOTARY PUBLIC
My Commission Expires June 30, 2010

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. 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

500 Chase Pkwy . Suite 3b . Waterbury
1389 West Main St . Suite 107 . Waterbury
NVMRI . 56 Franklin St . Waterbury
133 Scovill St . Suite 308 . Waterbury
305 Church St . Naugatuck
5 Waterbury Rd . Rt 69 . Prospect
5 Main St So . Union Square . Southbury

www.NVRANET.com

IMAGING NETWORK
the future of diagnostic care

BUSINESS OFFICE

UNION SQUARE BLDG #1 203 264.7999 PHONE

385 MAIN STREET SOUTH 203 264.7477 FAX

SOUTHBURY, CT 06488

June 15, 2007

RECEIVED
2007 JUN 18 A11:44

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

Dear Commissioner Vogel:

I am enclosing an original plus three copies of a Letter of Intent/Waiver Form (2030) for Prospect Diagnostic Imaging, LLC to replace and upgrade its Open MRI Scanner.

Should you have any questions regarding this Letter of Intent please do not hesitate to contact me at (203) 267-3340.

Sincerely,

Robert Gumbardo, M.D.
President
Naugatuck Valley Radiological Associates, P.C.

Enclosure

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 2, 2007

Paul Masotto
Executive Director, NVRA/CRN
Prospect Diagnostic Imaging, LLC
385 Main Street South
Building #1, Union Square
Southbury, CT 06488

RE: Certificate of Need Application Forms; Docket Number: 07-30988-CON
Prospect Diagnostic Imaging, LLC
MRI Scanner Acquisition and Operation

Dear Mr. Masotto:

Enclosed are the application forms for Prospect Diagnostic Imaging, LLC's Certificate of Need ("CON") proposal for the acquisition and operation of a MRI scanner with an associated capital expenditure of $1,506,896. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between August 17, 2007, and October 16, 2007.

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 that the electronic copy be in Adobe or MS Word format and that the Financial Attachments and other data as appropriate be 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

Enclosure

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, an answer of "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 17, 2007, and may be submitted no later than October 16, 2007. The OHCA Analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number:	07-30988-CON
Applicant Name:	Prospect Diagnostic Imaging, LLC
Contact Person:	Paul Masotto
Contact Title:	Executive Director, NVRA/CRN
Contact Address:	Prospect Diagnostic Imaging, LLC 385 Main Street South Building #1, Union Square Southbury, CT 06488
Project Location:	Prospect
Project Name:	MRI Equipment Replacement and Upgrade from a .23 Tesla, Open Unit to a .7 Tesla Open Unit
Proposal Type:	Section 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$1,506,896

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

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

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Facility Name) said facility 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 Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed equipment replacement 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) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The unit of service for the past three fiscal years by service area town.
   d) Describe the population to be served. Include demographic Information, as appropriate.
   e) Scheduling backlogs in service area.
   f) Travel distance from the Prospect imaging center to service area towns.
   g) Hours of operation of existing and /or proposed service.

ii) Provide the units of service projected for the first three years of operation of the service with the proposed new equipment. **Include the derivation/calculation.**

iii) Provide the current capacity of the existing MRI scanner showing the method use to calculate the annual volume of scans.

iv) Provide the anticipated capacity of the proposed MRI scanner showing the method use to calculate the annual volume of scans.

v) Identify the existing providers of the MRI services in your service area, including magnetic resonance imaging services provided by the NVRA network.

vi) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.) including magnetic resonance imaging services provided by the NVRA network?

vii) Provide the information as outlined in the following table concerning the existing providers, including magnetic resonance imaging services provided by the NVRA network, in the Applicant's PSA and SSA:

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

[1] Specify days of the week and start and end time for each day.
[2] Service volume performed by Provider for the most recent 12 month period, if known.

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. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. 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 _____

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

D. 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, technicians, etc., related to the proposal and a copy of their Curriculum Vitae.

E. 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]

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

G. Provide a copy of any plan of action which has been formulated to address the above action against the Applicant and/or any staff related to the proposal.

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

☐ A copy of the related Quality Assurance plan

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.

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.

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[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

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.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

C. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Please identify the entity that will be billing for the service.

9. Major Cost Components/Total Capital Expenditure

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

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

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

10. Construction Information

A. Provide a description of the proposed renovation including the related gross square feet of renovation.

B. Provide all schematic drawings related to the proposed floor plans.

C. Provide the following breakdown of the renovation costs:

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

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

E. Provide the following information regarding the schedule for renovation:

Building Commencement Date	
Building Completion 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:

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	____Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	Please submit a schedule of depreciation for the purchased equipment as an attachment.	

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

12. Type of Financing

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

☐ Applicant's equity:

Source and amount:

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

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

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

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

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

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

☐ Other financing alternatives:

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

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

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

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

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. 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 complete Financial Attachment 1, attached.** 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.). Note: Include

consideration of the Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development in the financial projections.

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) Please complete **Financial Attachment 2**, attached.

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

vi) Describe how this proposal is cost effective.

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

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

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

13.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:
# of Months in Operation

Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0