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	Windham Community Memorial Hospital	InSight Health Corp.
Doing Business As	Windham Community Memorial Hospital	Insight Health Corp
Name of Parent Corporation	N/A	InSight Health Services, Corp.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	112 Mansfield Avenue Willimantic, CT 06226	26250 Enterprise Court-Suite 100 Lake Forest, CA 92630-8405
What is the Applicant's Status: P for Profit or NP for Nonprofit	Non Profit	Profit
Does the Applicant have Tax Exempt Status?	Yes	No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Cynthia McClarran, Technical Director, Radiology	Kevin Vernon, PET Operations Manager
Contact Person's Mailing Address, if PO Box, include a street mailing address for	112 Mansfield Avenue Willimantic, CT 06226	118 Brayman Hollow Rd Pomfret Center, CT

Certified Mail		06259
Contact Person's Telephone Number	(O) 860-456-6757	(c) 860-428-0563
Contact Person's Fax Number	(F) 860-456-6972	(F) 860-974-0865
Contact Person's e-mail Address	cmcclarran@wcmh.org	kvernon@insighthealth.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of existing mobile PET service with mobile PET/CT service

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:

Windham Hospital, 112 Mansfield Street, Willimantic, CT

d. List each town this project is intended to serve: Abington, Andover, Ashford, Bolton, Canterbury, Chaplin, Columbia, Franklin, Griswold Hampton, Hebron, Lebanon, Mansfield, Plainfield, Scotland, Sterling, Thompson, Tolland, Voluntown, Willington, and Windham.

e. Estimated starting date for the project: January 2008

f. Type of project: 22, 26
(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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $1,750,000.00

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	$1,750,000.00
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	1,750,000.00

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
GE or Siemens	PET/CT	TBD	1	$1,750,000.00

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: WINDHAM COMMUNITY MEMORIAL HOSPITAL

Project Title: PET/CT

I, RICHARD BRVENIK, CEO
(Name) (Position – CEO or CFO)

of WINDHAM COMMUNITY MEMORIAL 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 WCMH (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.

Richard A. Brvenik
Signature

October 15, 2007
Date

RECEIVED
2007 NOV -7 A11:57
OFFICE OF HEALTHCARE ACCESS

Subscribed and sworn to before me on October 15, 2007

Sharon K. Lee
Notary Public/Commissioner of Superior Court

My commission expires: My Commission Expires January 31, 2012

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

Attachment B

REQUEST FOR REPLACEMENT OF PET SCANNER WITH PET/CT SCANNER
LETTER OF INTENT/WAIVER FORM 2030
INSIGHT HEALTH CORP.
JULY 6, 2007

1. **Currently what types of services are being provided? If applicable, please provide a copy of each Department of Public Health license held by the Petitioner.**

   Mobile PET scanning services, under approved CON Docket Number 01-515 dated August 6, 2001, are currently provided to Windham Hospital. Windham Hospital wishes to replace the mobile PET service with mobile PET/CT scanning service.

2. **What types of services are being proposed and DPH licensure categories will be sought, if applicable.**

   InSight and Windham Hospital intend to upgrade and enhance the PET service to PET/CT technology. PET/CT in-line scanning is the latest imaging technology that uses software to combine or "fuse" the molecular component (PET) with the anatomic component (CT) into one image display. PET/CT combines the advantages of both PET and CT into a single modality imaging device. The combination of these technologies and developments by the equipment vendors has created a non-invasive imaging tool with increased sensitivity, shorter imaging times and the ability to localize tumors more accurately. PET/CT scanners provide accurately aligned anatomical and functional patient images allowing abnormalities to be localized and distinguished from normal uptakes of the PET radioactive isotope.

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

   The current population served is that within Windham Hospital's service area. The target population is principally for Oncologic purposes however, since the original PET CON for Windham had been completed there have been two recently added CMS approved conditions:

   Alzheimer's disease (9/15/04) and,
   Staging for Invasive Cervical Cancer (1/28/05)

   It is anticipated these expanded applications will broaden the clinical usefulness of PET/CT technology.

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

The replacement of the PET scanner with a PET/CT scanner will allow Windham Hospital to offer this state-of-the-art service within their respective service area mitigating the need for patients to travel for this service. Windham Hospital has a comprehensive cancer program through its own staff and provides medical and radiation oncology services through collaborative relationships with Oncology Associates, P.C. The Hospital has provided PET scanning services since 2001

Cancer is the second leading cause of death in Connecticut, following heart disease. In 2001, more than 7,000 state residents died of cancer. Although Connecticut has one of the highest rates of new cancer cases in the U.S., in 2001 it had the 11th lowest death rate overall (eighth lowest for males and 25th lowest for females). More than half of all cancer deaths in Connecticut are due to cancers of the lung, colon/rectum, female breast, and prostate, all currently covered PET indications except for prostate cancer. [1]

The introduction of PET/CT technology at Windham Hospital through utilization of a mobile service will aid in earlier detection and improved treatment of cancer patients in support of the goals identified in the Comprehensive Cancer Control Plan.

In addition, PET/CT provides more precise tumor contouring permitting delivery of more radiation to the pathology with less collateral tissue impact enhancing the accuracy and efficacy of treatment options.

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

Backus Hospital of Norwich CT [Docket Number 01-509] and Day Kimball Hospital [Docket Number 05-30634] of Putnam, CT both have PET/CT services.

6. **What is the effect of this project on the health care delivery system in the State of Connecticut?**

Approval of this project will serve to improve the diagnostic and therapeutic treatment capabilities of the participating hospitals and their medical staffs. There is no material impact to the cost of the health care delivery system as existing technology is being replaced-not added.

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

InSight Health Corp. will provide the PET/CT equipment and technical staff to the hospital. The actual clinical service is provided by the hospital as follows:

Windham Hospital Radiologists are responsible for clinical management of the service and the diagnostic interpretation.

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[1] The Connecticut Comprehensive Cancer Control Plan 2005-2008.

Windham Hospital Staff will facilitate the scheduling, authorization and billing aspects.

8. **Who are the payers of this service**?
   Governmental and indemnity carriers are the primary payers of this service in addition to Private Insurer's and HMO's.

AFFIDAVIT

To be completed by each Applicant

Applicant: Insight Health Corp.

Project Title: PET/CT upgrade - Windham Comm. Mem. Hosp.

I, Kevin Vernon (Name), Area Manager (Position – CEO or CFO)

of Insight Health Corp. 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 I.H.C. (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.

KVernon
Signature

Oct-23-2007
Date

Subscribed and sworn to before me on October 23, 2007

Nora Johnson
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 3-31-2012

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2007

Cynthia McClarren
Technical Director, Radiolgy
Windham Community Memorial Hospital
112 Mansfield Avenue
Willimantic, CT 06226

RE: Certificate of Need Application Forms, Docket Number 07-31061-CON
Windham Community Memorial Hospital
Acquisition of a Mobile PET-CT scnner

Dear Ms. McClarren:

Enclosed are the application forms for Windham Community Memorial Hospital's Certificate of Need ("CON") proposal for the Acquisition of a Mobile PET-CT scnner with an associated capital expenditure of $1,750,000. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes the CON application may be filed between January 6, 2008, and March 6, 2008.

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 Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Steven W. Lazarus. Please feel free to contact him at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 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)

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 6, 2008 and may be submitted no later than March 6, 2008. The Analyst assigned to your application is Steven W. Lazarus, who may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	07-31061-CON
Applicant Name:	Windham Community Memorial Hospital
Contact Person:	Cynthia McClarran
Contact Title:	Technical Director, Radiology
Contact Address:	Windham Community Memorial Hospital 112 Mansfield Avenue Willimantic, CT 06226
Project Location:	Willimantic
Project Name:	Acquisition of a Mobile PET-CT Scanner
Type of proposal:	Sections 19a-638 & 19a-639, C.G.S.
Est. Capital Expenditure:	$1,750,000

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 (PET-CT scanner vs. PET scanner) in your service area.

B. Provide the following information:

i) List the service area towns for the proposed service. Provide a rationale for choosing the selected towns.

ii) Describe the population to be served with the proposed PET-CT scanner (i.e. conditions, diseases etc.).

iii) Discuss in detail the Windham Community Memorial Hospital's ("Hospital") current oncology department and the types of services currently provides.

iv) Please discuss in detail the use of PET-CT scanner for Alzheimer's disease.

v) Where is the proposed patient population currently receiving their PET-CT services?

vi) Where is the Hospital currently referring its patients requiring PET-CT services?

vii) Scheduling backlogs in the proposed service area.

viii) Travel distance from the proposed site to service area towns.

ix) Hours of operation of existing PET scanner and the proposed PET-CT scanner.

x) Please provide a rationale behind the proposed scheduled days of operations for the proposed PET-CT scanner?

xi) Provide a 7 day schedule for the proposed mobile PET-CT scanner, including names and address of the locations it will be providing services when not available at the Hospital.

B. Provide three years of historical volume (fiscal years ("FY") '05, '06 & '07) for the Hospital's existing PET scanner.

C. How many of the Hospital's patients during FY 2007 that utilized the PET scanner were referred to another facility for PET-CT services?

D. List the names and addresses of the facilities were the patients referred for PET-CT service by the Hospital received their PET-CT services during FY 2007.

E. Provide the units of service projected for the first three years of operation of the proposed service *by disease type*. **Include all assumptions used in the derivation/calculation of your projections.**

F. What will be the daily capacity of the proposed PET-CT scanner on the days it will be providing service at the Hospital?

G. Explain how the Applicant derived at the proposed daily capacity of the proposed PET-CT.

H. Provide the information as outlined in the following table concerning the existing providers' (in the Applicant total service area) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known.
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

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

J. 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.

K. 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, 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 (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

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

E. Provide 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)_____

[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.

7. Miscellaneous

A. Will this proposal result in new (or a 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.

C. 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.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) Please describe the billing structure in detail.

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. 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.

11. 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. Amortization schedule (if not level amortization payments),
   iii. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current and the payer mix for the **proposed service only, based on Gross 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				
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. Do the Applicants 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. **See Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicants audited financial statements.

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Please complete CON Financial Attachment II.

iii) 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 of the financial projections.*

iv) 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.

v) Provide the (daily, monthly, annual) number of scans that the Hospital will have to achieve to consider this proposal to "break-even" from a financial stand point.

vi) During which FY does the Hospital expect to achieve the "break-even" number of scans.

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

viii) Describe how this proposal is cost effective.

Windham Community Memorial Hospital

12.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		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
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

Windham Community Memorial Hospital

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

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 15, 2007

Cynthia McClarren
Technical Director, Radiology
Windham Community Memorial Hospital
112 Mansfield Avenue
Willimantic, CT 06226

Re: Letter of Intent, Docket Number 07-31061
Windham Community Memorial Hospital
Acquisition of a Mobile PET-CT Scanner
Notice of Letter of Intent

Dear Ms. McClarren:

On November 7, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Windham Community Memorial Hospital ("Applicant") for the Acquisition of a Mobile PET-CT Scanner, at a total capital expenditure of $1,750,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Chronicle* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 15, 2007

Requisition # HCA08-087
Fax: 423-7641

The Chronicle
One Chronicle Road
Box 148
Bristol, CT 06011-2158

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 **Monday, November 19, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SWL:lmg

c: Sandy Salus, OHCA

The Chronicle
Docket Number 07-31061

Letter of Intent
November 15, 2007

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-638 and 19a-639
Applicant:	Windham Community Memorial Hospital
Town:	Willimantic
Docket Number:	07-31061
Proposal:	Acquisition of a Mobile PET-CT Scanner
Capital Expenditure:	$1,750,000

The Applicant may file its Certificate of Need application between January 6, 2008 and March 6, 2008. 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.

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

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

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