71 Haynes Street
Manchester, CT 06040

ECHN
Eastern Connecticut Health Network, Inc.

Phone (860) 533-3414

March 4, 2008

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

Dear Commissioner Vogel:

Enclosed please find the Letter of Intent being filed on behalf of Manchester Memorial and Eastern Connecticut Health Network. We are proposing to replace the existing mobile PET service at Manchester Memorial Hospital with a fixed PET/CT, to be located in a new comprehensive cancer center being constructed on the hospital campus.

We look forward to working with you on the Certificate of Need process. If you have any questions or concerns regarding this submission, please do not hesitate to give me a call at (860) 533-3429.

Sincerely,

Dennis P. McConville
Senior Vice President, Strategic and Operational Planning

Enc.

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 the Applicant(s), 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
Full Legal Name	Manchester Memorial Hospital
Doing Business As	
Name of Parent Corporation	Eastern Connecticut Health Network, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP
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.	Dennis P. McConville Senior VP, Strategic and Operational Planning
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040
Contact Person's Telephone Number	(860) 533-3429
Contact Person's Fax Number	(860) 647-6860
Contact Person's e-mail Address	dmcconville@echn.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Replacement of existing mobile PET with a fixed PET/CT

b. Project Proposal: Eastern Connecticut Health Network and Manchester Memorial Hospital are proposing to replace the existing, part-time mobile PET service at the hospital with a full-time fixed PET/CT. The proposed PET/CT will be housed in a new Cancer Center to be built on the hospital campus and will provide direct support to the oncology service providers located within that facility.

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☒ **PET/CT Scanner** ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ **Yes** ☐ No

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

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

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

☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ **No**

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

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

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

Haynes Street, Manchester, CT 06040 *(numeric for street address to be determined; proposed PET/CT will be located in the Cancer Center to be constructed directly across the street from Manchester Memorial Hospital).*

g. List each town this project is intended to serve:

Response:

This proposal is intended to serve patients within the Manchester Memorial Hospital service area. The service area towns are listed below:

Primary Service Area	Secondary Service Area
Andover	Columbia
Ashford	East Hartford
Bolton	Glastonbury
Coventry	Hebron
East Windsor	Mansfield
Ellington	Somers
Manchester	Stafford
South Windsor	Union
Tolland	
Vernon	
Willington	

h. Estimated starting date for the project: June 2008

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
Not applicable				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $2,252,000

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

Major Medical Equipment Purchases*	$
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$ 52,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$ 52,000**
Major Medical Equipment – Fair Market Value of Leases Medical	$ 2,200,000
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	**$ 2,252,000**
Total Project Cost	$ 2,252,000
Capitalized Financing Costs (Informational Purpose Only)	TBD

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

Response:

More detailed expenditures and the itemized list of all medical and non-medical equipment will be determined by and provided in the CON application.

If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations Please check your preference.

☐ Yes ☒ **No**

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
PET/CT	TBD	TBD	1	$2,200,000

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

Response:

We are unable to provide a copy of the vendor quote at this time as we are still negotiating with multiple vendors for the proposed unit. A final quote will be available and provided at the time of the CON application is submitted.

e. 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

In paragraph format, 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 being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and 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: Manchester Memorial Hospital

Project Title: Replacement of existing mobile PET with a fixed PET/CT

I, Peter J. Karl (Name) President and CEO (Position – CEO or CFO)

of Eastern Connecticut Health Network (Organization Name) being duly sworn, depose and state that the

that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to

the best of my knowledge, and that Manchester Memorial Hospital (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.

RECEIVED
2008 MAR -4 A 11:05
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Signature Date 3/4/08

Subscribed and sworn to before me on March 4, 2008

Notary Public/Commissioner of Superior Court

My commission expires:

Judith S. Mitchell
NOTARY PUBLIC
State of Connecticut
My Commission Expires 6/30/2011

Section IV Projection Description

Manchester Memorial Hospital (MMH) currently provides PET services two days per week on the hospital campus, through a contractual arrangement with Insight Health Corporation utilizing a mobile PET scanner. Approval to operate the mobile PET service was received in August 2001 in Docket 01-515 as part of a consortium of hospitals wishing to provide PET services to their patients. Since that time, three of the five original hospitals have replaced their PET service with PET/CT, and Windham Community Memorial Hospital has recently filed its own Letter of Intent to upgrade to this service as well.

MMH recognizes that PET/CT has become the standard of care for treating cancer patients, and those patients and their physicians have come to expect this level of cancer care services within their community. Eastern Connecticut Health Network, in conjunction with Haynes Street Medical Associates II, LLC, has plans to construct a new, comprehensive cancer care facility across the street from the current John DeQuattro Community Cancer Center location on the MMH campus. With the construction of this facility, the Cancer Center will relocate its services across the street. As part of its efforts to enhance its existing cancer care program, and better support the services to be provided by the Cancer Center, MMH proposes to operate a fixed PET/CT within the new facility. The fixed PET/CT will replace the existing mobile PET service. The combined PET/CT offers better diagnostic capability by fusing the images received from the PET and CT into a single image, enabling patients to have access to the latest technology available in diagnostic cancer care services.

In addition to PET/CT services, Community CancerCare, the radiation therapy provider at the John DeQuattro Cancer Center, intends to utilize the PET/CT for CT simulation to determine proper radiation dosing for their patients. It is this additional demand for CT services that is driving the need for full-time CT services on site at the Cancer Center. The growing demand for emergent and inpatient CT services, as well as for CT assisted biopsies, on the hospital campus will prevent the existing CT units on the MMH campus from sufficiently accommodating the needs of these patients. In addition to providing patients with state-of-the -art technology, the PET/CT offers an efficient, cost effective means of providing multiple services to patients in a single, convenient and accessible outpatient location.

This proposal will meet the needs of the current population within the service area towns listed in Section II-g., above. The specific patients targeted are those treated at the Cancer Center. Presently, many of these patients must travel into Hartford to receive the PET/CT services requested by their physicians. While MMH is currently able to provide some of these patients with PET services, oncologists are increasingly requiring the detailed images produced by the fusing of images offered by the combined PET/CT. The ECHN medical oncologists are insisting that this service is necessary for the most appropriate care of their patients. In order for MMH to continue to accommodate the cancer patients within our own community, we must be able to offer the most up-to-date technology being utilized by oncologists.

There are presently no PET/CT services provided within the identified service area. As stated above, patients must travel into Hartford to receive this care from Hartford Hospital or Saint Francis Hospital. This poses an undo hardship on patients already burdened by the strain of living with cancer. Availability of these high-tech services close to home within their own community will help to fulfill this unmet need and minimize the unnecessary travel and

hardships experienced by these patients seeking such care, positively impacting the health care delivery system in this region of the State.

Currently, PET services are provided for MMH by Insight Health Corporation. With the replacement of the existing mobile unit, MMH will be purchasing the proposed PET/CT directly. MMH will be responsible for providing the service, including all staffing and billing functions, and the physicians of Eastern Connecticut Imaging, PC will continue to be responsible for reading the study results.

The current payers of this service include Medicare, Medicaid, and other non-government payers. Approximately 60% of the patients have either Medicare or Medicaid, with other non-government payers (HMO, PPO, and commercial insurers) responsible for remaining patients. MMH does not anticipate any changes with this patient population as a result of this proposal.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 3, 2008

Dennis P. McConville
Senior VP, Strategic and Operational Planning
Manchester Memorial Hospital
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application Forms; Docket Number: 08-31115-CON
Eastern Connecticut Health Network, Inc./Manchester Memorial Hospital
Acquisition of a Full-Time Positron Emission Tomography/Computed Tomography Scanner to Replace Manchester Memorial Hospital Part-Time Mobile Positron Emission Tomography Scanner

Dear Mr. McConville

Enclosed are the application forms for Eastern Connecticut Health Network, Inc./Manchester Memorial Hospital's Certificate of Need ("CON") proposal for the acquisition of a Positron Emission Tomography/Computed Tomography Scanner to replace Manchester Memorial Hospital's existing part-time mobile Positron Emission Tomography Scanner, with an estimated total capital expenditure of $2,252,000, According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between May 3, 2008 and July 2, 2008

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.

- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The CON analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012, if you have any questions.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Enclosures

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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, or 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)

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

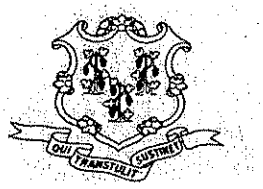
_____ _____
Signature Date

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 may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than May 3, 2008, and may be submitted no later than July 2, 2008. The Analyst assigned to your application is Steven W. Lazarus and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31115-CON

Applicant Name: Manchester Memorial Hospital/Eastern Connecticut Health Network, Inc.

Contact Person: Dennis McConville
Contact Title: Vice President, Strategic and Operational Planning
Manchester Memorial Hospital
Contact Address: 71 Haynes Street
Manchester, CT 06040

Project Location: Manchester

Project Name: Acquisition of a PET/CT Scanner to replace MMH's Existing Part-Time PET Scanner and Locate in the New Cancer Center on the MMH Campus

Type proposal: Section 19a-639, C.G.S.

Est. Capital Expenditure: $2,252,000

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 in detail how Eastern Connecticut Health Network/Manchester Memorial Hospital ("Applicant") determined need for this proposal.

B. Please address the following:

i. Provide a copy of analysis, needs assessment, studies that support the acquisition of the proposed Positron Emission Tomography/Computed Tomography ("PET/CT") scanner.

ii. Discuss the methodology utilized in determining a needs assessment for the proposed PET/CT scanner. Please document.

iii. Please discuss the anticipated volume growth of cancer patients as a result of the relocated Cancer Center ("Center"). Be sure to provide the basis for the volume growth.

iv. What cancer services will be added to the relocated Center.

C. List the service are towns for the proposed PET/CT scanner. Provide the rationale for choosing the selected towns.

D. The units of service for the past three fiscal years *and* the current fiscal year- to-date by service area town for the existing PET Scanner.

E. Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.

F. Hours of operation of the existing PET scanner *and* the proposed PET/CT scanner.

G. MMH is currently providing PET scanning services on part-time basis and proposing to offer the proposed PET/CT scanning services through a fixed full-time scanner. Please provide the rationale MMH applied to determine the need for a full-time PET/CT scanner. Please provide documentation as evidence.

H. Provide all schematic drawings of the new cancer center identifying the location of the proposed PET/CT scanner.

I. Does the Applicant plan to transfer any of the cancer services currently provided at MMH to the new cancer center? If so, list the services that will be transferred to the new cancer center.

J. Please complete the following table to include historical, current PET scanner and the projected PET/CT volume:

	Existing PET Scanner Historical (Last 3 FYs)			**Current Year**	**Projected PET/CT Scanner (First 3 *Full* FYs)***		
	FY '05	FY '06	FY '07	FY '08	FY '09	FY '11	FY ''12
Number of scans							

*If the first year of operation of the proposed scanner is only a partial year, the Applicant must provide the first partial year and then the first three full FYs.

Include all derivation/calculation.

K. Please complete the following tables to illustrate capacity of the existing PET scanner and the proposed PET/CT scanner:

	Existing PET Scanner (FY 2007)	Proposed PET/CT Scanner FY____ *(First full year of operation)*
Type of Scanner		
Avg. # of hours/day scanner operates		
Days/Week operational		
Weeks/Year operational		
Targeted utilization as % of capacity		
Annual total capacity for scans in hours		
Average scan time in hours		
Annual capacity- # scan/scanner		
Projected actual # of scans *(FY 2008 for the existing PET scanner & first full year of operation for the proposed PET/CT scanner)*		
% Total Capacity		

L. Provide the information as outlined in the following table concerning the existing providers' in the Applicant's service area:

PET/CT Service	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.

M. Where are the patients from service area currently receiving their PET/CT services.

N. Where is ECHN/MMH currently referring their patients for PET/CT services?

O. How many did ECHN/MMH refer for a PET/CT scan during FY 2007 and where to?

P. How many and where did John DeQuattro Community Cancer Center refer its patients during FY 2007 for a PET/CT scan?

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

R. According the Applicant's LOI, the proposed PET/CT scanner will be located at the new comprehensive cancer center (a joint venture with another entity). Please address the following:

i) Please detail the assumptions utilized in requesting a full-time fixed PET/CT at the future cancer center.

ii) Please list the types of scans that will be performed on the proposed PET/CT scanner.

iii) Since MMH will no longer have a PET scanner attached to its building, please explain how the patients in the Hospital building requiring a PET scan will have access to the proposed PET/CT scanner at the new cancer center.

S. 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.

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 Association of Child Bearing Centers
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ American College of Radiology
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Substance Abuse Society 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, 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.*

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

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

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

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

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

[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.

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
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

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 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. Ownership

It was noted in the Letter of Intent filed by Manchester Memorial Hospital/Eastern Connecticut Health Network that the Applicant in conjunction with Haynes Street Medical Associates, LLC has plans to construct a new, comprehensive cancer care facility across the street from the current John DeQuattro Community Cancer Center location on the MMH campus.

:

i. Describe the relationship between the Applicant and MSMA.

ii. Provide a copy of the written agreement or memorandum of understanding between the Applicant and HSMA related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

iii. Please describe the MMH's current role in the John DeQuattro Community Cancer Center.

iv. Please describe MMH's ownership in the new Cancer Center.

v. Who will be responsible for the operation of the proposed PET/CT scanner?

vi. Board of Directors or governing body resolutions approving the proposal.

vii. For hospitals, please identify if a new cost center will be established or if an existing cost center will be utilized. Provide the units of service for all new cost centers.

9. Financial Information

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

- ☐ Corporation (Inc.)
- ☐ Partnership
- ☐ Joint Venture
- ☐ Other (Specify):
- ☐ Limited Liability Company (LLC)
- ☐ Professional Corporation (PC)

B. Provide the following financial information:

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

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

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

iv) Provide a detailed discussion on the billing structure of the proposed PET/CT scanner.

v) Will the Hospital be charging a technical fee?

10. 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.

11. Capital Equipment Lease/ Purchase

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

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

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

12. 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 (if applicable),
   iii. Amortization schedule (if not level amortization payments).

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 *Gross Patient Revenue* in the following reporting format:

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

*Includes managed care activity.

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

B. Does the Applicant(s) 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 attached, Financial Attachment I.** 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) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer.** **See attached, 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 a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

13. 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.

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

FY _____	(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				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0