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2008 SEP 29 P 2:03
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

September 23, 2008

Christine A. Vogel, Commissioner
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P.O. Box 34038
Hartford, CT 06134

Reference: Modification of Current CON Relating to PET Imaging Services

Dear Commissioner Vogel:

The Charlotte Hungerford Hospital is requesting that OHCA allow for an expedited request to modify our current CON as it relates to PET imaging services.

Our existing vendor, Alliance Imaging, has informed our facility that they will no longer be supplying our facility with PET Imaging services. This technology is outdated and as a result Alliance Imaging is removing all of their PET scanners from service and replacing them with the newest technology which is PET/CT Imaging.

There won't be any changes to the level of service that we currently offer. Service will remain as it currently is at one day a week. Three of those days each month will be at The Charlotte Hungerford Hospital while one day each month will continue to be at Hungerford Emergency Medical Center in Winsted.

Alliance Imaging has also sent similar notifications to Milford Hospital and Johnson Memorial Hospital.

Should you have any questions regarding this Letter of Intent, you may contact me at 860-496-6611 or Jennifer Tyrian at 860-496-6552.

We very much appreciate your attention to this matter.

Sincerely,

John J Capobianco
Vice President of Patient Care Services
and Administration

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

State of Connecticut
Office of Health Care Access

Form 2030 Instructions:
Letter of Intent

Letter of Intent

All Applicants must complete the Letter of Intent (LOI) form prior to submitting a Certificate of Need (CON) application. The LOI, coupled with the CON application form specific to a given proposal, constitutes the CON request. The LOI consists of four sections that should provide sufficient information to allow the Office of Health Care Access (OHCA) to prepare the CON application form. These sections are:

- Section I — APPLICANT INFORMATION
- Section II — GENERAL APPLICATION INFORMATION
- Section III — ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION
- Section IV — PROJECT DESCRIPTION.

All portions of Section I – IV **must be completed.** If any portion is incomplete, the LOI will be returned to you for completion. An incomplete LOI will not be used for meeting statutory deadline purposes. OHCA recognizes that some of the information requested might not be pertinent to your proposal. If this is the case, please indicate that the question is "Not Applicable".

OHCA recognizes that at the LOI phase of the application process, some of the information may be preliminary in nature and subject to modification prior to or at the time of the submission of the CON application form. Please notify OHCA immediately of any *significant* change or changes to information filed in the LOI. These modifications may constitute the filing of a new LOI.

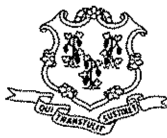
Section III

All Applicants must complete the item identified as "**ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION**".

OHCA requires an original and **six** copies of your completed Form 2030. All pages must be consecutively numbered. Please submit the completed Form 2030, Letter of Intent to:

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

If you have any questions concerning this form, please contact Kimberly Martone at (860) 418-7001.



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 One	Applicant Two
Full legal name	The Charlotte Hungerford Hospital	
Doing Business As	The Charlotte Hungerford Hospital	
Name of Parent Corporation	n/a	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	540 Litchfield Street Torrington, CT 06790	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Jennifer Tyrian Radiology Manager	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	540 Litchfield Street Torrington, CT 06790	
Contact Person Telephone Number	(860) 496-6552	
Contact Person Fax Number	(860) 496-6549	
Contact Person e-mail Address	jtyrian@hungerford.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Replacement of Mobile PET with Mobile PET/CT

b. Project Proposal: Replacement of Mobile PET with Mobile PET/CT

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 X 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.?

X Yes ☐ No

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

☐ New (F, S, Fnc) X 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 X 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:

540 Litchfield ST, Torrington, CT and 110 Spencer Street Winsted, CT

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

Torrington, Winsted, Harwinton, Litchfield, New Hartford, Norfolk, Sharon, Goshen, Thomaston, Canaan, Barkhamsted, Morris, Northfield

h. Estimated starting date for the project: October 5, 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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: No capital expenditure / $1200/ scan est.

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

Item	Amount
Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:______________	
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases 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	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. 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 X 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
Mobile PET/CT unit		GE	1	Fee per scan model

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

e. Type of financing or funding source (more than one can be checked):

X 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.

Charlotte Hungerford Hospital is requesting that OHCA allow for an expedited request to modify our current CON as it relates to PET imaging services.

Our existing vendor, Alliance Imaging, has informed our facility that they will no longer be supplying our facility with PET Imaging services. The termination date for services is December 1, 2008. This technology is outdated and as a result Alliance Imaging is removing all of their PET scanners from service in the entire region and replacing them with the newest technology, which is PET/CT Imaging.

There won't be any changes to the level of service that we currently offer. Service will remain as it currently is at one day a week. Three of those days each month will be at Charlotte Hungerford Hospital while one day each month will continue to be at Hungerford Emergency Medical Center in Winsted.

This service currently plays a very vital role in the cancer planning and treatment process for patients in this region. Should this application change, be denied or approval process extended beyond December 1, 2008, we will be faced with not being able to offer this vital service in our area. Patients will be forced to travel at least 30 minutes to receive the same service.

Alliance Imaging has also sent similar notifications to Milford Hospital and Johnson Memorial Hospital. Milford Hospital and Charlotte Hungerford Hospital currently share the same PET scanner that is being supplied by Alliance Imaging. Both hospitals are facing the same fate of discontinued service in this service area if our requests are denied.

Charlotte Hungerford Hospital and the community that we service urge you to please approve this modification in service in an expedited fashion so that we may be able to continue to offer uninterrupted service to the community in which we serve.

1. <u>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.</u>
   Charlotte Hungerford Hospital is an acute care hospital licensed by the State of Connecticut Department of Public Health.

2. <u>List the types of services being proposed and what DPH licensure categories will be sought, if applicable.</u>
   We would like to change from offering PET Imaging to PET/CT Imaging. This will be no change to our current licensure.

3. Identify the current population served and the target population to be served.
   The current population served for this service consists of: Torrington, Winsted, Harwinton, Litchfield, New Hartford, Norfolk, Sharon, Goshen, Thomaston, Canaan, Barkhamsted, Morris, and Northfield. The target population will consist of the same towns that are listed above.

4. Identify any unmet need and describe how this project will fulfill that need.
   PET/CT Imaging services are not available in the greater Torrington area. Residents currently travel to Hartford and Waterbury to access these services when needed. By allowing Charlotte Hungerford Hospital to update our current PET Imaging services to PET/CT Imaging services we will be providing local residents with the ability to access state of the art imaging services from within their community.

5. Are there any similar existing service providers in the proposed geographic area?
   No

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   There is no known effect to the state health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?
   Alliance Imaging along with Charlotte Hungerford Hospital will be responsible for providing the service. The Professional component i.e. interpretation of the studies will be performed by TORRAD, P.C.

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?
   We don't anticipate any change to the current payer mix. Medicare presently accounts for 37% of the mix. Cigna is at 14%. Blue Cross, HealthNet, and Medicaid are at 6% each. Blue Cross / Blue Shield is at 5%. Aetna and Anthem are at 4% each. Connecticare and Oxford are at 2% each. AARP, Blue Care, Community Care Network, Health New England, United Health, Sierra Health and Life Insurance Co. and Self Pay are at 1% each.

AFFIDAVIT

To be completed by each Applicant

Applicant: The Charlotte Hungerford Hospital

Project Title: Replacement of Mobile PET with Mobile PET/CT

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

of The Charlotte Hungerford Hospital being duly sworn, depose and state that the Information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that The Charlotte Hungerford Hospital complies with the appropriate
(Facility Name)
and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

[signature] 9/16/08
Signature Date

Subscribed and sworn to before me on September 16, 2008

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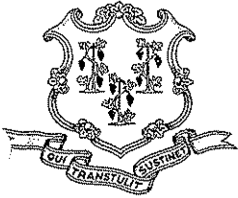
[signature]
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 04/30/2011



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 7, 2008

Jennifer Tyrian
Radiology Manager
The Charlotte Hungerford Hospital
540 Litchfield Street
Torrington, CT 06790

Re: Letter of Intent, Docket Number 08-31241
Acquisition and Operation of a 4-Slice PET-CT Scanner in Torrington
Notice of Letter of Intent

Dear Ms. Tyrian:

On September 29, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Charlotte Hungerford Hospital ("Applicant") for the acquisition and operation of a 4-Slice PET-CT Scanner in Torrington, with no capital expenditure.

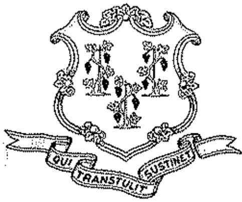
A notice to the public regarding OHCA's receipt of a LOI was published in *The Register Citizen* pursuant to Section 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

An Affirmative Action / Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 7, 2008

Requisition # HCA09-044
Fax: (860) 489-6790

The Register Citizen
190 Water Street
Torrington, CT 06790-0058

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 **Saturday, October 11, 2008.**

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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

The Register Citizen
Docket Number 08-31241

Letter of Intent
October 7, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	The Charlotte Hungerford Hospital
Town:	Torrington
Docket Number:	08-31241-LOI
Proposal:	Acquisition and operation of a 4-Slice PET-CT scanner
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between November 28, 2008 and January 27, 2009. 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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TRANSMISSION OK

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 7, 2008

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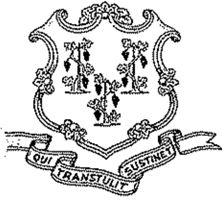
KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 8, 2008

Jennifer Tyrian
Radiology Manager
The Charlotte Hungerford Hospital
540 Litchfield Street
Torrington, CT 06790

RE: Certificate of Need Application Forms
Docket Number: 08-31241-CON
Acquisition and Operation of a 4-Slice PET-CT Scanner in Torrington

Dear Ms. Tyrian:

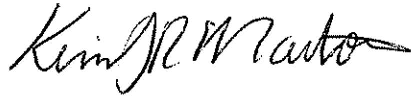
Enclosed are the application forms for The Charlotte Hungerford Hospital's Certificate of Need ("CON") proposal for the acquisition and operation of a 4-slice PET-CT scanner in Torrington with no associated capital expenditure. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between November 28, 2008, and January 27, 2009.

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 the submission, each 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 OHCA analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7035, 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, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than November 28, 2008 and may be submitted no later than January 27, 2009. The OHCA analyst assigned to your application is Paolo Fiducia. He may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31241-CON

Applicant Name: The Charlotte Hungerford Hospital

Contact Person: Jennifer Tyrian
Contact Title: Radiology Manager
Contact Address: The Charlotte Hungerford Hospital
540 Litchfield Street
Torrington, CT 06790

Project Location: Torrington

Project Name: Acquisition and Operation of a 4-Slice PET-CT Scanner in Torrington

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

Est. Capital Expenditure: $0

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. Has The Charlotte Hungerford Hospital ("Hospital") conducted a need assessment for the proposed PET-CT scanner? If so, provide a copy.

C. 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 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 and/or Hospital affiliated physicians currently referring their 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) Is the proposed PET-CT scanner a mobile or a fixed scanner?
xii) If it's a mobile scanner, please provide a 7 day schedule for the proposed PET-CT scanner, including names and addresses of the locations it will be providing services when not available at the Hospital.

D. Please provide the existing PET scanners historical volume and the projected volume for the proposed PET-CT scanner, in the following table:

	Actual Exam Volume (Last 3 Completed FYs)			CFY Volume*	Projected Exam Volume (First 3 Full Operational FYs)**		
	FY______	FY______	FY______	FY______	FY______	FY_____	FY______
PET							
PET-CT							

Number of Examinations

Notes: *Please report the annualized number of exams, identifying the respective number of months of recorded activity in your response.
**If the first year of operation of the proposed service site is only a partial year, the Hospital must provide the first partial year and then the first three full FYs. Include all derivations and/or calculations.

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

F. 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 the last complete FY and YTD.

G. 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.**

H. Please provide the capacity for the existing PET Scanner and the proposed PET-CT scanner in the table format provided below:

	Existing PET Scanner FY ____	Proposed PET-CT Scanner
Number of Scanner		
Average # Hours/Week Scanner Operates		
Weeks/Year Operational**		
Targeted Utilization as % of Capacity		
Annual Total Capacity for Scans in Hours		
Average Scan Time in Hours		
Annual Capacity - #Scans/Scanner		
Actual & Projected/Actual # scans		
% Total Capacity	____%	____%

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

J. 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.

K. List the nearest provider of PET-CT scanner service.

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

M. 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.

N. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ 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 sections of the Quality Assurance plan to the proposal and the corresponding sections of the latest annual evaluation report of the Hospital's Quality Assurance Committee.

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.

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:
   i. Letter of interest from the lending institution,
   ii. Amortization schedule (if not level amortization payments),
   iii. Lease agreement,
   iv. Vendor quote.

11. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current and the payer mix for the PET scanner and **proposed PET-CT scanner, based on Gross Patient Revenue** in the following reporting format:

Total Facility Description	Current Payer Mix (PET)	Year 1 Projected Payer Mix (PET-CT)	Year 2 Projected Payer Mix (PET-CT)	Year 3 Projected Payer Mix (PET-CT)
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. ***Note: Provide the calculation***

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) Provide a discussion on reimbursement for the proposed PET-CT scanner.

ix) Describe how this proposal is cost effective.

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: ________________________

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		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.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by 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

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: 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 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.