St.Vincent's Medical Center

October 10, 2008

Ms. Christine A. Vogel, Commissioner
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340208
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Enclosed please find the Letter of Intent being filed on behalf of St. Vincent's Medical Center. We are proposing to replace the existing mobile PET service at St. Vincent's Medical Center 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 (203)-576-6370.

Sincerely,

Rachel Giliotti

Rachel Giliotti
Director, Department of Radiology

Enc.
RG: mdl

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
Full legal name	**St. Vincent's Medical Center**
Doing Business As	
Name of Parent Corporation	**St. Vincent's Health Services**
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**2800 Main Street, Bridgeport CT**
Identify Applicant Status: P for Profit or NP for Nonprofit	**NP**
Does the Applicant have Tax Exempt Status?	Yes **X** No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Rachel Giliotti Director, Radiology
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Rachel Giliotti Radiology Department St. Vincent's Medical Center 2800 Main Street Bridgeport, CT 06606
Contact Person Telephone Number	(203) 576-6370
Contact Person Fax Number	(203) 581-6537

Contact Person e-mail Address	Rgiliotti@stvincents.org

SECTION II. GENERAL APPLICATION INFORMATION

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

b. Project Proposal: St. Vincent's Medical Center is proposing to replace the existing, part-time mobile PET/CT service at the Medical Center with a full-time fixed PET/CT scanner.

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:

2800 Main Street, Bridgeport, CT 06606

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

g. This proposal is intended to serve patients within the St. Vincent's Medical Center service area. The service towns are listed below:

Primary Service Area	Secondary Service Area
Bridgeport	Easton
Fairfield	Milford
Monroe	Newtown
Shelton	Norwalk
Stratford	Wilton
Trumbull	Westport

h. Estimated starting date for the project: Fall, 2009

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: **$ 3,248,450**

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

Major Medical Equipment Purchases*	**$ 2,698,450**
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	**$ 550,000**
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	**$ 2,698,450**
Total Project Cost	**$ 3,248,450**
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.

N/A ☐ 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
64 Slice PET/CT	**GE**	**Discovery VCT**	**1**	**2,698,450**

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):

- ☒ 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?

Section IV Project Description

St. Vincent's Medical Center currently provides PET/CT services two days per week on the main campus of the Medical Center through a contractual arrangement with Alliance Imaging. Approval to operate the existing mobile PET/CT service was received on August 11, 2003 in Docket 02-584 as part of a consortium of hospitals that formed the Fairfield County Mobile PET Collaborative. Since then, at least two of the six original hospitals have replaced their mobile PET services with fixed sites. With only two days available, patients served by St. Vincent's Medical Center requiring PET/CT scans may wait longer to be diagnosed or to have treatment initiated than if we had a fixed site available seven days a week.

St. Vincent's Medical Center recognizes that PET/CT has become the standard of care for diagnosing cancer patients and contributes greatly to their plan of care. Physicians and patients alike have come to expect this level of cancer care service within their community. Because of this and to plan for the future, shelled space has been reserved for a future PET/CT scanner in the proposed North Building which is underway and will be a new 125,000 square foot building between the existing main hospital, St. Vincent's College, and central utility plant. The new structure will house a new ambulatory Cancer Center, an expanded Emergency Department, Women's Imaging Center, physician offices and conference space. With the construction of this facility, the Cancer Center will relocate Radiation Oncology and the Ambulatory Infusion Center. In an effort to further enhance its existing program, and better support the services and to provide truly comprehensive care by the Cancer Center, St. Vincent's Medical Center proposes to operate a fixed PET/CT within the new facility which will replace the existing mobile PET/CT service. PET/CT offers improved diagnostic capability by fusing the images received from the CT scan and the PET scan into a single image. Having this capability available gives patients access to the latest technology in diagnostic cancer care.

In addition to diagnostic PET/CT services, the Radiation Oncology division in the Cancer Center intends to utilize the PET/CT for simulation purposes to determine dosimetry and treatment plans for radiation therapy. This technology provides the most advanced means for defining malignant areas and customizing Intensity Modulated Radiation Therapy (IMRT) treatments. This allows the Radiation Oncologist to deliver the highest appropriate radiation dose to treatment areas, while minimizing side effects of to healthy tissue.

There is also a higher demand for emergent and inpatient CT services as well as for CT guided interventional procedures which can delay the existing CT scanners in accommodating the needs of these patients. The addition of the PET/CT will offer efficient, cost effective means of providing CT services to patients in a single, outpatient accessible location and will allow expanded CT scan capacity and improved patient throughput. It will also offer the ability to perform PET/CT scans for inpatients.

St. Vincent's Medical Center accepts all patients regardless of their race, creed, age, gender, religion or their ability to pay. The current payers of this service include HMO, PPO and commercial insurance companies, Medicare and Medicaid. Approximately 60 % of patients have Medicare or Medicaid, with other non-government payers responsible for remaining patients. St. Vincent's Medical Center does not anticipate any changes with this payer mix as a result of this proposal. SVMC is also a member of the National Oncologic PET Registry.

AFFIDAVIT

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To be completed by each Applicant

Applicant: St. Vincent's Medical Center

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

I, Susan Davis (Name), President and CEO (Position – CEO or CFO)

of St. Vincent's Medical Center 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 St. Vincent's Medical Center (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.

Susan Davis
Signature

10.10.08
Date

Subscribed and sworn to before me on Friday, October 10, 2008

Dolores M. Mello
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2011

Quotation Number: P1-C23472 V 4

St Vincents Medical Center	Attn: Ms. Rachel Giliotti	Date: 05-05-2008
2800 Main St	2800 Main St	
Bridgeport CT 06606	Bridgeport CT 06606	

This agreement is by and between the customer and the GE Healthcare entity (referred to herein as "GE Healthcare"), each as identified in the applicable signature block below. GE Healthcare agrees to provide and customer agrees to pay for the products and/or services set forth in this agreement, all in accordance with the terms and conditions set forth herein. This agreement is comprised of:

1) This GE Healthcare Quotation (together with any applicable schedules referred to herein) that identifies the product and/or service offerings purchased or licensed by customer;

2) The attached (i) GE Healthcare Warranty documentation, (ii) GE Healthcare Additional Terms and Conditions documentation and (iii) GE Healthcare Statement of Service Deliverables documentation, as applicable; and

3) The attached GE Healthcare Standard Terms and Conditions-Sales and Service.

In the event of conflict among the foregoing items, the order of precedence is as numbered above. This agreement constitutes the complete agreement of the parties relating to GE Healthcare's delivery of the products and/or services identified in the GE Healthcare Quotation and supersedes all prior oral or written proposals, statements, agreements, commitments, or understandings with respect to the matters provided for herein. Quotation expiration date is as stated below unless otherwise indicated. This Quotation is subject to pricing, configuration and credit approval.

• Terms of Delivery:	FOB Destination
• Quotation Expiration Date:	07-01-2008
• Billing Terms:	10% down / 70% delivery / 20% installation or first patient use
• Payment Terms:	UPON RECEIPT
• Contract Price Protection:	12 months from date of contract execution, subject to increase 0.5% per month after such 12 months period.

Each party has caused this agreement to be signed by an authorized representative on the date set forth below.

General Electric Company, GE Healthcare

A GE Healthcare business

3200 N. Grandview Blvd., Mail Code WT-897, Waukesha, WI 53188

www.gemedical.com

Submitted By: _____ Date
Emily Kloeblen
Sales Representative

Agreed To By: _____ Date
Authorized Company Representative

CUSTOMER
Agreed To By: _____ Date
Authorized Customer Representative

Please return to your local sales representative.

PO#

_____
Print or Type Name

_____
Title

Qty	Catalog No.	Description
1		**Discovery VCT**
1	S9164LE	Discovery VCT Discovery(TM) VCT PET-CT Scanner (With Discovery Dimension Console) Discovery(TM) VCT world's first clinical volume PET-CT system can be used as a standalone Volume CT scanner or an integrated PET/CT scanner for all clinical and research applications. It supports PET-CT procedures with full flexibility in CT and PET protocol combinations. Discovery VCT includes Elite PET Detector, XtreamFX workflow technology, VUE Point PET Iterative Reconstruction, and multiple motion PET acquisition capability. The GE Discovery(TM) VCT Scanner consists of: One integrated gantry containing slip-ring design Volume CT X-Ray tube & 64 slice 40 mm coverage detector, 24 PET detector rings, high-speed acquisition electronics and image reconstruction system with high performance array processor. Patient port diameter: 70 cm One patient imaging table, head holder, and comfort accessories One fully integrated Discovery Dimension Console featuring: VUE Point: Precision Iterative PET Image Reconstruction with iterative image corrections. Rad Rx: advanced PET/CT protocol prescription. 4Dx: Diagnostic multi-gated PET acquisition (requires optional gating monitor). Volume Share: customizable multi-modality processing including fused Review, quantification, and data export Cardiac VUE: Cardiac PET processing including automatic volume orientation, and 3D filtering. Dynamic VUE Dynamic PET processing. ACQC PET/CT attenuation correction QC management tool Completely customizable protocol-driven scan control Two 19" color displays for high resolution PET/CT review, images and scanner controls at a glance. PET Subsystem High sensitivity Detector ring: 13,440 BGO 4.7 mm transaxial, 6.3 mm axial, 30 mm radial crystals, arranged in 24 rings of 560 crystals. 88.6 cm diameter. Transaxial FOV: 70 cm Axial FOV: 15.7 cm Number of image planes: 47 with 3.27 mm sampling interval Detector front and back Shielding and automatically retractable 0.8 mm tungsten inter-plane septa, 5.4 cm long minimize random and scattered coincidences. Laser positioning and large display on front and back of the gantry showing system count rate and acquisition time. Fast Automated PET QC and calibration System for minimum personnel exposure (Requires 68Ge rod source, not included). PET Acquisition and Reconstruction Individual position, energy, and timing mapping of each crystal improve spatial, energy, and timing resolution. Measured Detector Dead-time correction for enhanced count rate accuracy and quantification Random real time or off-line correction from acquired singles or delayed events. Static, whole body, multiple phase dynamic, ECG and respiratory multi-gated acquisitions (requires optional gating monitor). Coincidence Acquisition with or without axial septa and prospective reconstruction Volume Imaging Protocol (ViP) enabling retrospective data acquisition. Dynamic histogram memory 320 MB The VCT scanner sub-system includes: V-Res(TM) Detector technology with 58,368 detector elements of 64 0.625mm thick rows providing sub-mm acquisition in all scan modes. 40mm anatomical coverage per rotation at isocenter with 0.625mm slices Complete technology to support the 64 sub-mm slices acquisition

Qty	Catalog No.	Description
		per rotation including: Xtream(tm) FX, for reconstruction and network transfer rates of up to 16 images per second. Direct MPR: automatic prospective 3D image display of orthogonal planes. GE Volume CT Reconstruction delivering highest z-axis resolution Vari-Speed, GE's exclusive variable speed capability: 360 degree rotation in 0.35s, 037s, 0.4s, 0.42, 0.45, 0.47, 0.5, 0.6, 0.7, 0.8, 0.9, 1.0s. Performix Pro X-ray tube and generator technology delivering 100kW with peak 800mA capacity OptiDose management including: bowtie filters for coronary angiography and pediatric body exams, fully 3-D and ECG dose modulation, cardiac specific image filters, collimator hardware and software for x-ray beam tracking. Exam Split: networking of patient images in separate anatomical groups.
1	P5052PS	Discovery UPS Discovery ST Uninterruptible Power Supply
1	M81511F8	AW VolumeShare2 System with 2 Monitors, VolumeViewer3 and 4GB RAM AW VolumeShare2 with Two Flat Panel Monitors and 4GB of RAM AW VolumeShare2 provides 3D visualization and analysis with exceptional stability, quality and flexibility for powerful multi-modality image management, review, comparison and processing. It features state of the art 64 bit technology and 2 dual core processors for superior performance and large thin slice data set handling. In addition, AW VolumeShare2 features dramatic user interface enhancements that makes processing routine cases easy and complex cases simpler. The AW software family improves diagnostic/treatment workflow and enhances clinician-patient communication. AW VolumeShare2 software includes: • Volume Viewer 3.1: GE 3D software package that includes Volume Rendering, Volume Analysis, Navigator and other 3D visualization and analysis tools • Advanced X-ray Analysis: Accommodates routine and special procedures, providing tools specifically for the review of DICOM x-ray images. • 2D image viewer that displays RT, CT, MR, CR X-Ray (Angio and R&F), Digital X-Ray (DX), MG, NM, PET, U/S, Secondary Capture, Secondary Capture Color DICOM Image Objects • Filmer: Multimedia export tool that creates standard or free-format electronic films in DICOM SR that can be saved, networked or printed to a DICOM, DICOM color or a supported postscript printer. Electronic films can also be exported out of the DICOM environment in a variety of multimedia formats (HTML, PDF, JPEG, PNG, MPEG, AVI, QuickTimey VR). AW VolumeShare 2 ships with: • Post-processing software platform, Patient List, database, and DICOM networking

Qty	Catalog No.	Description
		• Volume Viewer 3.1(VA, VR, Navigator) • 2D Viewer • Filmer • Data Export • Advanced X-ray Analysis • Two 19" flat panel monitors • HP xw8400 Workstation: - 2 Intel Xeon Dual Core Processors @ 3.0GHz clock speed, 4MB shared L2 cache - 4GB DDR-2 RAM (expandable to 12GB) - 2 x 146 GB: SAS 15,000rpm hard disks (292 GB can be used for image storage) - 1 x 73 GB: SAS 15,000rpm hard disk for OS and system files - Internal DVD-ROM drive with CD burner (40x read/write) for DICOM media interchange and writing of DataExport electronic films - 10/100/1000 base-T network interface - USB Optical 3-button mouse - 3 inch floppy drive for service use and preset archive capability DOES NOT INCLUDE AUTOBONE XPRESS SOFTWARE OR ANY OTHER ADVANCED APPLICATIONS NOT LISTED
1	M81521VT	Volume Viewer 3 For Pet PET Volume Viewer 3 for Review Functionality. This catalog provides the License Key to enable PET Review Functionality in Volume Viewer 3. Features include: • SUV, Triangulation • PET/CT Drag and Drop Fusion • Isocontours
1	E8007NG	Medrad Stellant DX Dual Flow Injector - Ceiling Mount (Short Post) Medrad Stellant DX Dual-Flow Ceiling Mount Injection System with Short Post. Requires E8007NZ Mounting Plate be added to the order....E
1	E8007NZ	Medrad OCS Mounting Plate OCS Mounting Plate
1	E4502AE	125A Main Disconnect Panel (US) CT Main Disconnect Panel - 125 Amp

Qty	Catalog No.	Description
		This 125-amp main disconnect panel serves as the main power disconnect between the CT system and the facility 400-480V power source. It provides short circuit, overload, under voltage release, automatic restart, and emergency shut down for the CT system. It also reduces install ation time and cost by providing a single-point power connection eliminating the need to mount and wire a number of individual components, and its standardized design and testing assures high product quality and system reliability. On systems where the optional 12.5 KVA partial system UPS is ordered (E4502KT), the main disconnect panel also provides mandated emer gency power off control via a UPS output disconnect function included in the panel design. It also provides a standardized plat form for future UPS or other GE-engineered modifications or upgrades. This panel is compatible with GEHC LightSpeed Pro 16, Pro 32, LightSpeed VCT and RT CT systems. Customer is responsible for rigging and arranging for installation by a licensed electrician. This ITEM IS NON-RETURNABLE AND NON-REFUNDABLE. Warranty Code: Y
1	E8505MJ	RTP Couch Overlay for GT1700/GT2000 and PET Tables RTP Cradle Overlay for GT 1700, GT 2000, and GT PET Tables(RT16, DST VCT, and VCT) Flat-panel table inserts securely lock into the GE CT and PET/CT cradle for rapid, accurate and, repeatable patient set up and localization. It has a sturdy, lightweight foam core with durable, carbon fiber construction. Designed for optimum patient comfort and treatment flexibility, it attaches quickly and securely to the cradle for more accurate studies. The maximum working load is 400 lbs., and it is uniformly distributed while being supported by the table. Accuracy: Repeatability of positioning will be accurate within 1mm when table's top is setup correctly with proper techniques.
1	E8500NB	Patient Arm Support for NM, PET/CT, MR Patient Arm Support for NM, PET/CT, MR Padded Arm Rest combines total arm support and passive restraint, increasing patient comfort during extended procedures. Designed to accommodate virtually all patients. Compatible with most Nuclear Imaging systems and can also be used in MRI, CT and PET applications. Constructed with a comfortable, full support polyfoam with a seamless coated finish. Warranty Code: H
1	E8016BL	SLICKER FOR PET GT TABLE Slicker for PET GT Table Slicker Cushion Table Systems are comprised of cushion pads permanently encapsulated in clear, micro matte vinyl protective cover system and various accessories. Each Slicker cushion in a lined foam cushion that is permanently welded inside the clear Slicker cover. The cover minimizes contamination of the cushion and the underlying table by preventing penetration by any fluid or other contaminant. o Built using heavy, clear, micro matte vinyl, polyurethane foam,

Qty	Catalog No.	Description
		and top grade hook and loop tape to exactly fit the specified table. Expected life is between 1 to 2 years depending on usage. o Designed for easy cleanup and disinfection using standard bleach solutions.
1	E8690AD	Discovery Pin Source Discovery ST Pin Source Maximum activity of 2.7 mCi
1	W0100PT	6 Day PET TiP Onsite System Training 6 Day PET TiP Onsite System Training PET Onsite Training for a new PET system • One 4 day onsite visit to coincide with system start-up. • One 2 day onsite follow-up visit 6-8 weeks post system start up. During the first visit, the applications specialist will work with the medical and technical staff on system operation and patient procedures. The training produces the best results when a dedicated core group of 2-4 PET technologists complete the session with a modified patient schedule. It is suggested that key physicians are available to participate in the protocol implementation and image quality review sessions. By the end of this visit, the core group should be able to perform the routine patient procedures. The 2 day revisit is suggested after the staff has run the system for 6-8 weeks, however this is flexible based on the site needs. The training will focus on the intermediate and advanced functions of the system or special needs of the customer. The training produces the best results when the same dedicated core group of 2-4 PET technologists from the initial visit complete the session with a modified patient schedule.
1	W010CT	6 Day CT TiP Onsite System Training 6 Day CT TiP Onsite System Training CT Onsite Training for a new CT system • One 4 day onsite visit to coincide with system start-up. • One 2 day onsite follow-up visit 6-8 weeks post system start up. During the first visit, the applications specialist will work with the medical and technical staff on system operation and patient procedures. The training produces the best results when a dedicated core group of 2-4 CT technologists complete the session with a modified patient schedule. It is suggested that key physicians are available to participate in the protocol implementation and image quality review sessions. By the end of this visit, the core group should be able to perform the routine patient procedures.

Qty	Catalog No.	Description
		The 2 day revisit is suggested after the staff has run the system for 6-8 weeks, however this is flexible based on the site needs. The training will focus on the intermediate and advanced functions of the system or special needs of the customer. The training produces the best results when the same dedicated core group of 2-4 CT technologists from the initial visit complete the session with a modified patient schedule.
1	W0O21HC	TiP HQ Class Lightspeed VCT - Full Service TiP HQ Class LightSpeed VCT - Full Service 3.5 day CT course held in the Milwaukee area. Includes travel and modest living expenses. This course is designed to introduce the technologist to the CT LightSpeed VCT system.
1	W3O09HC	TiP HQ Class Intro to Discovery PET/CT - Full Service TiP HQ Class Intro to Discovery PET/CT Full Service 3.5 day TiP Discovery PET/CT course held in the Milwaukee area. Includes travel and modest living expenses. This course is designed to prepare technologists for performing the daily operations of combined PET/CT imaging. The program includes classroom instruction on physics, instrumentation, quality control, and acquisition.
		Quote Summary: **Total Quote Net Selling Price** **$2,698,450.00** (Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)

Options

(These items are not included in the total quotation amount)

Qty	Catalog No.	Description
1	S9113RD	Level 3 Cardiac PET & CT Coronary Angiography Package DST Complete PET/CT Cardiac Package A comprehensive package for the acquisition, processing and review of PET viability and perfusion studies. This package includes CT Calcium Scoring and CT Coronary artery acquisition, processing and review. The Discovery PET/CT provides routine gated cardiac acquisition- a GE Exclusive. This package includes: - IVY 3150 ECG Monitor w/ Stand and Starter Kit - ECG Simulator - ECG Simulator Adapter - SmartScore Calcium Scoring Software Package - SnapShot - CardIQ Physio - CardIQ Fusion Cardiac training is essential for PET/CT for acquisition and application. W7004CT for CT (3 days) and W0002NM for PET and Fusion (2 days) is recommended. Not included in the package. Note: Requires AW Hardware 8200 or greater or VolumeShare 2. This catalog item does not include an AW workstation. Customer must have or separately purchase an AW workstation that meets the minimum configuration specified below.
1	S9111RT	Discovery PET/CT Respiratory Gating Package A comprehensive package for the acquisition, processing and review of PET and CT respiratory gating studies. The Discovery PET/CT provides routine respiratory acquisition- a GE Exclusive. Includes: • Advantage 4D software for CT gating • RTP flat table top • Varian RPM Monitor • 2 days onsite PET 4D training • 1.5 days onsite CT 4D training • Respiratory Options for DVCT Discovery Advantage 4D is a Non-invasive Software/Hardware Option That can be used to Provide and Display CT Images of All Phases of a Breathing Cycle for the Evaluation of Respiration-induced Motion. The Software will allow the user to retrospectively define the best respiratory phase from an Image Quality standpoint, and group images by the phase selected. Discovery Advantage 4D can also be used for Target or Treatment Volume (DICOM Radiation Therapy Structure Sets) Verification. RTP Exact Couch for PET Discovery VCT Systems is a Flat-panel table that inserts securely to lock

Qty	Catalog No.	Description
		into the GE PET/CT cradle for rapid, accurate and, repeatable patient set up and localization. Sturdy, lightweight foam core; durable carbon fiber construction. Designed for optimum patient comfort and treatment flexibility. Attaches quickly and securely to the Discovery ST cradle for more accurate studies. Dimensions: Maximum Working Load: 450 lbs. Uniformly distributed while being supported by the table. Accuracy: Repeatability of positioning will be accurate within 1mm when tabletop is setup correctly with proper techniques. Compatible with GE PET/CT Discovery VCT System Varian RPM Respiratory Gating Device is the hardware to capture the respiratory signal in from the patient. It includes installation by the manufacturer.
1	P50801BA	Cortex ID for AW Cortex ID offers easy, robust and clinically validated review/analysis of PET and PET-CT neuro scans. Key features include: • Structure-function analysis with PET-CT • Fully automated, well proven, robust analysis method: 3D stereotactic surface projection (3D SSP) • Comparison to age-stratified asymptomatic normals database with MMSE evaluation and MR imaging • Qualitative and Quantitative assessment 1 minute • Effortless comparison to previous FDG PET • Effortless comparison to previous MRI (T1, T2, Flair) • Straightforward comparison to previous PET or PET-CT images with FDG or any other tracers • Intuitive and efficient workflow from image loading to saving and restoring results • Customizable and interactive reporting tool Cortex ID Requirements: AW 4.2P or later Dual-screen AW
1	P58501JH	ECToolbox 2.6 - PET Only ECToolbox 2.6 PET Only ECToolbox 2.6 PET only application provides all functionalities of PET cardiac package including full review, display and processing of PET data. It includes also Rubidium, Ammonia and FDG normal databases, FDG match mismatech analysis and left ventricular function analysis. This version does not process SPECT data. • ECToolbox 2.6 PET only runs only on AW 4.1 or higher. If the customer plans to do Cardiac

Qty	Catalog No.	Description
		gated acquisitions, then ECToolbox 2.6 PET only will require PET/CT Gating Kit for Discovery ST or LS, Invivo 3500 CTP EKG Monitor, CT 3500 Starter Kit and AW 4.1 (or higher). If customer wants to fuse coronary angiography from CT, then Heartfusion should be ordered that includes also all functionalities of ECToolbox 2.6 PET only application. • This catalog item does not include an AW 4.1 or higher workstation. Customer must have or separately purchase an AW 4.1 or higher workstation that meets the minimum configuration specified below. NOTE: Minimum of 512 MB memory required for Advantage Windows Workstation.
1	B79011ME	Advantage SimMD w/Organ Seg & Multi-Modality/Multi-Phase & CT/PET & CT/MR Fusion Advantage Sim MD Full Package Includes: Advantage Sim MD Organ Segmentation Multi-Modality/Multi-Phase CT/PET Fusion CT/MR Fusion Advantage Sim MD is used to prepare geometric and anatomical data relating to a proposed external beam radiotherapy treatment prior to dosimetry planning. Anatomical volumes can be defined automatically or manually in three dimensions using a set of CT images acquired with the patient in the proposed treatment position. Definition of the anatomical volumes may be assisted by additional CT, MR, PET or SPECT studies that have been co-registered with the planning CT scan. Additionally, CT & PET data from a respiratory tracked examination may be used to allow the user to define the target or treatment volume over a defined range of the respiratory cycle. The geometric parameters of a proposed treatment field are selected to allow non-dosimetric, interactive optimization of field coverage. Anatomical structures and geometric treatment fields are displayed on orthogonal plane CT images, or reformatted sagittal, coronal views structures are displayed with or without the digitally reconstructed radiograph. Integration: Review multi-modality in=mage data (CT,PET & MR) on one desktop by using up to eight view ports on two monitors ad increase your speed and precision by contouring on all simultaneously. Incorporation of CT simulation with the following enhancements in one integrated environment for advanced clinical functionality and flexibility. Organ Auto-Segmentation: Contour and organ in less than 5 seconds with Auto-segmentation features that automatically delineates critical organs and structures in 3D at the touch of a button. This improves speed and accuracy of organ segmentation for conventional treatment methods as well as newer 4D techniques. Currently supported organs include: o Lung o Spinal Cord o Liver o Kidney o Spleen o Eyes o Optic Nerve

Qty	Catalog No.	Description
		3D contour interpolation: This allows the user to define a full volume contour with a minimum of 3 contours in orthogonal views. This may be particularly useful for bladder delineation. Speed: The package allows complete 3D volumes to be defined and manipulated using automatic thresholding tools, structure drawing with or without "Live Wire" to pixel value gradients and automatic interpolation. Beam placement is facilitated with automatic isocenter and beam's eye view. Ease of use: The package is mouse driven with a windows user interface. The press of a single button using pre-defined and configurable treatment plan templates linked to patient anatomy offers many functions. Protocol specific structure names and properties, beam geometry and field shape can be loaded from a palette of templates. Pre-defined sequences of actions can then be applied adding to the ease of use. Flexibility: Contouring and fiedl definition parameters can be modified on the fly to allow thresholds, margins and display characteristics to be tailored to a given patient data. Efficiency: The package is designed for use independently of a treatment planning system, enabling the physician to define volumes and select treatment technique at a dedicated workstation. Any plan can be saved and pushed to a RTP system as standard DICOM RT objects. DICOM RT Structure Set and RT Plan objects cam also be received from DICOM RT compliant systems and re-simulated in AdvantageSim MD. Advantage CT/PET & CT/MR Fusion: Advantage Fusion is a software application that provides easy comparison of three-dimensional images from CT and PET amd CT and MR. It allows 3D registration between two volumetric acquisitions, which may come from different acquisition modalities. The registration mechanism is based on the semi-automatic identification of common surface and user validated by localization of common landmarks. Visual feedbacks amd scores are provided to assess matching accuracy. Advantage Fusion displays real time axial, sagittal, and coronal MPR views for both exams. Multiple correlated or fused display options bring out the full information from both acquisitions. Advantage Fusion results may either be fused or registered stack of DICOM images, and registered graphic contours defined from one modality and reported into the other modality.
1	B750OCT	2.5 days Onsite Oncology (Advantage SIM) Training CT Advantage Sim Training • (1) 2.5 Day On Site Visit for Training Advantage Sim and Advantage CT/MR Fusion
1	W040 0PT	4 Day Onsite Training for Cardiac PET 4 Days TiP PET Onsite Training Cardiac PET-CT

Qty	Catalog No.	Description
		One 4 day visit for customer new to cardiac PET-CT. This program spans 4 consecutive days and targets technologists who are new to cardiac PET-CT imaging.
1	W0101PT	2 days TiP PET 4D Respiratory Gating Onsite Training TiP PET 4D Respiratory Gated Onsite Training 2 day onsite training in the acquisition, processing, and display of 4D PET Respiratory Gated exams. Note: 4D CT training for Oncology RTP AW SIM must be included separately, if required.

(Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0057

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

St. Vincent's Medical Center of Bridgeport, CT, d/b/a St. Vincent's Medical Center is hereby licensed to maintain and operate a General Hospital.

St. Vincent's Medical Center is located at 2800 Main Street, Bridgeport, CT 06606

The maximum number of beds shall not exceed at any time:
47 Bassinets
473 General Hospital beds

This license expires **September 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2007.

License revised to reflect:
*Added 76 Beds effective 10/1/08

Satellites
St. Vincent's Immediate Health Care, 4600 Main Street, Bridgeport, CT
St. Vincent's Immediate Health Care, 1055 Post Road, Fairfield, CT
St. Vincent's Immediate Health Care, 2 Trap Falls Road, Shelton, CT
St. Vincent's Medical Center, Neighborhood at St. Joseph's Center, 43 Madison Avenue, Bridgeport, CT
Family Health Center, 760-762 Lindley Street, Bridgeport, CT
St. Vincent's Immediate Health Care, 401 Monroe Turnpike, Monroe, CT
St. Vincent's Family Practice, 2595 Main Street, Stratford, CT
The St. Vincent's Center for Wound Healing, 115 Technology Drive, Trumbull, CT
St. Vincent's Behavioral Health Center-Westport, 47 Long Lots Road, Westport, CT

J Robert Galvin MD MPH MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 7, 2008

Rachel Giliotti
Administrative Director
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

Re: Letter of Intent; Docket Number: 08-31252
St. Vincent's Medical Center
Acquisition of a Fixed PET/CT Scanner through Replacement of an Existing Mobile PET/CT Scanner

Dear Ms. Giliotti:

On October 15, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of St. Vincent's Medical Center ("Applicant") for the acquisition of a fixed PET/CT scanner through replacement of an existing Mobile PET/CT scanner, at a total capital expenditure of $3,248,450.

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

Sincerely,

Barbara Durdy
Director of Operations

BD:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 7, 2008

Requisition # HCA09-059
Fax: (203) 384-1158
Acct# 106794

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 **Tuesday, November 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 Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Barbara Durdy
Director of Operations
Attachment

BD:SWL:lmg

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	St. Vincent's Medical Center
Town:	Bridgeport
Docket Number:	08-31252-LOI
Proposal:	Acquisition of a Fixed PET/CT Scanner through Replacement of an Existing Mobile PET/CT Scanner
Capital Expenditure:	$3,248,450

The Applicant may file its Certificate of Need application between December 14, 2008 and February 12, 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 ***
****

TRANSMISSION OK

TX/RX NO	4273
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	11/07 15:29
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 7, 2008

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 10, 2008

Rachel Giliotti
Director
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

RE: Certificate of Need Application Forms; Docket Number: 08-31252-CON
St. Vincent's Medical Center
Acquisition of a Full-Time Positron Emission Tomography/Computed Tomography ("PET/CT")Scanner to Replace Hospital's Existing Mobile PET/CT Scanner

Dear Ms. Giliotti

Enclosed are the application forms for St. Vincent's Medical Center's Certificate of Need ("CON") proposal for the acquisition of a Full-Time Positron Emission Tomography/Computed Tomography ("PET/CT") Scanner to replace Hospital's existing mobile PET/CT Scanner, with an estimated total capital expenditure of $3,248,450, According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between December 14, 2008 and February 12, 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 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

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, 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)

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 December 14, 2008, and may be submitted no later than February 12, 2009. 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: 08-31252-CON

Applicant Name: St. Vincent's Medical Center.

Contact Person: Rachel Giliotti
Contact Title: Director
St. Vincent's Medical Center
Contact Address: 2800 Main Street
Bridgeport, CT 06606

Project Location: Bridgeport

Project Name: Acquisition of a Fixed Positron Emission Tomography-Computed Tomography ("PET/CT") Scanner to Replace Hospital's Existing Mobile PET/CT Scanner

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

Est. Capital Expenditure: $3,248,450

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 St. Vincent's Medical Center ("Applicant" or "SVMC") determined need to acquire a full-time fixed PET/CT scanner.

B. Did the Applicant consider other alternatives to the fixed PET/CT scanner? (i.e. increasing days on the existing mobile PET/CT scanner, etc.)

C. Please address the following:

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

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

iii. Regarding the proposed change in PET/CT imaging service location, please address the following.

1. Discuss the proposed relocation to the North Building.
2. Discuss other services that the Applicant is planning to relocate to the proposed building.
3. Delineate the impact of other relocated services to the North Building on the proposed Fixed PET/CT scanner.
4. What impact will the relocation have on the inpatient population access to PET/CT imaging?

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

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

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

G. Hours of operation of the existing mobile PET/CT scanner *and* the proposed fixed PET/CT scanner.

H. Provide a copy of the current mobile PET/CT scanner's weekly schedule (by faculty).

I. SVMC is currently providing PET/CT 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 SVMC applied to determine the need for a full-time PET/CT scanner. *Be sure to provide documentation as evidence.*

J. Provide all schematic drawings of the proposed North Building, identifying the location of the proposed PET/CT scanner and any related services.

K. Can the North Building accommodate a mobile PET/CT scanner?

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

	Existing PET/CT Scanner Historical (Last 3 FYs)			**Current Year**	**Projected PET/CT Scanner (First 3 *Full* FYs)***		
	FY '06	FY '07	FY '08	FY '09	FY '10	FY '12	FY ''13
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.

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

Total Capacity Based on Hours of Operation

	Existing mobile PET/CT Scanner (FY 2008)	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 2009 for the existing PET/CT scanner & first full year of operation for the proposed PET/CT scanner)*		
% Total Capacity		

N. 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.

O. Where did SVMC currently refer their patients for PET/CT services in FY 2008 when it was unable to accommodate them?

P. During FY 2008, how many patients was SVMC unable to accommodate for PET/CT imaging and where were the referred to ?

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. Please detail the assumptions utilized in requesting a full-time fixed PET/CT at the North Building.

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 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 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]

[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.

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

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. 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 SVMC be charging a technical fee?

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.

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 o f 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.

vii) Discuss the cost benefits of a mobile versus a fixed PET/CT scanner?

St. Vincent's Medical Center

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: 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.

St. Vincent's Medical Center

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		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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 19, 2008

Rachel Giliotti
Administrative Director
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

RE: Certificate of Need Application Forms, Docket Number 08-31252-CON
St. Vincent's Medical Center
Acquisition of a Fixed PET/CT Scanner Through Replacement of an Existing Mobile PET/CT Scanner.

Dear Ms. Giliotti:

Enclosed are the application forms for St. Vincent's Medical Center's Certificate of Need ("CON") proposal for the Acquisition of a Fixed PET/CT scanner through replacement of an existing Mobile PET/CT scanner with an associated capital expenditure of $3,248,450. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between December 14, 2008, and February 12, 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 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 analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012 if you have questions.

Sincerely,

Barbara Durdy
Director of Operations

Enclosures

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, 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)

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 December 14, 2008, and may be submitted no later than February 12, 2009. 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: 08-31252-CON

Applicant Name: St. Vincent's Medical Center.

Contact Person: Rachel Giliotti
Contact Title: Director
St. Vincent's Medical Center
Contact Address: 2800 Main Street
Bridgeport, CT 06606

Project Location: Bridgeport

Project Name: Acquisition of a Fixed Positron Emission Tomography-Computed Tomography ("PET/CT") Scanner to Replace Hospital's Existing Mobile PET/CT Scanner

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

Est. Capital Expenditure: $3,248,450

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 December 14, 2008, and may be submitted no later than February 12, 2009. 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: 08-31252-CON

Applicant Name: St. Vincent's Medical Center.

Contact Person: Rachel Giliotti
Contact Title: Director
St. Vincent's Medical Center
Contact Address: 2800 Main Street
Bridgeport, CT 06606

Project Location: Bridgeport

Project Name: Acquisition of a Fixed Positron Emission Tomography-Computed Tomography ("PET/CT") Scanner to Replace Hospital's Existing Mobile PET/CT Scanner

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

Est. Capital Expenditure: $3,248,450

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 St. Vincent's Medical Center ("Applicant" or "SVMC") determined need to acquire a full-time fixed PET/CT scanner.

B. Did the Applicant consider other alternatives to the fixed PET/CT scanner? (i.e. increasing days on the existing mobile PET/CT scanner, etc.)

C. Please address the following:

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

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

iii. Regarding the proposed change in PET/CT imaging service location, please address the following.

1. Discuss the proposed relocation to the North Building.
2. Discuss other services that the Applicant is planning to relocate to the proposed building.
3. Delineate the impact of other relocated services to the North Building on the proposed Fixed PET/CT scanner.
4. What impact will the relocation have on the inpatient population access to PET/CT imaging?

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

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

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

G. Hours of operation of the existing mobile PET/CT scanner *and* the proposed fixed PET/CT scanner.

H. Provide a copy of the current mobile PET/CT scanner's weekly schedule (by faculty).

I. SVMC is currently providing PET/CT 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 SVMC applied to determine the need for a full-time PET/CT scanner. *Be sure to provide documentation as evidence.*

J. Provide all schematic drawings of the proposed North Building, identifying the location of the proposed PET/CT scanner and any related services.

K. Can the North Building accommodate a mobile PET/CT scanner?

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

	Existing PET/CT Scanner Historical (Last 3 FYs)			Current Year	Projected PET/CT Scanner (First 3 *Full* FYs)*		
	FY '06	FY '07	FY '08	FY '09	FY '10	FY '12	FY ''13
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.

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

Total Capacity Based on Hours of Operation

	Existing mobile PET/CT Scanner (FY 2008)	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 2009 for the existing PET/CT scanner & first full year of operation for the proposed PET/CT scanner)*		
% Total Capacity		

N. 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.

O. Where did SVMC currently refer their patients for PET/CT services in FY 2008 when it was unable to accommodate them?

P. During FY 2008, how many patients was SVMC unable to accommodate for PET/CT imaging and where were the referred to ?

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. Please detail the assumptions utilized in requesting a full-time fixed PET/CT at the North Building.

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]

[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.

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

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. 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 SVMC be charging a technical fee?

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.

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.

vii) Discuss the cost benefits of a mobile PET/CT scanner versus a fixed PET/CT scanner?

St. Vincent's Medical Center

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: 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.

St. Vincent's Medical Center

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

PUBLIC NOTICES

STATE OF CONNECTICUT
REQUEST FOR PROPOSAL
JOINT COMMITTEE ON
LEGISLATIVE MANAGEMENT

Notice is hereby given pursuant to Section 2-71p of the Connecticut General Statutes, as amended, that the Joint Committee on Legislative Management of the Connecticut General Assembly has issued a Request for Proposal for Plaster Repairs - JCLM08REG0124.

Proposal responses are due no later than 12:00 p.m. (NOON) on December 12, 2008

posal to excavate a boat ramp into the Housatonic River. Approved with conditions.

2. PERMIT-APPLICATION #08-27, CUFF PROPERTY THE MAPLES - 121 INDIAN WELL ROAD. Proposal to replace retaining wall and construct home addition within regulated upland adjacent to Housatonic River. Approved with conditions.

3. APPLICATION #08-29, BARROZO PROPERTY - 23 MIMOSA LANE. Proposal to sustain landscaping work executed without authorization. Approved with conditions.

Detail of the above referenced application is on file in the office of the Shelton Inland Wetlands Commission, Shelton City Hall.

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS

ORDER OF NOTICE

NOTICE TO: **Thomas Tracy**
of parts unknown.

A petition/motion has been filed seeking:

Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.

The petition, whereby the court's decision can effect your parental rights, if any, re-

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DISTRICT OF Trumbull

NOTICE TO CREDITORS

ESTATE OF WILLIAM A.BOYD
Late of Trumbull

decree dated November 6, 2008, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Elizabeth S.Frassinelli, Clerk

The Fiduciary is

Maria C.Taylor
c/o John V.A.Murray, Diserio Martin O'Connor & Castiglioni, One Atlantic Street
Stamford, CT 06901

STATE OF CONNECTICUT
COURT OF PROBATE
District of Stratford

NOTICE TO

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
District of Stratford

NOTICE TO CREDITORS

ESTATE OF LINDA MARY COLLAZO
(08-7226)

below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Deirdre L.Bassett
Clerk

The fiduciary is:

Kenneth Pike
Administrator
c/o Attorney Peter Kaiser, Kaiser and Collier
1136 Broadbridge Avenue
Stratford, CT 06615

STATE OF CONNECTICUT
COURT OF PROBATE
District of Stratford

NOTICE TO CREDITORS

ESTATE OF GARY SHARP
(08-7250)

The Hon. F. Paul Kurmay, Judge of the Court of Probate, District of Stratford, by de-

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE,
DISTRICT OF Bridgeport

NOTICE OF CREDITORS

ESTATE OF KATHLEEN P.LUCAS

decree dated October 20, 2008, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of right to recover on such claim.

Jeannette Sargent, Clerk

The fiduciary is

Wieslaw Jablecki
c/o Peter Kaiser, Esquire, Kaiser and Collier, 1136 Broadbridge Ave,Stratford, CT 06615

STATE OF CONNECTICUT
COURT OF PROBATE,
DISTRICT OF Bridgeport

NOTICE OF CREDITORS

ESTATE OF

RENTALS

APARTMENTS FOR RENT

Bridgeport 3BR, Only $800/mo+sec! Maplewood Avenue Call 203-545-5628

BRIDGEPORT N.E., 2nd flr, 3Br, DR, LR, KIT, BA. $1250 + all utils. 203-610-2661.

BRIDGEPORT
M.Ahlberg
2885 Main Street
Stratford, CT 06614

STATE OF CONNECTICUT
COURT OF
PROBATE
District of
Stratford

NOTICE TO
CREDITORS

ESTATE OF
LENNY R.CLARK
(08-7200)

The Hon. F. Paul Kurmay, Judge of the Court of Probate, District of Stratford, by decree dated November 4, 2008, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Deirdre J.Bassett
Clerk

The fiduciary is:

APARTMENTS FOR RENT

BRIDGEPORT Desirable Embassy Towers Waterviews. All amenities. Lg studio apt. All new. 24hr sec. $975 Call Susan. Opt to buy. Av Dec. 1 203-610-5629.

LOOK

Harriet L. Sherman,
155 Brewster Street, Apt. 3-N, Bridgeport, CT 06605
c/o Thomas M Sutnick,
2 Corporate Drive, Suite 643
Shelton Ct. 06484

APARTMENTS FOR RENT

Bridgeport NE, brand new 3BR, Sec. 8 approved. $1350. Agent, 203-913-5818

BRIDGEPORT Hancock Ave. Newer 1BR, incls ht/hw. Sec 8 ok. $750/mo Agent Call 203-913-5818

BRIDGEPORT 2BR condo, HT/HW incl, no pets, Sec. 8 OK, $1050. 201-666-2031

APARTMENTS FOR RENT

Bridgeport 2BR apts avail. 299 Dover St. recent renov'n. $850/m. Sec 8 ok 847-5137

BRIDGEPORT Brdsly Pk. Mod 2BR $1050 & 1BR $975 + Util's. 203-953-4612

BRIDGEPORT Huntington Rd Nr. Dairy Queen. 2½BR, 1BA LR, DR, HW firs. Fplc. No smoke/pets. $1200 mo. 203-685-8788

may qualify for benefits such as training, job search and relocation allowances, income support and health coverage tax credit.

Eligible workers may contact the nearest Department of Labor/CTWorks Center for information and assistance.

PUBLIC NOTICES

NOTICE OF PUBLIC HEARING
Docket Number 08-31252

November 7, 2008

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant:	St. Vincent's Medical Center
Town:	Bridgeport
Docket Number:	08-31252-L01
Proposal:	Acquisition of a Fixed PET/CT Scanner through Replacement of an Existing Mobile PET/CT Scanner.
Capital Expenditure:	$3,248,450

The applicant may file its Certificate of Need application between December 14, 2008 and February 12, 2009. Interested persons are invited to submit written comments to Christine 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.

APARTMENTS RENT

BRIDGEPO
Black Rock, Be
1BR apt, lof
kitch/DR, LR,
or 2nd BR,
OSP. No smkg
Cred ck & refs
+ utils. Avail
Call 371-4766.

BRIDGEPORT
Denver. 2BR, L
2BA, 2nd/3rd
bined $1100. 52

BRIDGEPORT

Duplex 2BR,
1st flr. $850+1
sec. Mark 54

BRIDGEPORT
N.End loc. 2n
rms, 2BRs, m
bath, stv/refri
hdwd firs
OSP, $1350/m
all utils. 1st m
& 1 mo sec re
203-526-2424.

BRIDGEPORT
Englewood A
LR,DR,Kit.203
58 or 203.243.8

BRIDGEPORT
renov, lg. 2Br,
w/d in unit, Ma
Sth End, $1025
335-2005 Sec 8

BRIDGEPORT
Newly Renova
appl's. $900 m
sec. 203-943-0

BRIDGEPORT
Newly renov.
$750. Union
203-366-5581.

BRIDGEPORT
Clermont,1br,
KIT, rugs, la
osp. $820. 520-

BRIDGEPORT-
in Multi. fam ho
914-482-1145