71 Haynes Street
Manchester, CT 06040

ECHN

Eastern Connecticut Health Network, Inc.

Phone (860) 533-3414

May 26, 2009

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

Dear Commissioner Vogel:

Enclosed please find the Letter of Intent being filed on behalf of Manchester Memorial and Eastern Connecticut Health Network. We are proposing to replace the existing mobile PET service at Manchester Memorial Hospital with a mobile PET/CT.

If you have any questions or concerns regarding this submission, please do not hesitate to give me a call at (860) 533-3429.

Sincerely,

Dennis P. McConville
Senior Vice President of Planning, Marketing and Communications

Enc.

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One
Full legal name	Manchester Memorial Hospital
Doing Business As	
Name of Parent Corporation	Eastern Connecticut Health Network, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	71 Haynes Street Manchester, CT 06040
Identify Applicant Status: P for Profit or NP for Nonprofit	NP
Does the Applicant have Tax Exempt Status?	(Yes) No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Dennis P. McConville Senior Vice President of Planning, Marketing and Communications
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	71 Haynes Street Manchester, CT 06040
Contact Person Telephone Number	(860) 533-3429
Contact Person Fax Number	(860) 647-6860
Contact Person e-mail Address	dmcconville@echn.org

SECTION II. GENERAL APPLICATION INFORMATION

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

b. Project Proposal: Eastern Connecticut Health Network and Manchester Memorial Hospital are proposing to replace the existing, part-time mobile PET service at the hospital with a part-time mobile PET/CT.

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

Inpatient Service(s):

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

Outpatient Service(s):

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

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☒ 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:

71 Haynes Street, Manchester, CT 06040

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

Response:

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

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

h. Estimated starting date for the project: **October 1, 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: **$ 0**

Response:

There are no capital expenditures associated with the proposed replacement of the mobile PET unit with the mobile PET/CT unit. All expenses associated with this proposal are operating expenses.

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

Major Medical Equipment Purchases*	$0
Medical Equipment Purchases*	$0
Non-Medical Equipment Purchases*	$0
Land/Building Purchases	$0
Construction/Renovation	$0
Other (Non-Construction) Specify:_____	$0
Total Capital Expenditure	$0
Major Medical Equipment – Fair Market Value of Leases Medical	$0
Equipment – Fair Market Value of Leases	$0
Non-Medical Equipment – Fair Market Value of Leases*	$0
Fair Market Value of Space – Capital Leases Only	$0
Total Capital Cost	$0
Total Project Cost	$0
Capitalized Financing Costs (Informational Purpose Only)	$0

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

Response:

As noted above, there are no capital expenses associated with this proposal.

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

☐ Yes ☐ No ☒ **Not Applicable**

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

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

☐ Non Substantive

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

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Mobile PET/CT	Siemens or GE	TBD	1	See below response

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

Response:

The Applicant is proposing to contract with Alliance Imaging, a division of Alliance HealthCare Services, to provide mobile PET/CT services to replace the current PET service at Manchester Memorial Hospital. The vendor contract is still being negotiated at the time of this submission and will be provided to OHCA with the CON application.

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)* Per procedure fee (operating expense)**

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and the target population to be served.

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

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

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

AFFIDAVIT

To be completed by each Applicant

Applicant: Manchester Memorial Hospital

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

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

of Eastern Connecticut Health Network, Inc. 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 Manchester Memorial Hospital (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Peter J. Karl — Signature

5/26/09 — Date

Subscribed and sworn to before me on May 26, 2009

Carol Freeman
Notary Public/Commissioner of Superior Court

My commission expires: 4-30-2014

RECEIVED
2009 MAY 27 A 8:40
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Section IV Projection Description

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

MMH recognizes that PET/CT has become the standard of care for treating cancer patients, and those patients and their physicians have come to expect this level of cancer care services within their community. The combined PET/CT offers better diagnostic capability by fusing the images received from the PET and CT into a single image, enabling patients to have access to the latest technology available in diagnostic cancer care services. MMH is proposing to replace the current mobile PET service with mobile PET/CT.

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

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

Currently, PET services are provided for MMH by Insight Health Corporation. MMH plans to contract with Alliance Imaging to provide mobile PET/CT services to replace the service contract currently provided by Insight Health Corporation. The vendor will be responsible for providing the equipment, staffing and scheduling of the unit as part of the contracted service to MMH. MMH will be responsible for the billing functions related to the PET/CT service. The physicians of Eastern Connecticut Imaging, PC will continue to be responsible for reading the study results.

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 1, 2009

Dennis McConville
Vice President, Strategic and Operational Planning
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Letter of Intent; Docket Number: 09-31379
Eastern Connecticut Health Network, Inc.
Manchester Memorial Hospital's Proposal to Replace Current Mobile PET Service with Mobile PET/CT Service
Notice of Letter of Intent

Dear Mr. McConville:

On May 27, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Eastern Connecticut Health Network, Inc. ("Applicant") to replace current mobile PET service with mobile PET/CT service at Manchester Memorial Hospital with no associated capital expenditure.

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

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:LG:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 1, 2009

Requisition # HCA09-146
Email: Legals@JournalInquirer.com

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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 **Friday, June 5, 2009.**

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 Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

Journal Inquirer **Letter of Intent**
Docket Number: 09-31379-LOI **June 1, 2009**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Eastern Connecticut Health Network, Inc.
Town:	Manchester
Docket Number:	09-31379-LOI
Proposal:	Manchester Memorial Hospital proposes to replace its current mobile PET service with mobile PET/CT service
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between July 26, 2009 and September 24
, 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 at OHCA or on OHCA's website at www.ct.gov/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.

Greer, Leslie

From: Greer, Leslie
Sent: Monday, June 01, 2009 3:21 PM
To: 'legals@journalinquirer.com'
Subject: Legal Ad 09-31379-LOI
Attachments: 09-31379 LOI Journal Inquirer.doc

Please place the attached Legal Ad in your newspaper by June 5, 2009. Please notify me by email that this has been completed.

Thank you,

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: legals@journalinquirer.com
Sent: Tuesday, June 02, 2009 11:25 AM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31379-LOI

Good Morning Leslie,
Your legal ad is all set to run tommorrow, June 3, 2009. We will forward invoice for $110.18 aong with tear sheet and affidavit of publication as requested.
Thank you,
Tom
Classified Dept.

---- Original Message ----
From: Leslie.Greer@ct.gov
To: legals@journalinquirer.com
Subject: Legal Ad 09-31379-LOI
Date: Mon, 1 Jun 2009 15:21:24 -0400

>Please place the attached Legal Ad in your newspaper by June 5, 2009.
>Please notify me by email that this has been completed.
>
>
>
>Thank you,
>
>
>
>Leslie M. Greer
>
>Office of Health Care Access
>
>State of Connecticut
>
>410 Capitol Avenue
>
>Hartford, CT 06134
>
>Phone: (860) 418-7001
>
>Fax: (860) 418-7053
>
>Website: www.ct.gov/ohca <http://www.ct.gov/ohca>
>
>
>

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 3, 2009 via fax and email only

Dennis McConville
Vice President, Strategic and Operational Planning
Eastern Connecticut Health Network, Inc.
71 Haynes St.
Manchester, CT 06040

RE: Certificate of Need Application Forms, Docket Number 09-31379-CON
Eastern Connecticut Health Network, Inc.
Proposal to Acquire Mobile PET/CT Service to Replace Mobile PET Service at Manchester Memorial Hospital

Dear Mr. McConville:

Enclosed are the application forms for Eastern Connecticut Health Network, Inc.'s Certificate of Need ("CON") proposal for the Proposal to replace current mobile PET service with mobile PET/CT service with no associated capital expenditure. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between July 26, 2009, and September 24, 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 Laurie Greci. Please contact her at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Attachments

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 July 26, 2009, and may be submitted no later than September 24, 2009. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31379-CON
Applicant's Name:	Eastern Connecticut Health Network, Inc.
Contact Person:	Dennis McConville
Contact Title:	Vice President, Strategic and Operational Planning Eastern Connecticut Health Network, Inc.
Contact Address:	71 Haynes St. Manchester, CT 06040
Project Location:	Manchester
Project Name:	Acquire Mobile PET/CT Service to Replace Mobile PET Service at Manchester Memorial Hospital
Type proposal:	Sections 19a-638 and 19a-639, C.G.S.
Est. Capital Expenditure:	$0

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

TRANSMISSION OK

TX/RX NO	0201
RECIPIENT ADDRESS	96476860
DESTINATION ID	
ST. TIME	06/03 16:23
TIME USE	04'56
PAGES SENT	14
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DENNIS MCCONVILLE

FAX: 647-6860

AGENCY: EASTERN CONNECTICUT HEALTH NETWORK, INCL

FROM: LAURIE GRECI

DATE: 6/3/09 **TIME:**

NUMBER OF PAGES: 14
(including transmittal sheet

Comments: Docket 09-31379 CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

1. Provide a narrative detailing the proposal.

2. Identify the imaging modalities and other services currently offered by Eastern Connecticut Health Network ("ECHN") at *each* of its sites, and complete Table 1 for each scanner (of the type proposed) currently operated by the Hospital.

Table 1: Existing Scanners Operated by the Hospital

Provider Name Street Address Town and Zip code	**Description of Service ***	**Hours/Days of Operation ****	**Capacity *****	**Utilization ******

* Include equipment strength (e.g. slices, Tesla strength), whether scanner is open or closed (for MRI)
** Days of the week scanner is operational, and start and end time for each day;
*** Provide the methodology used; and
**** Number of scans performed on each scanner for the most recent 12-month period.

3. Describe how it was determined that there was a patient base in the area that would benefit from introduction of the proposed service.

4. Provide the following regarding the proposed scanner:

   a. Manufacturer, Model, Number of slices/Tesla strength
   b. Explain how the Hospital determined there was a need for the proposed scanner at the proposed location
   c. Provide a copy of any studies or reports that support the need to acquire the proposed scanner, along with an explanation regarding the relevance of the selected articles
   d. Describe the population to be served and where they are currently receiving services

5. Identify the days and hours of operation of the existing and proposed services.

6. Provide the following information regarding the proposal's location:

   a. The towns ("towns") where the majority of your patients reside;
   b. The rationale for choosing the towns;
   c. List the existing providers of the proposed service in the towns;
   d. Describe the effect of your proposal on existing providers of PET/CT service (i.e. patient volume, quality of care, etc.); and
   e. Identify the facilities to which the Hospital has referred patients for PET/CT scans.

7. Provide the following regarding current and projected volume:

   a. Complete the **Table 2** to include actual scans per fiscal year ("FY"), scans per current fiscal year ("CFY") and projected scans per FY for each of the Hospital's existing and proposed scanners;
   b. Indicate the Hospital's fiscal year utilized in completing Table 2;
   c. Explain any increase or decreases in volume seen in the table;
   d. Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volumes; and
   e. Provide volumes for the most recently completed FY by town

Table 2: Current and Projected Volume

Number of Procedures	**Actual Exam Volume (Last 3 Completed FYs)**			**CFY Volume***	**Projected Exam Volume (First 3 Full Operational FYs)****		
	FY____	**FY____**	**FY____**	**FY____**	**FY____**	**FY____**	**FY____**
List each scanner on a separate line.***							
Total							

* Please report the annualized number of scans, identifying the months covered if not a full FY.

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

*** Break out inpatient/outpatient/ED volumes if applicable. Also break out by type of scan if specializing (e.g. orthopedic, neurosurgery).

8. Check off the standard of practice guidelines that will be utilized by the Hospital for the proposed service.

   ☐ Report of the Inter-Council for Radiation Oncology
   ☐ American College of Radiology
   ☐ Other (Specify):_____

9. Provide excerpts relevant to the proposal and describe how the Hospital plans to meet the practice guidelines to be utilized.

10. Provide the following regarding the existing imaging unit:

    a. Location;
    b. Manufacturer;
    c. Model/make;
    d. Number of slices or Tesla strength;
    e. Age of the scanner;
    f. Date of installation;
    g. Cost of acquisition;
    h. General condition of the scanner;
    i. Add-ons or attachments to the base model scanner;

j. A copy of the ACR accreditation certificate(s) and, if applicable, description of where in the process the Hospital is regarding recertification;
k. Documentation of any downtime, and number of days per year.

11. Provide the following regarding the Hospital's existing mobile PET service:

a. Describe the conditions of the current contract with Insight Health Corporation.
b. If the Hospital plans to relocate the existing mobile PET service to another location, explain why and identify the location (name, address, and description of the location).

12. Identify any scans/exams that can be performed on the proposed scanner that the Hospital is unable to perform on its existing scanners. Provide the number of projected additional scans to be performed including the basis for the projection.

13. Indicate type of ownership (check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)
☐ Professional Corporation (PC) ☐ Other (Specify):

14. Provide a detailed explanation of the Hospital's and/or the vendor's plan concerning the existing PET scanner.

15. Provide audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.) These numbers should correspond to the actuals reported in Financial Attachment I.

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

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

17. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution; etc.

18. If the proposal includes a capital equipment lease and/or purchase, provide the following:

    a. The fair market value of the lease;
    b. Anticipated residual value at the end of the lease or loan term;
    c. The expected useful life of the equipment;
    d. The copy of the vendor quote or invoice as an attachment;
    e. The Schedule of depreciation for the purchased equipment; and
    f. A copy of the Lease agreement for the equipment.

19. Provide the current and projected patient population mix with the CON proposal for the total facility/proposed program using the following tabular format:

	PET	**PET/CT**		
Patient Population Mix	**Current FY ___**	**Year 1 FY ___**	**Year 2 FY ___**	**Year 3 FY ___**
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Other (specify):				
Total Government				
Commercial Insurers*				
Uninsured**				
Workers Compensation				
Other (specify):				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.

** Includes uninsured only; add additional payers as appropriate, e.g., self-pay, co-payments received from insured patients.

20. Provide the basis for the patient population mix for the proposed service. Detail any differences between the current mobile PET service and the PET/CT service.

21. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project for the Hospital and for ECHN. **Complete Financial Attachment 1 for MMH and ECHN.** (Note that the actual results for the fiscal year reported in the first column must agree with the Hospital's audited financial statements.) The projections must include the first three full fiscal years after project completion.

22. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years after project completion.

23. List all the assumptions utilized in developing both Financial Attachment I and II (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

24. Provide documentation to support the proposed rates and units of service for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service.

25. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

26. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

27. Relation of the proposal to the State Health Plan - No questions at this time.

28. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Provide a copy of their Curriculum Vitae.

29. Explain how this proposal contributes to the quality of health care delivery in the region.

30. Do any of the Section 19a-637, C.G.S., criteria listed below relate to your proposal? Specify the ones that apply to this proposal, explain how and provide supporting documentation:
    - Voluntary efforts to improve productivity and contain costs;
    - Change to your teaching or research responsibilities; and
    - Special characteristics of your patient/physician mix.

22. Please provide one year of actual results and three (3) years of projections of Manchester Memorial Hospital's 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										
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.

22. Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: 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.

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

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: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____	$_____.00
(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
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).	
SECTION B TOTAL FEE DUE: _____	$_____.00

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

510 APARTMENTS FOR RENT

SQUIRE VILLAGE APTS Available Market Rate Units 1,2, & 3 BR. Rent includes heat & hot water. Some amenities: fully applianced kitchen, w/w carpet, emergency maintenance. Laundry facilities & easy highway access. Section 8 vouchers/Section 8 certificates gladly accepted. Please call 646-1280 8:30-5pm EHO-CHFA Financed

STAFFORD 1 & 2 BR units avail, 68 West Main St, 2 mos sec, no pets. 860-745-0321.

STAFFORD SPRINGS
WESTBROOK APTS
22 West Street
New 3 room unit in brick garden apt building. Total electric. Range, refrigerator, disposal, carpeting. Absolutely no cats or dogs. Basement laundry & storage. $625/mo., 1 year lease. Call:
Jimmy Gessay
860-875-0134

SUFFIELD-1 bdrm 2nd flr Owner occp 3 fam Home Priv frnt prch Hdwd flr ac w/d. $695/mo 860-668-7603.

VERNON 1 BR apts, quiet 4-fam Victorian. $600 +utils No pets. Call 860-295-9903

VERNON 1 BR Quiet Area Heat incl. No Pets. Rent $700/mo, $950 sec dep. 860-281-4205

VERNON 2BR Twh, 1½ bath, Fin bsmt. Frpl. No pets. $1200+1 mo sec. 860-922-6172

VERNON 5 Rms. Priv. Vernon center area. $925. Wkdys 871-0840 Eves/Wk-ends 872-7697

Vernon- Briar Knoll Apts., spacious., 1 & 2 BR, private entry, pet friendly, Call to set up a tour. 860-871-8060

Vernon-remodeled 1br w/gar., & deck avail., immed., ht/hw inclu., no pets $850 872-7384

Vernon/Rockville -1 BR $600 2br $700+ util Pet friendly. Call 871-2121

VERNON Spacious 1 BR Free Ht/Ht.wtr Strge, balcony, starts @ $900. Pets OK. 870-9028

Vernon/Tolland 2BR Dplx Gar, w/d, Nice loc. Pets OK.

560 ROOMS FOR RENT

ENFIELD
SUPER 8 MOTEL
Stay 5 Nights Reg Rate Get Next 2 FREE! When you pay in advance Laundry on Premises Refrigerator- No Charge
Rates from $39.88/up
CALL 860-741-3636

MANCHESTER-Exc 2 lrg furn rms, male share kitch/bath, util other. $155 wk incl all. 643-6187

575 VACATION RENTALS

Newport RI available June 26th-July 3rd. Choice for 4-7 days. 2br, sleeps 6, $700-$1000 + sec 860-649-7531 evenings

605 BUSINESS PROPERTY

TOLLAND- 4.4 acres, 200 Road Frontage, Brook Frontage, Idle cated, Shenipsit Lake Rd, $119,900 owner Financing Available, Petrowsky Enterprises 860-836-9294 or E-mail Joe@righttracfg.com

Tri Town Business District. Ranch, commercial zoned, can be used for anything 432-7117

VERNON/MANCHESTER We can help your business. Exc. loc., pricing. Call 860-871-4112.

PUBLIC NOTICE

NOTICE TO CREDITORS
ESTATE OF
Harold P. Case, AKA
Harold Pershing Case (09-0210)

PUBLIC NOTICE

PUBLIC NOTICE

Statute Reference:	19a-639
Applicant:	Eastern Connecticut Health Network, Inc.
Town:	Manchester
Docket Number:	09-31379-LOI
Proposal:	Manchester Memorial Hospital proposes to replace its current mobile PET service with mobile PET/CT service
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between July 26, 2009 and September 24, 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 at OHCA or on OHCA's website at www.ct.gov/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.
Journal Inquirer
June 3, 2009

PUBLIC NOTICE
ANNUAL MEETING
CRYSTAL LAKE FIRE DISTRICT

The legal voters of the Crystal Lake Fire District, Inc., the town of Ellington, Connecticut, are hereby warned of the annual meeting of the said district to be held on Monday, June 29, 2009 at 8:00 p.m. EDT in the firehouse of Crystal Lake for the following reasons:

1. To hear and take action on the annual report of the committee for the said district.
2. Consider and if deemed advisable to empower the committee to contract with the Town of Ellington to provide fire protection in the Crystal Lake Fire District for a period of one year.