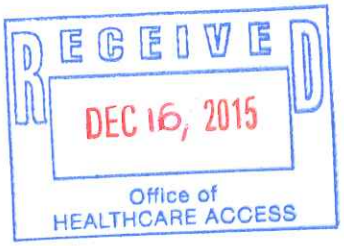
DKH DAY KIMBALL HEALTHCARE



December 14, 2015

Kimberly R. Martone
Director of Operations
State of Connecticut DPH
Office of Health Care Access
410 Capitol Ave., MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

Please find enclosed check #0566266 in the amount of $500.00 for the Certificate of Need submitted to the Office of Health Care Access ("OHCA"). Also attached is the evidence demonstrating that public notice has been published in the Norwich Bulletin on November 20, 21, and 22, 2015, which is at least 20 days prior to the submission of the CON application that OHCA has already received.

Should you need anything further, please feel free to contact Administration at 860-963-6310.

Sincerely,

Amy Franklin

Amy Franklin
Executive Assistant to the President & CEO

alf

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

RECEIVED
NOV 27 2015
By CFO

November 23, 2015

Certified Mail: 7005 0390 0001 3507 1184

Douglas P. Glazier
Chief Financial Officer
Day Kimball Hospital
320 Pomfret Street
Putnam, CT 06260

Dear Mr. Glazier,

Per your conversation with Steven Lazarus, the enclosed check #0566266 is being returned to you in the amount of $500.00 for the Certificate of Need submitted to the Office of Health Care Access ("OHCA"). As noted in the conversation, pursuant to 19-639 of the Connecticut General Statutes, OHCA requires evidence demonstrating that public notice has been published in the appropriate newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application and which must be provided to OHCA before OHCA can accept your CON application..

Since OHCA has already received the submission of your CON, we will set it aside and process it once you've submitted the proof of publication from the newspaper along with a fee of $500.

Sincerely,

Kimberly R. Martone
Director of Operations

PUBLISHER'S CERTIFICATE

State of Connecticut,

ss. Norwich

County of New London,

On this **4TH** day of **DECEMBER** **2015**

personally appeared before the undersigned, a Notary Public, within and for said County and State

Whitney Seidl, Proof of Publication

of the "THE BULLETIN" a daily newspaper published at Norwich, County of New London, State of Connecticut, who, being duly sworn, states on oath that

LEGAL NOTICE

PUBLIC NOTICE

DAY KIMBALL HEALTHCARE TO DISCONTINUE MRI SERVICES

39 KENNEDY DRIVE, PUTNAM, CT 06260

a true copy of which is hereto annexed, was published in said newspaper in its issue of the

20TH day of **NOVEMBER** **2015**

W Seidl

Subscribed and sworn to before me this 4th day

of December A.D. 2015

Michele Fel

Notary Public

My Commission Expires 9/30/2020

LEGAL NOTICE

Public Notice

Filing for Day Kimball Healthcare to Discontinue MRI Services at 39 Kennedy Drive, Putnam CT 06260

Statutory Reference: CT General Statutes §19a-638

Applicant: Day Kimball Healthcare

Project Address: 39 Kennedy Drive Putnam CT 06260

Proposal: The Applicant intends to file a Certificate of Need application with the State of Connecticut to transition all MRI services to the main hospital campus.

Capital Expenditure:None

PUBLISHER'S CERTIFICATE

State of Connecticut,

ss. Norwich

County of New London,

On this **4TH** day of **DECEMBER** **2015**

personally appeared before the undersigned, a Notary Public, within and for said County and State

Whitney Seidl, Proof of Publication

of the "THE BULLETIN" a daily newspaper published at Norwich, County of New London, State of Connecticut, who, being duly sworn, states on oath that

LEGAL NOTICE

PUBLIC NOTICE

DAY KIMBALL HEALTHCARE TO DISCONTINUE MRI SERVICES

39 KENNEDY DRIVE, PUTNAM, CT 06260

a true copy of which is hereto annexed, was published in said newspaper in its issue of the

21ST day of **NOVEMBER** **2015**

W Seidl

Subscribed and sworn to before me this 4th day

of December A.D. 2015

Michele Kelly

Notary Public

My Commission Expires 9/30/2020

LEGAL NOTICE

Public Notice

Filing for Day Kimball Healthcare to Discontinue MRI Services at 39 Kennedy Drive, Putnam CT 06260

Statutory Reference: CT General Statutes §19a-638

Applicant: Day Kimball Healthcare

Project Address: 39 Kennedy Drive Putnam CT 06260

Proposal: The Applicant intends to file a Certificate of Need application with the State of Connecticut to transition all MRI services to the main hospital campus.

Capital Expenditure:None

PUBLISHER'S CERTIFICATE

State of Connecticut,

ss. Norwich

County of New London,

On this **4TH** day of **DECEMBER** **2015**

personally appeared before the undersigned, a Notary Public, within and for said County and State

Whitney Seidl, Proof of Publication

of the "THE BULLETIN" a daily newspaper published at Norwich, County of New London, State of Connecticut, who, being duly sworn, states on oath that

LEGAL NOTICE

PUBLIC NOTICE

DAY KIMBALL HEALTHCARE TO DISCONTINUE MRI SERVICES

39 KENNEDY DRIVE, PUTNAM, CT 06260

a true copy of which is hereto annexed, was published in said newspaper in its issue of the

22ND day of **NOVEMBER** **2015**

W Seidl

Subscribed and sworn to before me this 4th day of December A.D. 2015

Michele Cal

Notary Public

My Commission Expires 9/30/2020

LEGAL NOTICE

Public Notice

Filing for Day Kimball Healthcare to Discontinue MRI Services at 39 Kennedy Drive, Putnam CT 06260

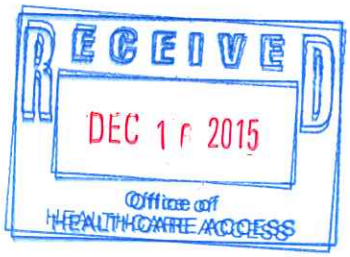
Statutory Reference: CT General Statutes §19a-638

Applicant: Day Kimball Healthcare

Project Address: 39 Kennedy Drive Putnam CT 06260

Proposal: The Applicant intends to file a Certificate of Need application with the State of Connecticut to transition all MRI services to the main hospital campus.

Capital Expenditure:None



State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- General Information
- Affidavit
- Abbreviated Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. All CON forms can be found on the OHCA website at OHCA Forms.

Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
(3)	**Transfer of ownership of a group practice**
(4)	**Establishment of a freestanding emergency department**
(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
(6)	**Establishment of an outpatient surgical facility**
(9)	**Establishment of cardiac services**
(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
(12)	**Increase in licensed bed capacity** of a health care facility
(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	**Transfer of Ownership / Sale of Hospital**

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Application Checklist

Instructions:

1. Complete the following checklist and **submit** as the first page of the CON application:

☒ Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.

☒ (**New**). A completed supplemental application form specific to the proposal type, available on OHCA's website under OHCA Forms (see previous page for the list of supplemental forms).

☒ Attached is the CON application filing fee in the form of a check made out to the "Treasurer State of Connecticut" in the amount of $500.

N/A Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

N/A Attached is a completed Financial Worksheet (A, B or C) available at OHCA's website under OHCA Forms.

☒ Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.

☒ The following have been submitted on a CD:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format; and
2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet) YES

For OHCA Use Only:

Docket No.: 15-32053 **Check No.:** 0566266
OHCA Verified by: SO **Date:** 12/10/15.

General Information

Name of Applicant:	Name of Co-Applicant:
Day Kimball Healthcare	Dba: Day Kimball Hospital

Connecticut Statute Reference:

CT Gen. Statute 4-166

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Day Kimball Hospital	004024931	Hospital	Day Kimball Healthcare
STREET & NUMBER			
320 Pomfret St			
TOWN			ZIP CODE
Putnam			06260

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
Outpatient MRI	004024931	Outpatient Office	Kennedy Drive MRI
STREET & NUMBER			
39 Kennedy Drive			
TOWN			ZIP CODE
Putnam			06260

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
STREET & NUMBER		
TOWN		ZIP CODE

Chief Executive

NAME		TITLE	
Robert E. Smanik		President & Chief Executive Officer	
STREET & NUMBER			
320 Pomfret Street			
TOWN		STATE	ZIP CODE
Putnam		CT	06260
TELEPHONE	FAX	E-MAIL ADDRESS	
860-928-6541	860-963-6018	rsmanik@daykimball.org	

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☐ NO ☐	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☐	
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start: October 01 End: September 30	

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information			
NAME		TITLE	
Douglas P. Glazier		Chief Financial Officer	
STREET & NUMBER			
320 Pomfret Street			
TOWN	STATE		ZIP CODE
Putnam	CT		06260
TELEPHONE	FAX		E-MAIL ADDRESS
860-928-6541			dpglazier@daykimball.org
RELATIONSHIP TO APPLICANT	Chief Financial Officer		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
NAME		TITLE	
Donald R. St.Onge		Sr. VP, COO, CNO	
STREET & NUMBER			
320 Pomfret Street			
TOWN	STATE		ZIP CODE
Putnam	CT		06260
TELEPHONE	FAX		E-MAIL ADDRESS
860-928-6541	860-963-6065		dstonge@daykimball.org
RELATIONSHIP TO APPLICANT	Sr. VP, COO, CNO		

Affidavit

Applicant: Day Kimball Healthcare, dba: Day Kimball Hospital

Project Title: Termination of Satellite MRI

I, Robert E. Smith, President & Chief Executive Officer
(Name) (Position – CEO or CFO)

of Day Kimball Healthcare, dba Day Kimball Hospital, being duly sworn, depose and state that the said facility 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.

Signature

11-3-15
Date

Subscribed and sworn to before me on November 3, 2015

Amy L. Franklin

Notary Public/~~Commissioner of Superior Court~~

My commission expires: June 30, 2016

AMY L FRANKLIN
NOTARY PUBLIC
STATE OF CONNECTICUT
My Commission Expires June 30, 2016

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview
of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

- This is a request to close a fixed MRI at a satellite location – 39 Kennedy Drive, Putnam CT. MRI services will continue to be provided utilizing the existing mobile MRI unit located at the main hospital campus at 320 Pomfret St, Putnam CT
- The fixed MRI equipment is a 1998 GE 1.0 Tesla Signa Lx Magnet that is nearing obsolescence and does not meet current standards as provided by the newer 1.5 Tesla Magnet in use at the mobile site at the hospital main campus.
- The satellite location is restricted from performing contrast as there is not a physician present on site which also reduces volume.
- The cost to purchase new, state of the art MRI equipment, far exceeds the revenue potential and the hospital's financial ability to purchase said equipment.
- The anticipated growth in volume that was predicted in 2010 has not been achieved due to the impact of high deductible insurance plans and stricter guidelines for approving use of an MRI as a diagnostic modality.
- The Kennedy Drive satellite MRI was mothballed effective 12-1-14 due to high operating costs and low volume
- Volume of growth at the main campus Hospital mobile MRI has not been realized for the same reasons noted above. There remains capacity at Mobile MRI on main campus to absorb this volume in one location as there has been no impact on access to care for patients requiring MRI's since the fixed unit was mothballed.
- Total combined MRI volume has dropped 11.8% since 2012
- Total Capacity at main campus Mobile MRI, utilizing existing hours of operation is 6760 per year.
- For FY 2015 the main campus Mobile MRI operated at 74% capacity

- Financial analysis reflects that the Kennedy Drive site was low volume with a high per unit cost.
- Closing the Kennedy Drive MRI improves quality, maintains access and reduces the potential cost of services to the patient.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a '§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

4. List the health care facility license(s) that will be needed to implement the proposal;

5. Submit the following information as attachments to the application:

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

   b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

   c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

   d. letters of support for the proposal;

   e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

   f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Public Need and Access to Care

§ "Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

> *§ "The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

> *§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

See Executive Summary

a. identify the target patient population to be served;

b. discuss how the target patient population is currently being served;

c. document the need for the equipment and/or service in the community;

d. explain why the location of the facility or service was chosen;

e. provide incidence, prevalence or other demographic data that demonstrates community need;

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

h. explain how access to care will be affected;

i. discuss any alternative proposals that were considered.

> § *"Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

   a. improve the quality of health care in the region; All MRI's will be performed utilizing 1.5 tesla magnet vs the older 1.0 tesla magnet.

   b. improve accessibility of health care in the region; No impact to accessiblity

   c. improve the cost effectiveness of health care delivery in the region. Cost per MRI utilizing mobile unit is 50% less than the cost per MRI at the fixed site. This has resulted in improved financial performance for this service line in FY 2015...

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)? No anticipated improvement in coordination of patient care as scheduling of MRI's and access to films by the ordering physician will not change.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons. There is no discernable impact to the Medicaid or indigent population.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

> § *"Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

> § *"Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Financial Information

> § *"Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))*

15. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

16. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3.**

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 and funds received to date; letter of interest or approval from a lending institution.

18. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

18. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

19. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

20. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

21. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Utilization

> § *"The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))*

21. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level. See attached tables

22. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

23. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues. Not relevant as populations served by payer mix is not expected to occur as these populations are already currently served by the main campus MRI.**

> § *"Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

24. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

25. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported. Data for MRI's not tracked by town. For purposes of this proposal there is no anticipated change in utilization by town.

> § *"The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))*

26. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area. Not applicable – no impact on providers.

27. Describe the effect of the proposal on these existing providers. There will be no impact on existing providers.

28. Describe the existing referral patterns in the area served by the proposal.

29. Explain how current referral patterns will be affected by the proposal.There will be no impact on referral patterns.

> § *"Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

30. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.
    This proposal in fact creates improved utilization of existing MRI resources located at main campus of the hospital. Helps to eliminate unnecessary duplication of services.

> § *"Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))*

31. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.
    There will be no impact on the diversity of health care providers

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
MRI	39 Kennedy Drive, Suite A Putnam, CT 06260	90,000	Monday through Friday 9am to 5pm	Terminate services due to low volume

[back to question]

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Brooklyn Canterbury Eastford Hampton Killingly Plainfield Pomfret Putnam Sterling Thompson Woodstock	• These are the towns served by our healthcare system. The vast majority of patients who require MRI services are provided at our main campus at the hospital. • Volume increases needed for this satellite MRI center were never achieved. Current operating capacity at main campus MRI is 74% • Main campus mobile unit is less than one mile from the satellite MRI center that is proposed for termination.

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

NOT APPLICABLE

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging) Land/Building Purchase* Construction/Renovation** Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 20__*	FY 20__*	FY 20__*
Revenue from Operations	$	$	$
Total Operating Expenses			
Gain/Loss from Operations	$	$	$

* Fill in years using those reported in the Financial Worksheet attached.

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013***	FY 2014***	FY 2015***	FY 2016***
Fixed MRI at 39 Kennedy Drive Mobile Unit at Main Hospital Campus	642 4502	648 4393	115 4885	Not available for incomplete month
Total	5144	5041	5000	

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.
** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2016**	FY 2017**	FY 2018**
ALL MRI services based on FY15 with a 2% growth on volume	5100	5202	5306
Total	5100	5202	5306

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

NOT APPLICABLE

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

[back to question]

TABLE 8
UTILIZATION BY TOWN

NOT APPLICABLE

Town	Utilization FY 20__**

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

NOT APPLICABLE

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

Supplemental CON Application Form

Termination of a Service

Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15)

Applicant:	**Day Kimball Healthcare** **Dba: Day Kimball Hospital** **320 Pomfret Street** **Putnam, CT 06260**
Project Name:	**Termination of Satellite MRI Services** **39 Kennedy Drive** **Putnam CT 06260**

Affidavit

Applicant: Day Kimball Healthcare

Project Title: Termination of Satellite MRI Services

I, Robert E. Smanik, President & Chief Executive Officer
(Name) (Position – CEO or CFO)

of Day Kimball Healthcare, being duly sworn, depose and state that the said facility 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.

Signature 11-3-15
Date

Subscribed and sworn to before me on November 3, 2015

Amy L. Franklin

Notary Public/~~Commissioner of Superior Court~~

My commission expires: June 30, 2016

AMY L FRANKLIN
NOTARY PUBLIC
STATE OF CONNECTICUT
My Commission Expires June 30, 2016

1. **Project Description: Service Termination**

   a. Please provide

      i. a description of the history of the services proposed for termination, including when they commenced:

         (1) It is proposed to terminate our satellite MRI services located at 39 Kennedy Drive, Putnam, CT. This MRI was placed in service in 2004 by Norwich Radiology, a private radiology group, and was purchased by Day Kimball Healthcare on or about December 2010. The equipment that was purchased consisted of a refurbished 1998 GE 1.0 tesla strength closed short bore CX Conquest MRI.

      ii. whether CON authorization was received:
         (1) A CON was requested and authorized on December 22, 2010.

      iii. if CON authorization was required, the docket number for that approval:
         (1) The docket number was 10-31602-CON

   b. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate:
      (1) The MRI equipment is fifteen years old and does not meet current standards for this technology.
      (2) The cost to purchase new state of the art MRI equipment exceeds the revenue potential.
      (3) The anticipated growth in volume has not been achieved due to the impact of high deductible insurance plans and stricter guidelines for approving use of an MRI for certain conditions.
      (4) Kennedy Drive volume FY 2012 = 739
      (5) Kennedy Drive volume FY 2013 = 642
      (6) Kennedy Drive volume FY 2014 = 648
      (7) Kennedy Drive volume FY 2015 = 115 (only open for October & November)
      (8) The Kennedy Drive site had a volume reduction of 12.4% from FY 2012 through FY 2014
      (9) Volume of growth at the main campus Hospital mobile MRI has not been realized for the same reasons noted above thus capacity remains to absorb this volume in one location.
      Hospital Mobile volume FY 2012 = 4871
      Hospital Mobile volume FY 2013 = 4502
      Hospital Mobile volume FY 2014 = 4393
      Hospital Mobile volume FY 2015 = 4885*
      (*FY 2015 includes all MRI volume as the satellite MRI was closed effective 12-1-14)

   (10). Total combined MRI volume for both sites has dropped 11% from FY 2012 through FY 2015

c. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted on. NOT APPLICABLE – DOES NOT REQUIRE A VOTE OF THE BOARD

2. Termination's Impact on Patients and Provider Community

a. For each provider to which the Applicant proposes transferring or referring clients, provide the below information for the last completed fiscal year and current fiscal year:

i. MRI services are currently provided at Day Kimball Hospital on its main campus utilizing a mobile 1.5 tesla MRI. The volume at 39 Kennedy Drive has been absorbed fully at the DKH Main Campus mobile MRI since Dec 2104

TABLE A
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity	Utilization FY XX**	Utilization Current CFY***
Day Kimball Hospital		320 Pomfret Street, Putnam CT	MRI 6760 / yr	3637	CY 2014 total was 4393	CY 2015 total was 5000 for all sites.

* Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.
** Fill in year and identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.
*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

a. Provide evidence (e.g., written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients:
   i. Written agreement not deemed necessary as the mobile unit is fully contracted to Day Kimball Hospital

b. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons:
   i. All patient populations are currently served by the mobile unit on the main hospital campus. There is no impact on special populations.

c. Describe how clients will be notified about the termination and transfer to other providers:
   i. Clients have been directed to the main hospital campus when scheduling the MRI since December 2014.
   ii. Mobile MRI has been located at the main campus for more than 20 years. Public is aware of this location.
   iii. Physicians on staff at Day Kimball Hospital have been notified.

d. For DMHAS-funded programs only, attach a report that provides the following information for the last three full FYs and the current FY to-date:
   i. This is not a DMHAS funded program.

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☐ NO ☐	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☐	
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start: October 01 End: September 30	

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information			
NAME		TITLE	
Douglas P. Glazier		Chief Financial Officer	
STREET & NUMBER			
320 Pomfret Street			
TOWN	STATE		ZIP CODE
Putnam	CT		06260
TELEPHONE	FAX		E-MAIL ADDRESS
860-928-6541			dpglazier@daykimball.org
RELATIONSHIP TO APPLICANT	Chief Financial Officer		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
NAME		TITLE	
Donald R. St.Onge		Sr. VP, COO, CNO	
STREET & NUMBER			
320 Pomfret Street			
TOWN	STATE		ZIP CODE
Putnam	CT		06260
TELEPHONE	FAX		E-MAIL ADDRESS
860-928-6541	860-963-6065		dstonge@daykimball.org
RELATIONSHIP TO APPLICANT	Sr. VP, COO, CNO		

Affidavit

Applicant: Day Kimball Healthcare, dba: Day Kimball Hospital

Project Title: Termination of Satellite MRI

I, Robert E. Smith, President & Chief Executive Officer
(Name) (Position – CEO or CFO)

of Day Kimball Healthcare, dba Day Kimball Hospital, being duly sworn, depose and state that the said facility 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.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview
of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

- This is a request to close a fixed MRI at a satellite location – 39 Kennedy Drive, Putnam CT. MRI services will continue to be provided utilizing the existing mobile MRI unit located at the main hospital campus at 320 Pomfret St, Putnam CT
- The fixed MRI equipment is a 1998 GE 1.0 Tesla Signa Lx Magnet that is nearing obsolescence and does not meet current standards as provided by the newer 1.5 Tesla Magnet in use at the mobile site at the hospital main campus.
- The satellite location is restricted from performing contrast as there is not a physician present on site which also reduces volume.
- The cost to purchase new, state of the art MRI equipment, far exceeds the revenue potential and the hospital's financial ability to purchase said equipment.
- The anticipated growth in volume that was predicted in 2010 has not been achieved due to the impact of high deductible insurance plans and stricter guidelines for approving use of an MRI as a diagnostic modality.
- The Kennedy Drive satellite MRI was mothballed effective 12-1-14 due to high operating costs and low volume
- Volume of growth at the main campus Hospital mobile MRI has not been realized for the same reasons noted above. There remains capacity at Mobile MRI on main campus to absorb this volume in one location as there has been no impact on access to care for patients requiring MRI's since the fixed unit was mothballed.
- Total combined MRI volume has dropped 11.8% since 2012
- Total Capacity at main campus Mobile MRI, utilizing existing hours of operation is 6760 per year.
- For FY 2015 the main campus Mobile MRI operated at 74% capacity

- Financial analysis reflects that the Kennedy Drive site was low volume with a high per unit cost.
- Closing the Kennedy Drive MRI improves quality, maintains access and reduces the potential cost of services to the patient.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

4. List the health care facility license(s) that will be needed to implement the proposal;

5. Submit the following information as attachments to the application:

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

   b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

   c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

   d. letters of support for the proposal;

   e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

   f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Public Need and Access to Care

§ "Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

> § *"The relationship of the proposed project to the statewide health care facilities and services plan," (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

> § *"Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

See Executive Summary

a. identify the target patient population to be served;

b. discuss how the target patient population is currently being served;

c. document the need for the equipment and/or service in the community;

d. explain why the location of the facility or service was chosen;

e. provide incidence, prevalence or other demographic data that demonstrates community need;

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

h. explain how access to care will be affected;

i. discuss any alternative proposals that were considered.

> § *"Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

   a. improve the quality of health care in the region; All MRI's will be performed utilizing 1.5 tesla magnet vs the older 1.0 tesla magnet.

   b. improve accessibility of health care in the region; No impact to accessiblity

   c. improve the cost effectiveness of health care delivery in the region. Cost per MRI utilizing mobile unit is 50% less than the cost per MRI at the fixed site. This has resulted in improved financial performance for this service line in FY 2015...

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)? No anticipated improvement in coordination of patient care as scheduling of MRI's and access to films by the ordering physician will not change.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons. There is no discernable impact to the Medicaid or indigent population.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

> § *"Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

> § *"Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Financial Information

> *§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))*

15. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

16. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

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 and funds received to date; letter of interest or approval from a lending institution.

18. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

18. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

19. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

20. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

21. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Utilization

> § *"The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))*

21. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level. See attached tables

22. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

23. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues. Not relevant as populations served by payer mix is not expected to occur as these populations are already currently served by the main campus MRI.**

> § *"Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

24. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

25. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported. Data for MRI's not tracked by town. For purposes of this proposal there is no anticipated change in utilization by town.

> § *"The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))*

26. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area. Not applicable – no impact on providers.

27. Describe the effect of the proposal on these existing providers. There will be no impact on existing providers.

28. Describe the existing referral patterns in the area served by the proposal.

29. Explain how current referral patterns will be affected by the proposal.There will be no impact on referral patterns.

> § *"Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

30. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.
    This proposal in fact creates improved utilization of existing MRI resources located at main campus of the hospital. Helps to eliminate unnecessary duplication of services.

> § *"Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))*

31. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.
    There will be no impact on the diversity of health care providers

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
MRI	39 Kennedy Drive, Suite A Putnam, CT 06260	90,000	Monday through Friday 9am to 5pm	Terminate services due to low volume

[back to question]

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Brooklyn Canterbury Eastford Hampton Killingly Plainfield Pomfret Putnam Sterling Thompson Woodstock	• These are the towns served by our healthcare system. The vast majority of patients who require MRI services are provided at our main campus at the hospital. • Volume increases needed for this satellite MRI center were never achieved. Current operating capacity at main campus MRI is 74% • Main campus mobile unit is less than one mile from the satellite MRI center that is proposed for termination.

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

NOT APPLICABLE

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging) Land/Building Purchase* Construction/Renovation** Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 20__*	FY 20__*	FY 20__*
Revenue from Operations	$	$	$
Total Operating Expenses			
Gain/Loss from Operations	$	$	$

* Fill in years using those reported in the Financial Worksheet attached.

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013***	FY 2014***	FY 2015***	FY 2016***
Fixed MRI at 39 Kennedy Drive Mobile Unit at Main Hospital Campus	642 4502	648 4393	115 4885	Not available for incomplete month
Total	5144	5041	5000	

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.
** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2016**	FY 2017**	FY 2018**
ALL MRI services based on FY15 with a 2% growth on volume	5100	5202	5306
Total	5100	5202	5306

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

NOT APPLICABLE

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

[back to question]

TABLE 8
UTILIZATION BY TOWN

NOT APPLICABLE

Town	Utilization FY 20__**

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

NOT APPLICABLE

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0043

General Hospital

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

Day Kimball Hospital of Putnam, CT d/b/a Day Kimball Hospital is hereby licensed to maintain and operate a General Hospital.

Day Kimball Hospital is located at 320 Pomfret Street, Putnam, CT 06260-1836.

The maximum number of beds shall not exceed at any time:

18 Bassinets
104 General Hospital Beds

This license expires **September 30, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2015. RENEWAL.

Satellites:

Plainfield Medical Building, 31 Dow Road, Plainfield, CT
Thompson Medical Building, 415 Riverside Drive, Thompson, CT
Plainfield Healthcare Center, 12 Lathrop Road, Plainfield, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

Greer, Leslie

Subject: FW: Completeness Letter, Docket Number: 15-32053-CON
Attachments: Day Kimball Hospital Completeness Letter.docx; Financial Workbook A.xlsx

From: Huber, Jack
Sent: Friday, January 15, 2016 3:11 PM
To: Glazier, Douglas P. (DPGlazier@DayKimball.org)
Cc: Veyberman, Alla; Fernandes, David
Subject: Completeness Letter, Docket Number: 15-32053-CON

Good Afternoon Mr. Glazier,

Please find the attached Completeness Letter in the matter of Day Kimball Hospital's proposal to terminate its magnetic resonance imaging ("MRI") service located at 39 Kennedy Drive in Putnam, CT. In responding to the Completeness Letter questions, please follow the instructions included in the letter and provide the response letter as an attachment to an email only. Email the response letter to OHCA@ct.gov and copy Jack.Huber@ct.gov, Alla.Veyberman@ct.gov and David.Fernandes@ct.gov. No hard copies are required. If you have any questions regarding the completeness letter, please feel free to contact me at (860) 418-7069, Ms. Veyberman at (860) 418-7007 or Mr. Fernandes at (860) 509-8162.

Sincerely,

Jack A. Huber

Jack A. Huber, Health Care Analyst
Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308 MS #13HCA | Hartford, CT 06134 |Ph:860-418-7069| Fax:860-418-7053| Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca

Dear Mr. Glazier:

On December 16, 2015, OHCA received the Certificate of Need application of Day Kimball Hospital proposing to terminate its magnetic resonance imaging ("MRI") service located at 39 Kennedy Drive in Putnam. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). Please be advised that OHCA's review of your CON submission revealed that responses to a substantial number of application questions were not provided. The length of this completeness letter is, in part, due to this finding. *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 39** and reference "**Docket Number: 15-32053-CON**."

1. With respect to the Executive Summary presented on page 7 of the CON application, please provide information on the following:

    a. The fixed-based satellite MRI scanner is said to be nearing obsolescence and does not meet current standards as provided by the newer 1.5 telsa-strength magnet in use at the mobile Hospital-based site. Identify the ways in which the fixed-based satellite MRI scanner does not meet "current standards."

    b. Discuss in more detail why the Hospital was not able to achieve the growth anticipated for its MRI services. Explain if there were internal factors inherent in either the operation of the individual MRI scanners or the service as a whole that led to an under achievement in estimated service growth. The application mentions that the satellite scanner was restricted from performing contrast studies as there was not a physician present on site. Did the service experience staffing difficulties? What has been the downtime experience by the Hospital with respect to the operation of the scanners? Address any other factors internal to the MRI service that may have affected service growth.

    c. The Hospital further indicates that it was unable to achieve MRI service growth due to the impact of high deductible insurance plans and stricter guidelines for approving use of an MRI scan as a diagnostic modality. Provide evidence regarding these factors, in the form of quantifiable data, if available, to support these claims and provide detailed information as to how and to what degree these two factors affected MRI utilization. Provide any other external factors that may have affected service growth.

    d. Identify the hours of operation for the mobile Hospital-based MRI scanner.

    e. Identify the methodology used to determine capacity at 74% .What will be capacity when the volume of the fixed unit is absorbed?

2. Provide the history and timeline of the proposal. When did the Hospital begin discussions to terminate the fixed-based satellite MRI service? When will the satellite MRI location be closed and when will the scanner be dismantled?

3. Submit the following information as attachments to the application:

    a. A list of all key professional, administrative, clinical and direct service personnel (e.g., Hospital CEO, Chief Radiologist, Radiology Director, Chief Technician, etc.) related to the proposal and attach a copy of their Curriculum Vitae; and

    b. Letters of support, either internal to (e.g. Chief Radiologist, Radiology Director, etc.) or external to the Hospital, for the proposal.

4. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health. Will the proposal be consistent with policies and standards set forth in Connecticut General Statutes section 19a-639(a)(1) in that the proposed termination will be subject to OHCA's prior CON authorization?

5. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan ("SHCFSP"), available on OHCA's website.

6. With respect to the proposal, provide evidence and documentation to support clear public need:

    a. Identify the target patient (i.e., MRI) population to be served.

    b. Discuss how the target patient population is currently being served.

    c. Document the need for the equipment/service in the community;

    d. Discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

    e. Explain how access to MRI services will be affected;

    f. Discuss any alternative proposals that were considered.

7. Provide further discussion on how the proposal will:

    a. Improve or maintain the quality of MRI imaging services in the region.

    b. Improve or maintain accessibility to MRI services in the region.

c. Improve the cost effectiveness of health care delivery in the region. Provide the analysis with calculations and assumptions that shows the cost of operating the mobile-based Hospital MRI scanner is 50% less than the cost of operating the fixed-based satellite MRI scanner.

d. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

8. Will the proposal reduce access to services by Medicaid recipients or indigent persons? If so, provide an explanation of good cause for doing so.

9. Will terminating the satellite MRI service incur a cost to the Hospital? What is the cost relating to the dismantling and disposal of the fixed-based satellite scanner? What source of funding will be used to cover this cost? Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

10. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the Hospital.

11. Include as an attachment a complete **Financial Worksheet A (*email attachment*)**, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statement previously submitted by the Hospital to OHCA.

12. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet A.

13. Complete **OHCA Table 4** for the satellite MRI location utilizing the information reported in the attached Financial Worksheet A above.

14. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

15. Page 21 of the application states, "Total combined MRI volume for both sites has dropped 11% since FY2012 through FY2015," yet on Table 6 for projected MRI volume for the next three years demonstrates an annual 2% increase. Provide an explanation for the discrepancy.

16. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal and/or hospital using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

17. Using **OHCA Table 8**, provide a breakdown of number of MRI scans by town for FY 2015.

18. Using **OHCA Table 9**, identify all existing MRI providers in the Hospital's service area.

19. The application states that the satellite MRI service ended on January 1, 2014. What caused the Hospital to re-open the Kennedy Drive location in October and November 2015, as indicated on page 21 of the application?

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than **March 15, 2016**, otherwise your application will be automatically considered withdrawn. **Please email your responses to all of the following email addresses: OHCA@ct.gov** and copy ***alla.veyberman@ct.gov, david.fernandes@ct.gov,* and *jack.huber@ct.gov.*** If you have any questions concerning this letter, please feel free to contact Alla Veyberman at (860) 418-7007, David Fernandes at (860) 509-8162 or Jack Huber at (860) 418-7069.

Sincerely,

Jack A. Huber

Jack A. Huber, Health Care Analyst
CT Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308, MS #13HCA | Hartford, CT 06134-0308|Ph: 860-418-7069|Fax: 860-418-7053
Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca

Applicant:

Financial Worksheet (A)

Please provide **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
LINE	**Total Entity:**	**FY12**	**FY12**	**FY12**	**FY13**	**FY13**	**FY13**	**FY14**	**FY14**	**FY14**	**FY15**	**FY15**	**FY15**	**FY16**	**FY16**	**FY16**	**FY17**	**FY17**	**FY17**	**FY18**
		Projected	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**
A.	**OPERATING REVENUE**																			
1	Total Gross Patient Revenue			$0			$0			$0			$0			$0			$0	
2	Less: Allowances			$0			$0			$0			$0			$0			$0	
3	Less: Charity Care			$0			$0			$0			$0			$0			$0	
4	Less: Other Deductions			$0			$0			$0			$0			$0			$0	
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare			$0			$0			$0			$0			$0			$0	
6	Medicaid			$0			$0			$0			$0			$0			$0	
7	CHAMPUS & TriCare			$0			$0			$0			$0			$0			$0	
8	Other			$0			$0			$0			$0			$0			$0	
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers			$0			$0			$0			$0			$0			$0	
10	Uninsured			$0			$0			$0			$0			$0			$0	
11	Self Pay			$0			$0			$0			$0			$0			$0	
12	Workers Compensation			$0			$0			$0			$0			$0			$0	
13	Other			$0			$0			$0			$0			$0			$0	
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
17	Net Assets Released from Restrictions			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**																			
1	Salaries and Wages			$0			$0			$0			$0			$0			$0	
2	Fringe Benefits			$0			$0			$0			$0			$0			$0	
3	Physicians Fees			$0			$0			$0			$0			$0			$0	
4	Supplies and Drugs			$0			$0			$0			$0			$0			$0	
5	Depreciation and Amortization			$0			$0			$0			$0			$0			$0	
6	Provision for Bad Debts-Other[b]			$0			$0			$0			$0			$0			$0	
7	Interest Expense			$0			$0			$0			$0			$0			$0	
8	Malpractice Insurance Cost			$0			$0			$0			$0			$0			$0	
9	Lease Expense			$0			$0			$0			$0			$0			$0	
10	Other Operating Expenses			$0			$0			$0			$0			$0			$0	
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
C.	**PROFITABILITY SUMMARY**																			
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**			**0**			**0**			**0**			**0**			**0**			**0**	
E.	**VOLUME STATISTICS[c]**																			
1	Inpatient Discharges			**0**			**0**			**0**			**0**			**0**			**0**	
2	Outpatient Visits			**0**			**0**			**0**			**0**			**0**			**0**	
	TOTAL VOLUME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]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.

Applicant:

Financial Worksheet (A)

		(20)	(21)		(22)	(23)	(24)
LINE	**Total Entity:**	**FY18**	**FY18**		**FY19**	**FY19**	**FY19**
		Projected	**Projected**		**Projected**	**Projected**	**Projected**
	Description	**Incremental**	**With CON**		**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**						
1	Total Gross Patient Revenue		$0				$0
2	Less: Allowances		$0				$0
3	Less: Charity Care		$0				$0
4	Less: Other Deductions		$0				$0
	Net Patient Service Revenue	**$0**	**$0**		**$0**	**$0**	**$0**
5	Medicare		$0				$0
6	Medicaid		$0				$0
7	CHAMPUS & TriCare		$0				$0
8	Other		$0				$0
	Total Government	**$0**	**$0**		**$0**	**$0**	**$0**
9	Commercial Insurers		$0				$0
10	Uninsured		$0				$0
11	Self Pay		$0				$0
12	Workers Compensation		$0				$0
13	Other		$0				$0
	Total Non-Government	**$0**	**$0**		**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**		**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts		**$0**				**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**		**$0**	**$0**	**$0**
15	Other Operating Revenue		**$0**				**$0**
17	Net Assets Released from Restrictions		**$0**				**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**		**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**						
1	Salaries and Wages		$0				$0
2	Fringe Benefits		$0				$0
3	Physicians Fees		$0				$0
4	Supplies and Drugs		$0				$0
5	Depreciation and Amortization		$0				$0
6	Provision for Bad Debts-Other[b]		$0				$0
7	Interest Expense		$0				$0
8	Malpractice Insurance Cost		$0				$0
9	Lease Expense		$0				$0
10	Other Operating Expenses		$0				$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**		**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**		**$0**	**$0**	**$0**
	NON-OPERATING REVENUE		**$0**				**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**		**$0**	**$0**	**$0**
	Principal Payments		**$0**				**$0**
C.	**PROFITABILITY SUMMARY**						
1	Hospital Operating Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**		**0**				**0**
E.	**VOLUME STATISTICS[c]**						
1	Inpatient Discharges		**0**				**0**
2	Outpatient Visits		**0**				**0**
	TOTAL VOLUME	**0**	**0**		**0**	**0**	**0**

[a]Total amount should equal the total amount on ce

[b]Provide the amount of any transaction associatec

[c]Provide projected inpatient and/or outpatient stati

Greer, Leslie

From: Fernandes, David
Sent: Wednesday, March 16, 2016 8:46 AM
To: Riggott, Kaila; Huber, Jack; Veyberman, Alla
Cc: Greer, Leslie
Subject: FW: DKH Completeness Letter - Initial Responses
Attachments: DKH Completeness Letter - Initial Responses.docx

Good Morning,
Not sure if everyone received the completeness responses from Day Kimball since the email was only addressed to me. Attached you will find them.

Thanks,

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

---

From: Glazier, Douglas P. [mailto:DPGlazier@DayKimball.org]
Sent: Tuesday, March 15, 2016 4:30 PM
To: Fernandes, David <David.Fernandes@ct.gov>
Subject: FW: DKH Completeness Letter - Initial Responses

David

My apologies in leaving a letter our or your e-mail address as it was returned to me as undeliverable.

Doug

From: Glazier, Douglas P.
Sent: Tuesday, March 15, 2016 4:28 PM
To: 'OHCA@ct.gov'
Cc: 'Jack.Huber@ct.gov'; 'David.Fernandes@ct.go'; 'Alla.Veyberman@ct.gov'
Subject: DKH Completeness Letter - Initial Responses

mailgate1.daykimball.org made the following annotations

The information contained in this electronic mail transmittal is protected by law and is intended only for the use

DAY KIMBALL HOSPITAL
Proposal to Terminate Magnetic Resonance Imaging Service
39 Kennedy Drive Putnam, CT

Docket Number 15-32053-CON: Review Questions - Responses

On December 16, 2015, OHCA received the Certificate of Need application of Day Kimball Hospital proposing to terminate its magnetic resonance imaging ("MRI") service located at 39 Kennedy Drive in Putnam. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). Please be advised that OHCA's review of your CON submission revealed that responses to a substantial number of application questions were not provided. The length of this completeness letter is, in part, due to this finding. *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 39** and reference "**Docket Number: 15-32053-CON**."

1. With respect to the Executive Summary presented on page 7 of the CON application, please provide information on the following:

   a. The fixed-based satellite MRI scanner is said to be nearing obsolescence and does not meet current standards as provided by the newer 1.5 telsa-strength magnet in use at the mobile Hospital-based site. Identify the ways in which the fixed-based satellite MRI scanner does not meet "current standards."

   Response:
   - The 1.0T no longer meets the minimum recommended Magnet Strength
   - Many hospitals are now skipping the purchase of the 1.5T and moving to the purchasing of the 3.0T
   - Image quality has declined with the age of the equipment
   - The equipment is unable to perform the new exams/procedures

   b. Discuss in more detail why the Hospital was not able to achieve the growth anticipated for its MRI services. Explain if there were internal factors inherent in either the operation of the individual MRI scanners or the service as a whole that led to an under achievement in estimated service growth. The application mentions that the satellite scanner was restricted from performing contrast studies as there was not a physician present on site. Did the service experience staffing difficulties? What has been the downtime experience by the Hospital with respect to the operation of the scanners? Address any other factors internal to the MRI service that may have affected service growth.

   Response:
   - The nature of the tenants is the facility changed creating the absence of a physician presence that is required for certain types of procedures.
   - There were no staffing problems as it was managed and operated by a third party which included the

provision of the technician.

- Key limitations were the age of the equipment, limitations on types of scans that could be performed and availability of alternatives.

c. The Hospital further indicates that it was unable to achieve MRI service growth due to the impact of high deductible insurance plans and stricter guidelines for approving use of an MRI scan as a diagnostic modality. Provide evidence regarding these factors, in the form of quantifiable data, if available, to support these claims and provide detailed information as to how and to what degree these two factors affected MRI utilization. Provide any other external factors that may have affected service growth.

Response:

- Both of these are national trends that effected this and others MRI operations by DKH. It is not possible to determine how much of an impact occurred on the service growth.

d. Identify the hours of operation for the mobile Hospital-based MRI scanner.

Response:

- Hours were limited due to lack of scheduled patients but generally 8:00AM to 4:00PM.

e. Identify the methodology used to determine capacity at 74% .What will be capacity when the volume of the fixed unit is absorbed?

Response:

- It was an estimate by the organization who owns, manages & operates the onsite Mobile MRI under contract with DKH. The volume will improve by approximately 1 ½ scans per day well within the capacity of the site.

2. Provide the history and timeline of the proposal. When did the Hospital begin discussions to terminate the fixed-based satellite MRI service? When will the satellite MRI location be closed and when will the scanner be dismantled?

Response:

- Discussion began concerning the inefficient operations at approximately 1 ½ exams per day in January 2015. I believe it was closed in the spring or summer of 2015 and the scanner was dismantled in December of 2015 when the property lease expired.

3.

4.

5. With respect to the proposal, provide evidence and documentation to support clear public need:

a. Identify the target patient (i.e., MRI) population to be served.

Response:

- Downtown Putnam & immediate surrounding towns.

b. Discuss how the target patient population is currently being served.

Response:

- Patients are now seen at the main campus of Day Kimball Hospital located 1 ½ miles from the fixed

site at Kennedy Drive.

c. Document the need for the equipment/service in the community;

Response:

- The mobile MRI on the main campus continues to meet the needs of the physician and patient community operating at approximately 80% of capacity with a larger breadth of service capabilities.

d. Discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

Response:

- There has been no change in the access, the same level of service is available at the main campus of Day Kimball Hospital for patients from all walks of life, ethnic backgrounds, and financial status.

e. Explain how access to MRI services will be affected;

Response:

- No impact as the Mobile MRI at the Main Campus of Day Kimball Hospital is located 1 ½ miles from the site. In addition Saturday hours are available 15 minutes south in Plainfield.

Greer, Leslie

From: Fernandes, David
Sent: Tuesday, April 12, 2016 9:05 AM
To: Glazier, Douglas P. (DPGlazier@DayKimball.org)
Cc: Veyberman, Alla; Riggott, Kaila; Greer, Leslie
Subject: Completeness Letter 2: 15-32053
Attachments: Day Kimball Hospital Completeness Letter 2 updated final.docx

Good Morning Mr. Glazier:

Attached please find a second completeness letter for Day Kimball Hospital's termination of MRI services (docket number 15-32053). Instructions for responding are included in the body of the attached letter. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

Dear Mr. Glazier:

On March 16, 2016, OHCA received responses from the Applicant to OHCA's completeness questions. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). Please be advised that OHCA's review of the completeness responses revealed not all of the completeness questions had responses. The length of this completeness letter is, in part, due to this finding. *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 42** and reference "**Docket Number: 15-32053-CON**."

1. With respect to the responses provided to question 1 of the completeness letter, please provide additional information on the following:

    a. Provide an explanation as to why the 1.0T no longer meets the minimum recommended Magnet Strength along with a source for this information.

    b. Indentify the specific exams/procedures the 1.0T is unable to perform and why.

    c. What specifically changed to result in the departure of the physician in the following statement? "The facility changed creating the absence of a physician presence that is required for certain types of procedures."

    d. The Hospital further indicates that it was unable to achieve MRI service growth due to the impact of high deductible insurance plans and stricter guidelines for approving the use of an MRI scan as a diagnostic modality. Please elaborate further and provide evidence to support the national and regional decline in the use of imaging equipment due to high deductible plans.

    e. Identify the days of operation for the mobile Hospital-based MRI scanner.

    f. Identify the methodology used by the organization who owns, manages and operates the onsite Mobile MRI to determine MRI capacity. Clarify whether capacity of the MRI is currently 74% found throughout the application or 80% as indicated on page 41.

2. Provide the official date of closure for the fixed MRI facility.

3. Submit the following information as <u>attachments</u> to the application:

a. A list of all key professional, administrative, clinical and direct service personnel (e.g., Hospital CEO, Chief Radiologist, Radiology Director, Chief Technician, etc.) related to the proposal and attach a copy of their Curriculum Vitae; and

b. Letters of support, either internal to (e.g. Chief Radiologist, Radiology Director, etc.) or external to the Hospital, for the proposal.

4. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

5. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan ("SHCFSP"), available on OHCA's website.

6. For question 6e on pg. 41 of the completeness responses, it was stated that Saturday hours will be available 15 minutes south of Plainfield. Provide the name of the provider along with the type of imaging equipment on site.

7. Discuss any alternative proposals that were considered.

8. Provide further discussion on how the proposal will:

   a. Improve or maintain the quality of MRI imaging services in the region.

   b. Improve or maintain accessibility to MRI services in the region.

   c. Improve the cost effectiveness of health care delivery in the region. Provide the analysis with calculations and assumptions that shows the cost of operating the mobile-based Hospital MRI scanner is 50% less than the cost of operating the fixed-based satellite MRI scanner.

   d. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

9. Will the proposal reduce access to services by Medicaid recipients or indigent persons? If so, provide an explanation of good cause for doing so.

10. Will terminating the satellite MRI service incur a cost to the Hospital? What is the cost relating to the dismantling and disposal of the fixed-based satellite scanner? What source of funding will be used to cover this cost? Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

11. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the Hospital.

12. Include as an attachment a complete **Financial Worksheet A (*email attachment*)**, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statement previously submitted by the Hospital to OHCA.

13. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet A.

14. Complete **OHCA Table 4** for the satellite MRI location utilizing the information reported in the attached Financial Worksheet A above.

15. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

16. Page 21 of the application states, "Total combined MRI volume for both sites has dropped 11% since FY2012 through FY2015," yet on Table 6 for projected MRI volume for the next three years demonstrates an annual 2% increase. Provide an explanation for the discrepancy.

17. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal and/or hospital using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

18. Using **OHCA Table 8**, provide a breakdown of number of MRI scans by town for FY 2015.

19. Using **OHCA Table 9**, identify all existing MRI providers in the Hospital's service area.

20. The application states that the satellite MRI service ended on January 1, 2014. What caused the Hospital to re-open the Kennedy Drive location in October and November 2015, as indicated on page 21 of the application?

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than June **11, 2016**, otherwise your application will be automatically considered withdrawn. **Please email your responses to all of the following email addresses: OHCA@ct.gov** and copy ***alla.veyberman@ct.gov,*** and ***david.fernandes@ct.gov.*** If you have any questions concerning this letter, please feel free to contact Alla Veyberman at (860) 418-7007 or David Fernandes at (860) 509-8162.

Sincerely,

David Fernandes

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

Greer, Leslie

From: Fernandes, David
Sent: Tuesday, April 12, 2016 9:42 AM
To: Glazier, Douglas P. (DPGlazier@DayKimball.org)
Cc: Veyberman, Alla; Riggott, Kaila; Greer, Leslie
Subject: RE: Completeness Letter 2: 15-32053
Attachments: Financial Workbook A.XLSX

Hello Mr. Glazier,
Attached is the Financial Worksheet A which corresponds with question 12 of the completeness letter. The attachment was inadvertently left off the previous email. If you have any questions on the Financial Worksheet, please let me know.

Thanks,

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

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From: Fernandes, David
Sent: Tuesday, April 12, 2016 9:05 AM
To: Glazier, Douglas P. (DPGlazier@DayKimball.org) <DPGlazier@DayKimball.org>
Cc: Veyberman, Alla <Alla.Veyberman@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>
Subject: Completeness Letter 2: 15-32053

Good Morning Mr. Glazier:

Attached please find a second completeness letter for Day Kimball Hospital's termination of MRI services (docket number 15-32053). Instructions for responding are included in the body of the attached letter. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

David Fernandes
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

Applicant:

Financial Worksheet (A)

Please provide **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
LINE	**Total Entity:**	**FY12**	**FY12**	**FY12**	**FY13**	**FY13**	**FY13**	**FY14**	**FY14**	**FY14**	**FY15**	**FY15**	**FY15**	**FY16**	**FY16**	**FY16**	**FY17**	**FY17**	**FY17**	**FY18**
		Projected	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**
A.	**OPERATING REVENUE**																			
1	Total Gross Patient Revenue			$0			$0			$0			$0			$0			$0	
2	Less: Allowances			$0			$0			$0			$0			$0			$0	
3	Less: Charity Care			$0			$0			$0			$0			$0			$0	
4	Less: Other Deductions			$0			$0			$0			$0			$0			$0	
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare			$0			$0			$0			$0			$0			$0	
6	Medicaid			$0			$0			$0			$0			$0			$0	
7	CHAMPUS & TriCare			$0			$0			$0			$0			$0			$0	
8	Other			$0			$0			$0			$0			$0			$0	
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers			$0			$0			$0			$0			$0			$0	
10	Uninsured			$0			$0			$0			$0			$0			$0	
11	Self Pay			$0			$0			$0			$0			$0			$0	
12	Workers Compensation			$0			$0			$0			$0			$0			$0	
13	Other			$0			$0			$0			$0			$0			$0	
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
17	Net Assets Released from Restrictions			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**																			
1	Salaries and Wages			$0			$0			$0			$0			$0			$0	
2	Fringe Benefits			$0			$0			$0			$0			$0			$0	
3	Physicians Fees			$0			$0			$0			$0			$0			$0	
4	Supplies and Drugs			$0			$0			$0			$0			$0			$0	
5	Depreciation and Amortization			$0			$0			$0			$0			$0			$0	
6	Provision for Bad Debts-Other[b]			$0			$0			$0			$0			$0			$0	
7	Interest Expense			$0			$0			$0			$0			$0			$0	
8	Malpractice Insurance Cost			$0			$0			$0			$0			$0			$0	
9	Lease Expense			$0			$0			$0			$0			$0			$0	
10	Other Operating Expenses			$0			$0			$0			$0			$0			$0	
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Principal Payments			**$0**			**$0**			**$0**			**$0**			**$0**			**$0**	
C.	**PROFITABILITY SUMMARY**																			
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**			**0**			**0**			**0**			**0**			**0**			**0**	
E.	**VOLUME STATISTICS[c]**																			
1	Inpatient Discharges			**0**			**0**			**0**			**0**			**0**			**0**	
2	Outpatient Visits			**0**			**0**			**0**			**0**			**0**			**0**	
	TOTAL VOLUME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]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.

Applicant:

Financial Worksheet (A)

		(20)	(21)		(22)	(23)	(24)
LINE	**Total Entity:**	**FY18**	**FY18**		**FY19**	**FY19**	**FY19**
		Projected	**Projected**		**Projected**	**Projected**	**Projected**
	Description	**Incremental**	**With CON**		**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**						
1	Total Gross Patient Revenue		$0				$0
2	Less: Allowances		$0				$0
3	Less: Charity Care		$0				$0
4	Less: Other Deductions		$0				$0
	Net Patient Service Revenue	**$0**	**$0**		**$0**	**$0**	**$0**
5	Medicare		$0				$0
6	Medicaid		$0				$0
7	CHAMPUS & TriCare		$0				$0
8	Other		$0				$0
	Total Government	**$0**	**$0**		**$0**	**$0**	**$0**
9	Commercial Insurers		$0				$0
10	Uninsured		$0				$0
11	Self Pay		$0				$0
12	Workers Compensation		$0				$0
13	Other		$0				$0
	Total Non-Government	**$0**	**$0**		**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**		**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts		**$0**				**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**		**$0**	**$0**	**$0**
15	Other Operating Revenue		**$0**				**$0**
17	Net Assets Released from Restrictions		**$0**				**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**		**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**						
1	Salaries and Wages		$0				$0
2	Fringe Benefits		$0				$0
3	Physicians Fees		$0				$0
4	Supplies and Drugs		$0				$0
5	Depreciation and Amortization		$0				$0
6	Provision for Bad Debts-Other[b]		$0				$0
7	Interest Expense		$0				$0
8	Malpractice Insurance Cost		$0				$0
9	Lease Expense		$0				$0
10	Other Operating Expenses		$0				$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**		**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**		**$0**	**$0**	**$0**
	NON-OPERATING REVENUE		**$0**				**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**		**$0**	**$0**	**$0**
	Principal Payments		**$0**				**$0**
C.	**PROFITABILITY SUMMARY**						
1	Hospital Operating Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**		**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**		**0**				**0**
E.	**VOLUME STATISTICS[c]**						
1	Inpatient Discharges		**0**				**0**
2	Outpatient Visits		**0**				**0**
	TOTAL VOLUME	**0**	**0**		**0**	**0**	**0**

[a]Total amount should equal the total amount on ce

[b]Provide the amount of any transaction associatec

[c]Provide projected inpatient and/or outpatient stati