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

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Robert D. Russo, M.D. and Associates Radiology, P.C.	
Doing Business As	Same	
Name of Parent Corporation	N/A	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	2660 Main Street, Suite 216, Bridgeport, CT 06606	
Applicant type (e.g., profit/non-profit)	For-Profit	
Contact person, including title or position	Robert D. Russo, M.D., President & Owner	
Contact person's street mailing address	2660 Main Street, Suite 216, Bridgeport, CT 06606	
Contact person's phone #, fax # and e-mail address	Tel.: 203-610-6805 ext 332 Fax.: 203-610-6813	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of CT Scanner

b. Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc)	☒ Replacement	☐ Additional (F, S, Fnc)
☐ Expansion (F, S, Fnc)	☐ Relocation	☐ Service Termination
☐ Bed Addition`	☐ Bed Reduction	☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than $ 1,000,000

☒ Equipment Acquisition greater than $ 400,000

☐	New	☒	Replacement	☐	Major Medical
☒	Imaging	☐	Linear Accelerator		

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):

4699 Main Street, Bridgeport, Connecticut 06606

d. List all the municipalities this project is intended to serve:

This equipment will serve patients from the following cities and towns:

Primary Service Area: Bridgeport, Stratford, Shelton, Trumbull, Monroe, Fairfield, Easton, Seymour, Ansonia, Wilton, Norwalk, Westport, and Weston.

Secondary Service Area: Milford, Stamford, New Canaan, Darien, and Ridgefield.

e. Estimated starting date for the project: **January 1, 2006**

f. Type of project: **20** **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: **$1,308,098.00**

b. Please provide the following breakdown as appropriate:

Construction/Renovations	**$ 10,000.00**
Medical Equipment (Purchase)	
Imaging Equipment (Lease (FMV)	**$1,224,621.00**
Non-Medical Equipment (Purchase)	
Sales Tax	**$73,477.00**
Delivery & Installation	
Total Capital Expenditure	**$1,308,098.00**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$1,308,098.00**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CT Scanner	**Philips**	**100016 Brillinace CT**	**1**	**$1,224,621.00**

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

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

☐	Applicant's Equity	☒	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

   Answer: The Applicant's practice represents a fully functional radiology practice. The types of radiology services now performed at this location in Bridgeport are: Plain X-Ray, X-Ray & Flouroscopy, Ultrasound, CT, Digital Mammography and Bone Densitometry. The Applicant maintains other offices with additional imaging services, including Nuclear Medicine, Open MRI and 1.5T MRI services.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

   Answer: The Applicant is proposing to add state of the art CT Service at this location. No DPH licensure is required.

3. Who is the current population served and who is the target population to be served?

   Answer: The current and target populations to be served are the present patient population located in the Primary and Secondary Service Areas as listed in Section II.d. herein.

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

   Answer: There has been CT Scanner service provided at this location by the Applicant since 1981. The existing CT Scanner is fully depreciated and the Applicant wishes to replace it with a state of the art unit.

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

   Answer: CT services are offered at all major imaging centers in this service area.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

   Answer: The replacement of the Applicant's existing CT scanner at this practice location would increase access and quality of care to the residents served from this location.

7. Who will be responsible for providing the service?

   Answer: The radiologists employed by the Applicant.

8. Who are the payers of this service?

   Answer: The Applicant's practice has a payer mix which is primarily made up of third party payers. The present mix is as follows:

66%	**Commercial payers;**
29%	**Government payers**
2%	**Self-Pay**
1%	**Workers Compensation**
2%	**Uncompensated care**

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☒ This request is for Replacement Equipment.

- ☒ The original equipment was authorized by the Commission/OHCA in Docket Number: **86-1001; on December 21, 1998 Docket # 98-1504 approved a replacement.**
- ☒ The cost of the equipment is not to exceed $2,000,000.
- ☒ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: **Robert D. Russo, M.D. & Associates Radiology, P.C.**

Project Title: **Replacement of CT Scanner**

I, Robert D. Russo, M.D., President of Robert D. Russo, M.D. & Associates Radiology, P.C. being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Robert D. Russo, M.D. & Associates Radiology, P.C. 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 9/9/05

Subscribed and sworn to before me on 9/9/05

Elaine Russo
Notary Public/Commissioner of Superior Court

My commission expires: 7/31/07

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical