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	Applicant Three
Full legal name	DePaul Health Services Corporation	New Haven Radiology Associates, P.C.	Naugatuck Valley Radiology Associates, P.C.
Doing Business As	North Haven Diagnostic Imaging, LLC	North Haven Diagnostic Imaging, LLC	North Haven Diagnostic Imaging, LLC
Name of Parent Corporation	Saint Raphael Healthcare System, Inc.	N/A	N/A
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	1450 Chapel ST New Haven, CT 06511	PO Box 8416 New Haven, CT 06530	385 Main St South Union Square Bldg. #1 Southbury, CT 06488
Applicant type (e.g., profit/non-profit)	Not-For-Profit	Profit	Profit
Contact person, including title or position	Jeffrey B. Hughes Director Planning & Business Development	Edward K. Prokop, M.D., Chairman, New Haven Radiology Associates, PC	Paul Masotto Executive Director, Naugatuck Valley Radiology Associates
Contact person's street mailing address	Hospital of St Raphael 1450 Chapel ST New Haven, CT 06511	PO Box 8416 New Haven, CT 06530	385 Main St South Union Square Bldg. #1 Southbury, CT 06488
Contact person's phone #, fax # and e-mail address	Tele: 203 789-5961 Fax: 203 789-3653 jhughes@srhs.org	Tele: 203 789-3135 Fax: 203 867-5249 eprokop@srhs.org	Tele: 203 267-3340 Ext 1101 Fax: 203 267-3342 pmasotto@nvranet.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **Establishment of a free standing imaging center in North Haven, Connecticut**

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): **Washington Avenue (Route 5), North Haven, Connecticut 06473**

d. List all the municipalities this project is intended to serve: **Hamden, North Branford, North Haven, and Wallingford**

e. Estimated starting date for the project: **July 2007**

f. Type of project: **19, 20, 22 (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: **$5,663,056**

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$ 900,000
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	$ 300,000
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$ 1,200,000**
Fair Market Value of Leased Equipment	$ 4,463,056
Total Capital Cost	**$ 5,663,056**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
MRI	Toshiba	Excelart Vantage XGV High Field MRI System	1	$1,930,434
CT	Toshiba	Aquilion 64 CFX Fast Whole Body Scanner	1	$1,592,112
Ultrasound	Toshiba	Aplio XV Radiology Ultrasound Imaging System	1	$ 146,910
Computed Radiography	Fuji	CR	1	$ 120,000
Radiography	Shimadzu	RadSpeed Elevating Table Radiographic System	1	$ 75,000
PACS	DR Systems	DR Systems	1	$ 309,600
Fluoroscopy	Shimadzu	YSF-300 Fluoromax Radiographic – Fluoroscopic System	1	$ 289,000

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

Response:
Copies of the vendor quotes will be submitted with the CON Application.

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

[X]	Applicant's Equity	[X]	Lease Financing	[X]	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.

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

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

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

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

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

7. Who will be responsible for providing the service?

8. Who are the payers of this service?

PROJECT DESCRIPTION:

The Applicants are proposing to establish and operate a free standing, diagnostic imaging center, North Haven Diagnostic Imaging, LLC ("NHDI"), in North Haven, Connecticut. NHDI is a Limited Liability Company, whose Members include DePaul Health Services Corporation (50% ownership), New Haven Radiology Associates, P.C. (25% ownership), and Naugatuck Valley Radiology Associates, P.C. (25% ownership). DePaul Health Services Corporation is a not-for-profit subsidiary of St. Raphael Healthcare System, Inc. the parent corporation of the Hospital of St. Raphael.

The services provided by NHDI will include: High Field Open MR, Multi-detector CT, Ultrasound, Diagnostic Radiography, and Fluoroscopy.

NHDI will lease approximately 6,000 square feet in a new building that will be constructed on Route 5, Washington Avenue, in North Haven, Connecticut. NHDI will be responsible for all internal build-outs/tenant improvements to the leased space.

NHDI will apply for DPH licensure as an outpatient facility and will be the healthcare entity that provides all services. It is expected that it will be a participating provider with all payers including Medicare, Medicaid, commercial insurance, managed care, and self pay.

The targeted population will include the residents of the towns of Hamden, North Haven, North Branford, and Wallingford.

The rationale for NHDI is based on several factors:

- The Applicants have an established market share in the proposed service area. NHDI will enable the Hospital of St. Raphael, New Haven Radiology Associates, and Naugatuck Valley Radiology Associates to better service their affiliated physicians who are practicing in this community and their patients that are residing in this community.

- NHDI will improve access to imaging services for the Applicants' existing patients as measured by decreased travel times and reductions in scheduling delays. NHDI will enable the Applicants to respond to the imaging needs of their current and future patients.

- The expected continued growth in demand for imaging services and the aging of the population also support the need for the establishment of a diagnostic imaging center.

- The service area has a higher than average percentage of its population in the age cohorts that generally utilize more imaging services.

- In addition, the close proximity of NHDI to the proposed Hospital of St. Raphael satellite emergency room will enable NHDI to function as the imaging services provider for the proposed emergency services facility.

This project will positively impact on the health care delivery system in the State of Connecticut for it will provide convenient access to advanced imaging services at a competitive price to the

residents of this community. NHDI's facility will be environmentally friendly for the proposed advanced digital diagnostic imaging services will be in a film-less environment linked through state of the art networking and communication systems. The use of the electronic digital network limits film processing.

Outpatient imaging providers located in the proposed service area include: Radiology Associates, Inc. (Wallingford), Radiology Group P.C. (Hamden), Whitney Imaging Center (Hamden), and Mid-State Radiology (Wallingford).

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: _____.
- ☐ 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: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ 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 _____ complies with the appropriate and
(Facility Name)
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: _____

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