DIAGNOSTIC IMAGING
of SOUTHBURY

Your health, your choice.

November 24, 2006

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

Dear Commissioner Vogel:

I am enclosing an original plus three copies of a Letter of Intent/Waiver Form (2030) for PET CT of Southbury, LLC to lease and operate a mobile PET-CT Scanner one day a week. PET CT of Southbury, LLC is a limited liability company, whose Members include Southbury Holding, LLC, and Radcorp of Southbury, LLC. Southbury Holding, LLC and Radcorp of Southbury, LLC are subsidiaries of Naugatuck Valley Radiology Associates, PC, and Northeast Radiology, PC, respectively.

Naugatuck Valley Radiology Associates, PC, and Northeast Radiology, PC, are professional corporations comprised of radiologists, who offer comprehensive full service imaging services in the proposed service area.

Should you have any questions regarding this Letter of Intent please do not hesitate to contact me at (203) 267-3340.

Sincerely,

Robert Gumbardo, M.D.
President
Naugatuck Valley Radiology Associates, P.C.

Enclosure

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Naugatuck Valley Radiology Associates, P.C./ Southbury Holding, LLC	Northeast Radiology, P.C./ Radcorp of Southbury, LLC
Doing Business As	PET CT of Southbury, LLC	PET CT of Southbury, LLC
Name of Parent Corporation	Not Applicable	Not Applicable
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	385 Main St South Union Square Bldg. #2 Southbury, CT 06488	385 Main St South Union Square Bldg. #2 Southbury, CT 06488
What is the Applicant's Status: P for Profit or NP for Nonprofit	Profit	Profit
Does the Applicant have Tax Exempt Status?	Yes No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Paul Masotto, Administrative Director Robert Gumbardo, M.D. President, Naugatuck Valley Radiology Associates, P.C.	Scott Nadel, M.D. President, Northeast Radiology, P.C.
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	385 Main St South Union Square Bldg. #2 Southbury, CT 06488	73 SandPit Road, Suite #209 Danbury, CT 06810
Contact Person's Telephone Number	203 267-3340 Ext 1101	203 798-0303
Contact Person's Fax Number	203 267-3342	845 278-7802
Contact Person's e-mail Address	pmasotto@nvranet.com	sn@nerad.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **Operation of a Mobile PET-CT Scanner One Day A Week**

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

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

[X] New (F, S, Fnc) [ ] Replacement [X] Additional (F, S, Fnc)

[ ] Expansion (F, S, Fnc) [ ] Relocation [ ] Service Termination

[ ] Bed Addition` [ ] Bed Reduction [ ] Change in Ownership/Control

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

[ ] Project expenditure/cost cost greater than $ 3,000,000

[X] Equipment Acquisition

[X] New [ ] Replacement [ ] Major Medical (> $3,000,000)

[X] Imaging [ ] Linear Accelerator

[ ] Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code: **385 Main Street South, Union Square, Building #2, Southbury, Connecticut 06488**

d. List each town this project is intended to serve: **Southbury, Woodbury, Newtown, Waterbury, Oxford, Middlebury, Bethlehem, Watertown, and Naugatuck.**

e. Estimated starting date for the project: **April 1, 2007**

f. Type of project: **22, 26**
(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 or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$ 2,450,000**

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	$28,000
Land/Building Purchases	
Construction/Renovation	$22,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$50,000**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	$2,400,000
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**$2,450,000**
Total Project Cost	**$2,450,000**
Capitalized Financing Costs (Informational Purpose Only)	

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

Response: An itemized list of the non-medical equipment that will be purchased as part of this project will be submitted with the CON Application.

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☐ Yes

If you checked "Yes" above, please check the appropriate box below:

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

Response: N/A

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Response: N/A

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
PET CT (Mobile)	Philips	Gemini	1	$2,400,000

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

Response: A copy of the lease agreement will be submitted with the CON Application.

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

[X]	Applicant's Equity	[ ]	Capital Lease	[ ]	Conventional Loan
[ ]	Charitable Contributions	[X]	Operating Lease	[ ]	CHEFA Financing
[ ]	Funded Depreciation	[ ]	Grant Funding	[ ]	Other (specify): _____

Response: The non-medical equipment and renovation costs will be financed using equity. The mobile PET-CT Scanner will be leased one day a week.

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

PET CT of Southbury, LLC
Operation of a Mobile PET-CT Scanner One Day A Week

Project Description

PET CT of Southbury, LLC is a limited liability company, whose Members include Southbury Holding, LLC, and Radcorp of Southbury, LLC. Southbury Holding, LLC and Radcorp of Southbury, LLC are subsidiaries/affiliates of Naugatuck Valley Radiology Associates, PC, and Northeast Radiology, PC, respectively.

Naugatuck Valley Radiology Associates, PC, and Northeast Radiology, PC, are professional corporations comprised of radiologists, who offer comprehensive full service imaging services in the proposed service area.

PET CT of Southbury is submitting this Letter of Intent to operate a Positron Emission Tomography and Computed Tomography ("PET-CT") Scanner. This project would involve the leasing of a mobile Philips Gemini Open PET-CT scanner one day a week from Mobile PET/T Associates, LLC ("Integral Mobile".) Integral Mobile is a Pennsylvania limited liability company engaged in the business of providing PET-CT scanning services. Integral Mobile will be responsible for the operation and maintenance of the equipment and performance of the scans. PET CT of Southbury's physicians will be responsible for the interpretation of all PET-CT scans performed on the unit.

The target population for this proposal is the patients of Naugatuck Valley Radiology Associates' and Northeast Radiology 's existing physician referral base: residents primarily from the towns of Southbury, Woodbury, and Newtown. The secondary service area includes Waterbury, Oxford, Middlebury, Bethlehem, Watertown, and Naugatuck.

PET CT of Southbury is the entity that will bill for the PET-CT services and receive payments for those services. Anticipated payer sources include Medicare, Medicaid, self pay, commercial, and managed care payers.

The mobile PET-CT Scanner would be located in Union Square Plaza between Building 1 and 2 for easy and convenient access for patients. The necessary concrete docking pad, power supply, data and phone connectivity were installed previously for a mobile MRI unit so the project costs for installation are reduced significantly. The non medical equipment required for this project consists of the computer hardware and software needed to integrate this service into the existing information system network.

The incorporation of PET-CT Services will provide Naugatuck Valley Radiology Associates and Northeast Radiology with the functionality to expand their imaging services and provide new procedures in the areas of oncology, cardiology, neurology, and psychiatry. The demand for PET-CT imaging continues to grow nationally and is predicted to increase over 50% annually for the next several years.

There are no providers of PET-CT services located in the proposed primary service area. The Harold Leever Regional Cancer Center, located in Waterbury, offers PET-CT services.

This project will positively impact on the health care delivery system in the State of Connecticut by improving quality of care for residents of the proposed service area as measured by accessibility to the current standard of care for PET-CT services.

AFFIDAVIT

To be completed by each Applicant

Applicant: **PET CT of Southbury, LLC**

Project Title: **Operation of a Mobile PET-CT Scanner One Day A Week**

I, Robert Gumbardo, M.D. (Name), President (Position – CEO or CFO)

of Naugatuck Valley Radiology Associates, P.C. and Southbury Holding, LLC

being duly sworn, depose and state that the

information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that PET CT of Southbury, LLC (Facility Name) complies with the appropriate and

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

11-21-06
Date

Subscribed and sworn to before me on November, 21, 2006

Notary Public/Commissioner of Superior Court

DEBORAH E. SHUPENIS
NOTARY PUBLIC
My Commission Expires June 30, 2010

My commission expires: _____

Form 2030
Revised 7/06

DEBORAH E. SHUPENIS
NOTARY PUBLIC
My Commission Expires June 30, 2010

AFFIDAVIT

To be completed by each Applicant

Applicant: **PET CT of Southbury, LLC**

Project Title: **Operation of a Mobile PET-CT Scanner One Day A Week**

I, Scott Nadel, M.D., President
(Name) (Position – CEO or CFO)

of Northeast Radiology, P.C. and Radcorp of Southbury, LLC being duly sworn, depose and state that the

information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best

of my knowledge, and that PET CT of Southbury, LLC 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

11/21/06
Date

Subscribed and sworn to before me on November 21, 2006

Notary Public/Commissioner of Superior Court

DEBORAH E. SHUPENIS
NOTARY PUBLIC
My Commission Expires June 30, 2010

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. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 22, 2006

Requisition # HCA07-102
FAX #: 203-754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, December 26, 2007.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SL:dd

c: Sandy Salus, OHCA

Waterbury Republican American
Docket Number 06-30875LOI

Letter of Intent
December 22, 2006

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638 and 19a-639
Applicants:	Naugatuck Valley Radiology Associates P.C. / Southbury Holding and Northeast Radiology, P.C. / Radcorp of Southbury, LLC d/b/a PET-CT of Southbury, LLC
Town:	Southbury
Docket Number:	06-30875LOI
Proposal:	Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, South, CT
Total Capital Expenditure:	$2,450.00

The Applicant may file its Certificate of Need application between January 26, 2007 and March 27, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 22, 2006

Requisition # HCA07-101
FAX #: 203-792-4211
Account#: 501989

The News Time
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, December 26, 2007.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SL:dd

c: Sandy Salus, OHCA

The News Times **Letter of Intent**
Docket Number 06-30875LOI **December 22,**
2006

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638 and 19a-639
Applicants:	Naugatuck Valley Radiology Associates P.C. / Southbury Holding and Northeast Radiology, P.C. / Radcorp of Southbury, LLC d/b/a PET-CT of Southbury, LLC
Town:	Southbury
Docket Number:	06-30875LOI
Proposal:	Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, South, CT
Total Capital Expenditure:	$2,450.00

The Applicant may file its Certificate of Need application between January 26, 2007 and March 27, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 22, 2006

Paul Masotto
Administrative Director
Naugatuck Valley Radiology Associates
P.C./ Southbury Holding, LLC
385 Main Street South
Union Square Bldg. #42
Southbury, CT 06488

Scott Nadel, M.D.
President
Northeast Radiology/Radcorp of
Southbury, LLC
73 SandPit Road
Suite# 209
Danbury, CT 06810

Re: Letter of Intent, Docket Number 06-30875
Naugatuck Valley Radiology Associates, P.C. / Southbury Holding and Northeast Radiology, P.C. / Radcorp of Southbury, LLC d/b/a PET-CT of Southbury, LLC
Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, South, CT
Notice of Letter of Intent

Dear Mr. Masotto and Dr. Nadel:

On November 27, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Naugatuck Valley Radiology Associates, P.C. / Southbury Holding and Northeast Radiology, P.C. / Radcorp of Southbury, LLC d/b/a PET-CT of Southbury, LLC ("Applicants") for Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, South, CT, at a total capital expenditure of $2,450,00.

A notice to the public regarding OHCA's receipt of a LOI was published in *The News Times and Waterbury Republican American* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:dd

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

TRANSMISSION OK

TX/RX NO	1628
RECIPIENT ADDRESS	912037540644
DESTINATION ID	
ST. TIME	12/22 13:56
TIME USE	00'45
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 22, 2006

Requisition # HCA07-102
FAX #: 203-754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, December 26, 2007.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

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

TRANSMISSION OK

TX/RX NO	1629
RECIPIENT ADDRESS	912037924211
DESTINATION ID	
ST. TIME	12/22 13:58
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 22, 2006

Requisition # HCA07-101
FAX #: 203-792-4211
Account#: 501989

The News Time
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, December 26, 2007.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 18, 2006

Paul Masotto
Administrative Director
Naugatuck Valley Radiology Associates,
P.C./Southbury Holding, LLC
385 Main Street South
Union Square Bldg. #42
Southbury, CT 06488

Scott Nadel, M.D.
President
Northeast Radiology/Radcorp of
Southbury, LLC
73 SandPit Road
Suite # 209
Danbury, CT 06810

RE: Certificate of Need Application Forms; Docket Number: 06-30875-CON
Naugatuck Valley Radiology Associates, P.C./Southbury Holding, LLC and Northeast Radiology, P.C./Radcorp of Southbury, LLC d/b/a PET CT of Southbury, LLC
Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, Southbury, Connecticut

Dear Sirs:

Enclosed are the application forms for Naugatuck Valley Radiology Associates, P.C./Southbury Holding, LLC and Northeast Radiology, P.C./Radcorp of Southbury, LLC d/b/a PET CT of Southbury, LLC's Certificate of Need ("CON") proposal for the establishment and operation of a mobile PET-CT Scanner one day per week at Union Square Building #2, 385 Main Street, Southbury, Connecticut at a total capital expenditure of $2,450,000. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes, the CON application may be filed between January 26, 2007 and March 27, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The OHCA analyst assigned to the CON application is Steven W. Lazarus. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Facility Name) 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: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.**	
_____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____	$_____.00
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

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

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 26, 2007, and may be submitted no later than March 27, 2007. The Analyst assigned to your application is Steven W. Lazarus and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 06-30875-CON

Applicants Name: Naugatuck Valley Radiology Associates, P.C./Southbury Holding, LLC and Northeast Radiology, P.C./Radcorp of Southbury, LLC d/b/a PET CT of Southbury, LLC

Contact Person:	Paul Masotto	Scott Nadel, M.D.
Title:	Administrative Director	President
Representing:	Naugatuck Valley Radiology Associates, P.C./Southbury Holding, LLC	Northeast Radiology/Radcorp of Southbury, LLC
Contact Person Address:	385 Main Street South Union Square Bldg. #42 Southbury, CT 06488	73 SandPit Road Suite # 209 Danbury, CT 06810

Project Location: Southbury

Project Name: Establishment and Operation of a Mobile PET-CT Scanner One Day Per Week at Union Square Building #2, 385 Main Street, Southbury, CT

Type proposal: Sections 19a-638 and 19a-639, C.G.S.

Est. Capital Expenditure: $2,450,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicants' Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Ownership

A. Provide a corporate chart of organization for each of the member Applicants.

B. Provide a corporate chart of organization for PET CT of Southbury, LLC.

C. Provide a copy of the written agreement or memorandum of understanding between Naugatuck Valley Radiology Associates, Southbury Holding, LLC, Northeast Radiology P.C. and Radcorp of Southbury, LLC as related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

5. Clear Public Need

Note: Sections 19a-634 and 19a-637 of the Connecticut General Statutes specifically mandate that OHCA consider the availability, scope and need for services for the residents of Connecticut. Therefore, OHCA does not consider out-of-state volume in its evaluation of need for the proposed service.

A. Provide the primary service area ("PSA") and the secondary service area ("SSA") towns.

B. Explain the specific proposed towns were chosen as primary and secondary service areas for the proposed PET CT service.

C. Explain how it was determined there was a need for the proposal in the proposed service area.

D. For each Applicant, provide PET and CT volumes for the past three fiscal years (i.e. procedure, scan, visit, etc.) by service area town.

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

F. Please complete the following table regarding the Applicants' existing imaging equipment, include imaging equipment being operated by the provider or any of its subsidiary:

Provider (Applicant)	Type of Imaging Equipment*	Locations	Hours/Days of Operation	FY 2006 Utilization by modality
Naugatuck Valley Radiology Associates, P.C				
Southbury Holding, LLC				
Northeast Radiology				
Radcorp of Southbury, LLC				

*Please include the equipment detail i.e. tesla strength, number of slices etc.

G. Provide a breakdown of the utilization for FY 2006 for each of the Applicants' listed in the table above by town.

H. Scheduling backlogs in service area.

I. Where are the patients from the PSA and SSA currently receiving their PET-CT services? Be sure to include each providers name and address.

J. Travel distance from proposed site to service area towns

K. Hours of operation for each of the Applicants' existing service by location and the proposed service.

L. Identify the existing providers of the proposed service in your service area.

M. Identify the closest provider of the proposed service to the proposed location.

N. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

O. Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

P. Provide the information as outlined in the following table concerning the existing providers' (in the Applicants' PSA) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] If proposal concerns imaging equipment, provide a description of the equipment used by the Provider, if known. For MRI scanners, include Tesla strength, and whether or not the scanner is considered to be "open" or "closed".
[2] Specify days of the week and start and end time for each day.
[3] Number of scans performed on specified scanner by Provider for the most recent 12 month period, if known.

Q. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

R. Provide copies of any of the following plans, studies or reports related to your proposal:

- ☐ Epidemiological studies
- ☐ Public information reports
- ☐ Needs assessments
- ☐ Market share analysis
- ☐ Other (Identify)
- ☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

6. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

- ☐ American College of Cardiology
- ☐ National Association of Child Bearing Centers
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ American College of Radiology
- ☐ Substance Abuse Society and Mental Health Services Administration
- ☐ Other, Specify:

C. Describe in detail how the Applicants' plan to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: *For physicians, please provide a list of hospitals where the physicians have admitting privileges.*

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports (New Out-of-State Providers)
- ☐ AAAASF

Note: Above referenced acronyms are defined below. [1]

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against any of the Applicants, Physicians and any staff related to the proposal, for the past five (5) years.

G. Provide a copy of any plan of action which has been formulated to address the above action against the Applicants, Physician(s) working at the Hospital and/or any staff related to the proposal.

H. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

7. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

8. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

D. Please provide the names of the members of PET CT of Southbury and its parent corporation who are members of Diagnostic Imaging of Southbury.

9. Financial Information

A. Type of ownership: (Please check off all that apply)

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

B. Provide the following financial information:

i) For **each** Applicant, please submit the audited financial statements for the most recently completed fiscal year. If the Applicants have no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

10. Major Cost Components/Total Capital Expenditure

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

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

* Provide an itemized list of all non-medical equipment.

11. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

12. Capital Equipment Lease

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	___ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
Please submit a schedule of depreciation for the purchased equipment as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

13. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicants' equity:

Source and amount **by Applicant**:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	_____
CON Proposed debt financing	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years
Debt service reserve fund	_____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	_____
CON Proposed lease financing	_____
Fair market value of leased assets at lease inception	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
i. Letter of interest from the lending institution,
ii. Letter of interest from CHEFA,
iii. Amortization schedule (if not level amortization payments),
iv. Lease agreement.

14. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix for **each Applicant** and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Do any of the Applicants' have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections for **each** of the Applicant:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment II.**

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

PET CT of Southbury, LLC

14. C i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Radcorp, Of Southbury, LLC

14. C i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Northeast Radiology, P.C.

14. C i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Southbury Holding, LLC

14. C i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

PET CT of Southbury, LLC

14.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

Naugatuck Valley Radiology Associates, P.C.

14.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:

# of Months in Operation

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

Southbury Holding, LLC

14.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:
# of Months in Operation

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

Northeast Radiology, P.C.

14.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:

# of Months in Operation

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

Radcorp of Southbury, LLC

14.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:
# of Months in Operation

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

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

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PAGES SENT	25
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FAX SHEET

TO: **Paul Masotto**

FAX: **203-267-3342**

AGENCY: **NAGATUCK VALLEY RADIOLOGY ASSOCIATES**

FROM: **STEVEN LAZARUS**

DATE **12/18/06**

NUMBER OF PAGES **16**

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IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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Hartford. CT 06134

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TIME USE	10'30
PAGES SENT	25
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FAX SHEET

TO: Scott Nadel, M.D.

FAX: ~~860~~-278-7802
845

AGENCY: NORTHEAST RADIOLOGY/RADCORP OF SOUTHBURY, LLC

FROM: STEVEN LAZARUS

DATE 12/~~18~~19/06

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