PAUL A. AIELLO, M.D., P.C.
13 THOR PLACE
FAIRFIELD, CONNECTICUT 06824-3042

April 12, 2004

Ms. Karen Roberts
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: MRI Unit Docket # 99-548

Dear Ms. Roberts:

As your office is aware, I maintain an MRI unit currently located at 46 Prince Street, New Haven, Connecticut. I would like to relocate this MRI unit, previously approved under CON (Docket # 99-548), from 46 Prince Street, New Haven, Connecticut to 425 Post Road, Fairfield, Connecticut. The current value of the MRI unit is less than $400,000. This relocation will not result in any increase in the capital expenditure authorized in the CON and this relocation will not result in any change in service provided. Please advise me if there is any other information your office may need to affect this relocation.

Very truly yours,

Paul A. Aiello, M.D.

Paul A. Aiello, M.D.

PHONE: 203.256.1494 • FAX: 203.256.1930

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul A. Aiello M.D.

FAX: 203-256-1930

AGENCY: Paul A. Aiello, M.D., P.C.

FROM: Karen Roberts OHCA

DATE: 4/21/04 **Time:** 9:30 Am

NUMBER OF PAGES: 9
(including transmittal sheet

Comments:

Regarding MRI relocation request
DN 99-548

PLEASE PHONE 860-418-7001 ***IF THERE ARE ANY TRANSMISSION PROBLEMS.***

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

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 21, 2004

Paul A. Aiello, M.D., P.C.
13 Thor Place
Fairfield, CT 06824-3042

RE: **Docket No. 04-22633-MDF**; Modification of the CON under Docket No. 99-548
A request to relocate authorized MRI unit from New Haven to Fairfield

Dear Dr. Aiello:

On April 15, 2004, the Office of Health Care Access ("OHCA") received your letter in which you discuss your plan to relocate the MRI unit authorized under Docket Number 99-548 from the New Haven location to 425 Post Road in Fairfield.

Please note that, as Certificate of Need ("CON") authorizations are site specific {i.e, the review of the CON was specific to the town in which the proposal was based}, this request requires a modification of the Certificate of Need ("CON") authorized under Docket Number 99-548. As such, please complete the attached CON Modification Request Form 2050 and submit it at your earliest convenience. Please reference Docket Number 04-22633-MDF in your submission.

If you have any questions regarding the above, please contact me at (860) 418-7001.

Sincerely,

Karen Roberts

Karen Roberts
Compliance Officer

Enclosure

Copy: Cristine A. Vogel, Commissioner, OHCA

State of Connecticut
Office of Health Care Access

Instructions for Modification of Previously Authorized CON Form

Form 2050

Form 2050 must be filed for any petition for a modification to a previously authorized Certificate of Need. The Form consists of 7 Section. These sections are:

- Section I — PETITIONER INFORMATION
- Section II — GENERAL PROPOSAL INFORMATION
- Section III — IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT
- Section IV — IF REQUESTING AN INCREASE IN THE AUTHORIZED CAPITAL EXPENDITURE OR THE AUTHORIZED CAPITAL COST
- Section V — IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE
- Section VI — IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION (*other than extension of the CON expiration date*)
- Section VII — OTHER

All portions of Section I, II, and VII **must be completed**. OHCA requires an original and two copies of your completed Form 2050. All pages must be consecutively numbered.

Please send completed Form 2050 to:

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

If you have any questions concerning this form, please contact Karen Roberts, OHCA Compliance Officer at (860) 418-7041.

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need
Form 2050

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted 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. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name		
Doing Business As		
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail		
Petitioner type (e.g., P for profit and NP for Not for Profit)		
Name of Contact person, including title		
Contact person's street mailing address		
Contact person's phone, fax and e-mail address		

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

_____

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

_____

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Increase in the Authorized Capital Expenditure or Capital Cost

☐ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other (such as Relocation) _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN INCREASE IN THE AUTHORIZED CAPITAL EXPENDITURE OR THE AUTHORIZED CAPITAL COST:

a. Total Previously Authorized Capital Expenditure/Cost: $_____

b. Proposed Incremental Increase: $ _____
(See note #1 below)

c. Proposed revised total capital expenditure/cost $ _____

d. Provide a rationale for the requested increase in capital expenditure or capital cost:

_____

_____

_____

_____

Note #1: Please see attached Filing Fee Computation Schedule for any increase in the authorized capital expenditure exceeding $100,000.

e. Provide the following breakdown for the incremental amount listed on line IV (b) above:

New Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Other: Identify	
Total Proposed Incremental Capital Expenditure	$
Fair Market Value of Leased Equipment	
Total Proposed Incremental Capital Cost	$

f. Identify the type of financing or funding source for the requested incremental increase:

- ☐ Operating Funds
- ☐ Lease Financing
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ CHEFA Financing
- ☐ Grant Funding
- ☐ Funded Depreciation
- ☐ Other (specify): _____

SECTION V. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION VI. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

_____

b. Provide the rationale for such requested change:

_____

SECTION VII. OTHER / PROJECT SPECIFIC

a. Submit a completed CON Modification Affidavit that is attached to Form 2050.

b. Indicate if the MRI unit authorized under Docket Number 99-548 (Hitachi Airius II Open MRI) is the same that will be relocated to the new site.

c. Is the new location in Fairfield, an existing Paul A. Aiello, P.C. radiology office location or is this a new office location for this P.C.?

d. Is this new location dedicated to MRI services only or will this location have multiple radiology modalities available from Paul A. Aiello, P.C.

e. Verify that the MRI studies at the Fairfield location will be billed under the Paul A. Aiello, P.C. identification number.

f. The capital expenditure authorized under Docket Number 99-548 was $1,310,193. Approximately $975,000 was for the value of the MRI unit. Please explain how the unit can have a current value at this time of under $400,000.

g. Is the Applicant requesting a waiver of public hearing pursuant to Section 19a-643-45 due to the Request being non-substantive as defined in 19a-643-95(3) of the Regulations of Connecticut State Agencies?

☐ Yes

☐ No

CON MODIFICATION AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge, and that _____ complies with the appropriate
(Facility Name)

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 MODIFICATION OF PREVIOUS CERTIFICATE OF NEED APPROVALS

FILING FEE COMPUTATION SCHEDULE

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

SECTION A - REQUEST FOR MODIFICATION OF PRIOR APPROVED CON

1. Check off the statute reference as applicable to the original CON authorization: (*See the statutes for detail or the original CON authorization*)
   _____ 19a-638. Additional function or service, Change of Ownership, or Service Termination.
   _____ 19a-639. Capital Expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000.

2. Enter $0 on "Total Fee Due" line (SECTION B) if section 19a-639 is not checked, or if the proposed additional cost is less than $100,000 beyond the original authorization; otherwise go on to line 3.

3. Enter $500 on "Total Fee Due" line (SECTION B) if the proposed additional cost is greater than $100,000 beyond the original authorization but less than or equal to $1,000,000.

4. If section 19a-639 is checked above or if both 19a-638 and 19a-639 are checked and the proposed additional cost is greater than $1,000,000 beyond the original authorization or if the modification request aggregated with other prior modification requests (for which a fee was not paid) totals greater than $1,000,000:

   a. Base fee of $1,000.00: $ 1,000.00

   b. Additional fee: (Incremental Capital Expenditure Requested) >$100,000 individually or in aggregate with prior modification approvals.
      (To calculate: Total requested incremental capital expenditure including capitalized financing costs multiplied by .0005, rounded to the nearest dollar.)
      ($_____ X .0005) $_____.00

   c. **Sum of Base Fee plus Additional Fee**: _____ $_____.00

   d. Enter the amount shown on line A4c on "Total Fee Due" line (SECTION B)

SECTION B TOTAL FEE DUE: _____ $_____.00

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

Form 2050
Revised 10/03

Confirmation Report – Memory Send

Time : Apr-21-2004 09:40
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	171
Date	:	Apr-21 09:36
To	:	912032561930
Document pages	:	009
Start time	:	Apr-21 09:36
End time	:	Apr-21 09:40
Pages sent	:	009
Status	:	OK

Job number : 171 *** SEND SUCCESSFUL ***

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul A. Aiello M.D.
FAX: 203-255-1930
AGENCY: Paul A. Aiello, M.D., P.C.
FROM: Karen Roberts OHCA
DATE: 4/21/04 **Time:** 9:30 Am
NUMBER OF PAGES: 9
(including transmittal sheet)

Comments:
Regarding MRI relocation request
DN 99-548

PLEASE PHONE 860-418-7001 *IF THERE ARE ANY TRANSMISSION PROBLEMS.*

Phone: (860) 418-7001 *Fax: (860) 418-7053*
410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

PAUL A. AIELLO, M.D., P.C.
13 THOR PLACE
FAIRFIELD, CONNECTICUT 06824-3042

May 12, 2004

Ms. Karen Roberts
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Re: Docket No. 04-22633-MDF; Modification of the CON under Docket No.99-548

Dear Ms. Roberts:

In response to your letter dated April 21, 2004, enclosed is my CON Modification Request Form 2050 to relocate my MRI unit, previously approved under CON (Docket # 99-548), from 46 Prince Street, New Haven, Connecticut to 425 Post Road, Fairfield, Connecticut. I have attached a letter from the manufacturer of my MRI unit stating that the current value of the MRI unit is less than $400,000. This relocation will not result in any increase in the capital expenditure authorized in the CON and this relocation will not result in any change in service provided. Please advise me if there is any other information your office may need to affect this relocation.

Very truly yours,

Paul A. Aiello, M.D.

PHONE: 203.256.1494 • FAX: 203.256.1930

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need
Form 2050

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted 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. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	**Paul A. Aiello, M.D., P.C. 13 Thor Place Fairfield, CT 06824-3042**	
Doing Business As	**Paul A. Aiello, M.D., P.C.**	
Name of Parent Corporation	**n/a**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**Paul A. Aiello, M.D., P.C. 13 Thor Place Fairfield, CT 06824-3042**	
Petitioner type (e.g., P for profit and NP for Not for Profit)	**Profit**	
Name of Contact person, including title	**Dr. Paul A. Aiello**	
Contact person's street mailing address	**13 Thor Place Fairfield, CT 06824-3042**	
Contact person's phone, fax and e-mail address	**P-203-256-1494 F-203-256-1930**	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):
Answer: Open MRI Unit Replacement; Docket # 99-548

b. Location of proposal (Town including street address):
Answer: 425 Post Road, Fairfield, Connecticut

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Increase in the Authorized Capital Expenditure or Capital Cost

☐ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

X Other – Describe:
Answer: Relocation of the Open MRI Unit previously approved under Docket # 99-548 from 46 Prince Street, New Haven, CT to 425 Post Road, Fairfield, CT.

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN INCREASE IN THE AUTHORIZED CAPITAL EXPENDITURE OR THE AUTHORIZED CAPITAL COST:

a. Total Previously Authorized Capital Expenditure/Cost: $_____

b. Proposed Incremental Increase: $ _____
(See note #1 below)

c. Proposed revised total capital expenditure/cost $ _____

d. Provide a rationale for the requested increase in capital expenditure or capital cost:

_____

_____

_____

_____

Note #1: Please see attached Filing Fee Computation Schedule for any increase in the authorized capital expenditure exceeding $100,000.

e. Provide the following breakdown for the incremental amount listed on line IV (b) above:

New Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Other: Identify	
Total Proposed Incremental Capital Expenditure	**$**
Fair Market Value of Leased Equipment	
Total Proposed Incremental Capital Cost	**$**

f. Identify the type of financing or funding source for the requested incremental increase:

- ☐ Operating Funds
- ☐ Lease Financing
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ CHEFA Financing
- ☐ Grant Funding
- ☐ Funded Depreciation
- ☐ Other (specify): _____

SECTION V. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION VI. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

_____

b. Provide the rationale for such requested change:

_____

_____

_____

_____

_____

SECTION VII. OTHER

a. Submit a completed CON Modification Affidavit that is attached to Form 2050.
Answer: Please see attached completed CON Modification Affidavit.

b. Indicate if the MRI unit authorized under Docket Number 99-548 (Hitachi Airis II Open MRI) is the same that will be relocated to the new site.
Answer: Yes, this CON Modification is for the same MRI Unit authorized under Docket #99-548 (Hitachi Airis II Open MRI).

c. Is the new location in Fairfield an existing Paul A. Aiello, P.C. radiology office location or is this a new office location for this P.C.?
Answer: This is a new office location for Paul A. Aiello, M.D., P.C.

d. Is this new location dedicated to MRI services only or will this location have multiple radiology modalities available from Paul A. Aiello, P.C.?
Answer: Paul A. Aiello, M.D., P.C. will be providing only MRI services at the new office location.

e. Verify that the MRI studies at the Fairfield location will be billed under the Paul A. Aiello, P.C. identification number.
Answer: The MRI studies at the new Fairfield office location will be billed under the Paul A. Aiello, M.D., P.C. Federal Tax Identification #061380510.

f. The capital expenditure authorized under Docket Number 99-548 was $1,310,193. Approximately $975,000 was the value of the MRI unit. Please explain how the unit can have a current value at this time of under $400,000.

Answer: The MRI Unit has depreciated to its present value. Please see attached letter from Hitachi (Exhibit A, page 8) which quotes the current value.

g. Is the Applicant requesting a waiver of public hearing pursuant to Section 19a-643-45 due to the Request being non-substantive as defined in 19a-643-95(3) of the Regulations of Connecticut State Agencies?

X Yes

☐ No

CON MODIFICATION AFFIDAVIT

Applicant: **Paul A. Aiello, M.D., P.C.**

Project Title: **Docket No. 04-22633-MDF; Modification of the CON under Docket No. 99-548**

I, **Paul A. Aiello, M.D.**, (Name) **President and CEO** (Position – CEO or CFO)

of **Paul A. Aiello, M.D., P.C.** being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge, and that **Paul A. Aiello, M.D., P.C.** (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 05/12/2004
Date

Subscribed and sworn to before me on 5/12/04

~~Notary Public~~/Commissioner of Superior Court
PAUL L QUATTRELLA

~~My commission expires:~~ _____

Form 2050
Revised 10/03

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR MODIFICATION OF PREVIOUS CERTIFICATE OF NEED APPROVALS

FILING FEE COMPUTATION SCHEDULE

APPLICANT: **Paul A. Aiello, M.D., P.C.** PROJECT TITLE: **Docket No. 04-22633-MDF; Modification of the CON under Docket No. 99-548** DATE: **May 1, 2004**	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 - REQUEST FOR MODIFICATION OF PRIOR APPROVED CON

1. Check off the statute reference as applicable to the original CON authorization: (*See the statutes for detail or the original CON authorization*)
   _____ 19a-638. Additional function or service, Change of Ownership, or Service Termination.
   ___X_ 19a-639. Capital Expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000.

2. Enter $0 on "Total Fee Due" line (SECTION B) if section 19a-639 is not checked, or if the proposed additional cost is less than $100,000 beyond the original authorization; otherwise go on to line 3.

3. Enter $500 on "Total Fee Due" line (SECTION B) if the proposed additional cost is greater than $100,000 beyond the original authorization but less than or equal to $1,000,000.

4. If section 19a-639 is checked above or if both 19a-638 and 19a-639 are checked and the proposed additional cost is greater than $1,000,000 beyond the original authorization or if the modification request aggregated with other prior modification requests (for which a fee was not paid) totals greater than $1,000,000:

   a. Base fee of $1,000.00: $ 1,000.00

   b. Additional fee: (Incremental Capital Expenditure Requested) >$100,000 individually or in aggregate with prior modification approvals.
      (To calculate: Total requested incremental capital expenditure including capitalized financing costs multiplied by .0005, rounded to the nearest dollar.)
      ($_____ X .0005) $_____.00

   c. **Sum of Base Fee plus Additional Fee:** _____ $_____.00

   d. Enter the amount shown on line A4c on "Total Fee Due" line (SECTION B)

SECTION B TOTAL FEE DUE: _____ $___**0**___.00

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

HITACHI

HITACHI MEDICAL SYSTEMS AMERICA, INC.
1959 Summit Commerce Park
Twinsburg, Ohio 44087-2371
Tel.: 330.425.1313
Fax: 330.425.1410

May 6, 2004

Paul A. Aiello, M.D., PC
Prince Professional Building
46 Prince
New Haven, CT 06519

Dear Dr. Aiello:

This letter is in response to your request concerning AIRIS II Serial No. C320 located at Open MRI of S. Connecticut, 46 Prince Street, New Haven, CT 06519. This MRI system was manufactured by Hitachi Medical Corporation and has consistently been maintained by Hitachi Medical Systems America, Inc. since its installation. HMSA is therefore familiar with the configuration and condition of this system and HMSA is of the opinion that the trade-in value of the used AIRIS II as of the date hereof is $375,000. This amount does not represent the retail value due to options, warranty and other allowances that may be provided in connection with such resale as well as re-marketing and service costs that may be incurred.

This letter is for appraisal purposes only and is not intended as an offer to purchase the above referenced system. This appraisal is based upon HMSA's current expectations, assumptions and estimates about the medical imaging industry and could change if such expectations, assumptions and/or estimates change.

I hope that this letter provides the information that you are seeking. If you have any questions, please contact Mike Hughes at 800 800-3106, ext. 2791.

Very truly yours,

Rick Miller
Sales Administrator