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	NRC Equipment Associates & SWC Corp. SWC Corporation is a for profit subsidiary of the Norwalk Health Services Corporation, which is the parent corporation of Norwalk Hospital.	
Doing Business As	Norwalk Radiology & Mammography Center	
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	Norwalk Radiology & Mammography Center ATTN: Alan H. Richman M.D. 148 East Avenue Norwalk CT 06851	
What is the Applicant's Status: P for Profit or NP for Nonprofit	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.	Alan H. Richman, M.D. President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Norwalk Hospital Maple Street Norwalk CT 06856	
Contact Person's Telephone Number	203-852-2715	
Contact Person's Fax Number	203-855-3967	
Contact Person's e-mail Address	alan.richman @norwalkhealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **CTi Upgrade**

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 $ 3,000,000

☐ Equipment Acquisition

☐ New ☒ Replacement ☐ Major Medical (> $3,000,000)

☒ 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:
148 East Avenue, Norwalk CT 06851

d. List each town this project is intended to serve: Norwalk, Westport, Wilton, Weston, New Canaan

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

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 or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $605,200

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	522,600
Non-Medical Equipment Purchases*	0
Land/Building Purchases	0
Construction/Renovation	82,600
Other (Non-Construction) Specify:_____	0
Total Capital Expenditure	**$605,200**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**$605,200**
Total Project Cost	**$605,200**
Capitalized Financing Costs (Informational Purpose Only)	

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

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:

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CT	GE	16 slice	1	504,000
UPS	Exide		1	18,600

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

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

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

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.
   Norwalk Radiology & Mammography Center provides a full range of outpatient imaging services including digital mammography, CT scanning, ultrasound, plain x-rays, osteoporosis

scanning, fluoroscopy a CON approved High field MRI and a CON approved open MRI in conjunction with Norwalk Hospital. Norwalk Hospital supports the submission of this letter of intent. A Department of Public Health license was not required by Norwalk Radiology & Mammography Center.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable **Norwalk Radiology & Mammography Center performed 12,056 CT scans in FY 2006 utilizing two CT scan machines. We are proposing to replace our older, obsolete single-slice CT scanner that was originally purchased as a refurbished machine. This would be replaced with a Multidetector CT scanner for improved diagnostic imaging and reduced radiation dose. Images will be obtained faster - reducing motion artifact and the images will be obtained with thinner slices improving spatial resolution. For some indications, this new technology will allow for the replacement of more expensive imaging procedures such as angiography with less expensive non-invasive CT scan. DPH licensure categories are not applicable.**

3. Identify the current population served and who is the target population to be served. **The current populations are the outpatients referred to Norwalk Radiology & Mammography Center by physicians who practice primarily in the Norwalk, Westport, Weston, Wilton and New Canaan areas. This population is approximately 150,000. The target population is the same as the current population.**

4. Identify any unmet need and describe how this project will fulfill that need. **The existing single slice scanner is technologically limited. It is unable to complete the full range of diagnostic scans required by our patients, and requires prolonged procedure/exposure times for the patients. The new scanner will be able to perform new types of studies currently not adequately performed on a single slice machine including advanced cardiovascular/peripheral vascular imaging, coronary CT angiography, dynamic imaging of the head, neck and body, vascular imaging for aneurisms and performing CT scans on children without sedation.**

5. Are there any similar existing service providers in the proposed geographic area? **No. The Norwalk Hospital proposed 64-slice Multidetector CT scanner would provide services to inpatients, emergency patients as well as to outpatient volume. The proposed 64 slice scanner has capabilities in cardiac scanning not available with the 16 slice CT scanner. This proposal is for the purchase of a Multidetector CT scanner which would be a replacement for an obsolete scanner that can no longer provide for current and growing need from the existing referral base. The 16 slice would not be at the same level of technology as the proposed 64-slice scanner at Norwalk Hospital, nor would it be at the same cost.**

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut. **This proposal will improve the quality and availability of services already provided and to help bring the level of care in the State of Connecticut to the level available in adjacent states. The primary benefit will be to improve patient care for a large existing referral base of outpatients scanned on the existing older machine. Improved productivity with a faster scanner will also allow for technologists to be more productive and help bring down per procedure cost as well as increase capacity.**

7. Who will be responsible for providing the service? **Norwalk Radiology Consultants, P.C. a professional corporation, provides the medical services at the Radiology office located at 148 East Avenue, Norwalk Connecticut**

   Norwalk Radiology Consultants, P.C. also provides the professional radiology services for Norwalk Hospital.

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational? **We accept virtually all third party payers including Medicare and Medicaid and provide services regardless of ability to pay. We anticipate no changes.**

AFFIDAVIT

To be completed by each Applicant

Applicant: NRC Equipment Associates & SWC Corp - DBA Norwalk Radiology & Mammography Center.

Project Title: CTi upgrade

I, Alan H. Richman M.D. _____, Managing Partner
(Name) (Position – CEO or CFO)

of Norwalk Radiology & Mammography Center 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 Norwalk Radiology & Mammography Center 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.

Alan H. Richman MD
Signature

7/12/07
Date

RECEIVED
2007 JUL 19 A 10:25

Subscribed and sworn to before me on July 12, 2007

Janet L. Johnson
Notary Public/Commissioner of Superior Court

JANET L. JOHNSON
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2012

My commission expires: 5/31/2012

Form 2030
Revised 7/06

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

July 24, 2007

Alan Richman, M.D.
President
Norwalk Radiology & Mammography Center
148 East Ave.
Norwalk, CT 06851

RE: Certificate of Need Application Forms, Docket Number 07-31009-CON
Norwalk Radiology & Mammography Center Replacement of CT Scanner

Dear Dr. Richman:

Enclosed are the application forms for Norwalk Radiology & Mammography Center's Certificate of Need ("CON") proposal for the CT Scanner Replacement with an associated capital expenditure of $605,200. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between September 17, 2007, and November 16, 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 that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Alexis G. Fedorjaczenko. Please feel free to contact her at (860) 418-7067 if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 September 17, 2007, and may be submitted no later than November 16, 2007. The Analyst assigned to your application is Alexis G. Fedorjaczenko. She may be reached at the Office of Health Care Access at (860) 418-7067.

Docket Number:	07-31009-CON
Applicant's Name:	NRC Equipment Associates & SWC Corp. d/b/a Norwalk Radiology & Mammography Center
Contact Person:	Alan Richman M.D.
Contact Title:	President
Contact Address:	148 East Avenue Norwalk, CT 06851
Project Location:	Norwalk, Connecticut
Project Name:	Replacement of CT Scanner
Proposal Type:	Section 19a-639, C.G.S.
Estimated Capital Expenditure:	$605,200

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. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary service area ("PSA") and secondary service area ("SSA") towns
   b) Explain how it was determined there was a need for the proposal in your service area.
   c) Provide the rationale for choosing the proposed primary and secondary service area towns.
   d) The unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   e) The population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   f) Scheduling backlogs in service area
   g) Travel distance from proposed site to service area towns
   h) Hours of operation of existing/proposed service

ii) Identify the existing providers of CT scanners in your service area.

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

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

v) Provide the information as outlined in the following table concerning the existing CT providers in the Applicant's PSA & SSA:

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.
[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.

B. 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.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

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

☐ Other: Specify _____

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. 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.

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

☐ DPH	☐ JCAHO
☐ Fire Marshall Report	☐ Other States Health Dept.Reports (new out-of-state providers)
☐ AAAHC	☐ AAAASF
☐ Other: _____	

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

[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.

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

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

G. 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

6. 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 ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

B. 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.

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

☐ Yes ☐ No

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

D. 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.

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has 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.

9. Major Cost Components/Total Capital Expenditure

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

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

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

10. 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	

11. Capital Equipment Lease/ Purchase

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

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	___ Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	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.

12. Type of Financing

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

☐ Applicant's equity:

Source and amount:

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.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix 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 or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total 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. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See Financial Attachment I, attached.** 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) Provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See Financial Attachment II, attached.**

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.). ***Note:*** *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

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

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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

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

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: _____

13. B 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.

12.B(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

FY _____	(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 NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 25, 2007

Alan Richman, M.D.
President
Norwalk Radiology & Mammography Center
148 East Avenue
Norwalk, CT 06851

Re: Letter of Intent, Docket Number 07-31009
Norwalk Radiology & Mammography Center
Replacement of CT Scanner
Notice of Letter of Intent

Dear Dr. Richman:

On July 19, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Norwalk Radiology & Mammography Center ("Applicant") for the replacement of CT Scanner, at a total capital expenditure of $605,200.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hour* pursuant to Section 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:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 25, 2007

Requisition # HCA08-014
EMAIL: OBIT@The Hour.com

The Hour
P.O. Box 790
Norwalk, CT 06852-0790

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 **Sunday, July 29, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AF:lmg

c: Sandy Salus, OHCA

The Hour **Letter of Intent**
Docket Number 07-31009 **July 25, 2007**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Norwalk Radiology & Mammography Center
Town:	Norwalk
Docket Number:	07-31009
Proposal:	Replacement of CT Scanner
Capital Expenditure:	$605,200

The Applicant may file its Certificate of Need application between September 17, 2007 and November 16, 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.

Greer, Leslie

From: obit Classified [obit@thehour.com]
Sent: Wednesday, July 25, 2007 2:08 PM
To: Greer, Leslie
Subject: RE: Legal Ad 07-31009

Leslie,

The total would be $115.40 and it will run tomorrow.
Thanks!
Jocelyn at The Hour

-----Original Message-----
From: Greer, Leslie [mailto:Leslie.Greer@po.state.ct.us]
Sent: Wed 7/25/2007 1:03 PM
To: obit Classified
Subject: Legal Ad 07-31009

Legal Ad,

Please run the attached Public Notice in your newspaper by July 29, 2007. Please notify me that you have received this request.

Thank you,

Leslie M. Greer

Office of Healthcare Access

State of Connecticut

410 Capital Avenue

Hartford, CT 06134

Phone: (860) 418-7001

Fax: (860) 418-7053

PUBLISHER'S AFFIDAVIT

STATE OF CONNECTICUT)
ss. Norwalk
COUNTY OF FAIRFIELD)

I, MICHAEL L. SWANN, being duly sworn, dispose and say:

1. I am over the age of eighteen (18) and believe in the obligation of an oath;

2. I am the Classified Advertising Director of The Hour Publishing Company, publisher of the following newspapers:

   1) The Hour, a daily newspaper, published in Norwalk, Connecticut;

   2) The Wilton Villager, a weekly newspaper, published in Norwalk, Connecticut; and

   3) The Stamford Times, a weekly newspaper, published in Norwalk, Connecticut.

3. On July 26, 2007 an advertisement placed by Office of Health Care Access was published in The Hour.

LEGAL NOTICE

Statute Reference:
19a-639

Applicant:
Norwalk Radiology & Mammography Center

Town:
Norwalk

Docket Number:
07-31009

Proposal:
Replacement of CT Scanner

Capital Expenditure:
$605,200

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Michael L. Swann, Classified Advertising Director

Subscribed and sworn to before me this 27th day of July, 2007.

Brett L. Whitton
Commissioner of the Superior Court