FAX TRANSMISSION

BERSHTEIN, VOLPE, & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET
NEW HAVEN, CT 06511
(203) 777-5800 Fax: (203) 777-5806

FAX #: (860) 418-7053

DATE: August 9, 2007

TO: Honorable Christine Vogel
Office of Health Care Access

PAGES: 10 including this page

FROM: Michele M. Volpe

MATTER: #053147

SUBJECT: Robert D. Russo & Associates Radiology, P.C.

COMMENTS:

Dear Commissioner Vogel:

Please see the attached.

Thank you.

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

August 9, 2007
Via Facsimile (860) 418-7053
and First Class USPS Mail

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

Re: Robert D. Russo, M.D. & Associates Radiology P.C.
Letter of Intent – Form 2030
Replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-Up Open MRI Unit at Norwalk Office Location

Dear Commissioner Vogel:

Enclosed please find an original and five (5) copies of Robert D. Russo, M.D. & Associates Radiology P.C.'s Letter of Intent – Form 2030 regarding the replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-Up Open MRI Unit at 111 East Avenue, Suite 100 in Norwalk.

Thank you.

Very truly yours,

Michele M. Volpe

MMV:bt
Enclosures

F:\Doc\05 3101-3150\053147 Russo, Robert MD and Associates re General\LOI\OHCA (Comm Vogel) 8.09.07 (LOI).doc

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	Robert D. Russo, M.D. & Associates Radiology P.C.	
Doing Business As	East Avenue Radiology	
Name of Parent Corporation	Not Applicable	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	111 East Avenue, Suite 100 Norwalk, 06851	
What is the Applicant's Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes **No X**	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Robert D. Russo, M.D. President and Owner	Michele M. Volpe, Esq.
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	2660 Main Street, Suite 216, Bridgeport, CT 06606	105 Court Street 3rd Floor New Haven, CT 06511

Contact Person's Telephone Number	203-610-6805 ext 332	203-777-5800
Contact Person's Fax Number	203-610-6813	203-777-5806
Contact Person's e-mail Address	drrdrusso@aol.com	michelemvolpe@aol.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-UP Open MRI Unit at Norwalk Office Location

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.:

☐ New (F, S, Fnc) X 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

X Equipment Acquisition

☐ New X 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:

111 East Avenue, Suite 100, Norwalk, CT 06851

d. List each town this project is intended to serve:

The primary towns include Norwalk (encompassing Rowayton, South Norwalk and East Norwalk), as well as Westport, Wilton, New Canaan and Weston.

e. Estimated starting date for the project: **January 1, 2008**

f. Type of project: **19**
(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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$1,750,000.00**

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	$1,500,000.00
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$250,000.00
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,750,000.00**
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	**$1,750,000.00**

Total Project Cost	**$1,750,000.00**
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: **NA**

☐ 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
Open MRI	**Fonar**	**Indomitable Stand-UP MRI System**	**One (1)**	**$1,500,000.00**

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	X	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.

   Currently, the Applicant performs MRIs scanned in an open unit using its 0.2 Tesla unit.

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

   Replacing the older unit with new technology will allow the Applicant to better service the needs of its patients. Acquisition of the Fonar Tesla Stand-Up MRI System will allow the Applicant to provide unique multi-positional MRI services to its patients. The Stand-Up MRI is a multi-positional system that provides an unrestricted range of motion for flexion, extension, lateral bending and rotation studies of the cervical and lumbar spine. It can scan spines and joints in the weight-bearing state or in the conventional recumbent position.

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

   The target population to be served will be the same as the existing population being served by the current unit, including, but not limited to, patients from the towns of Norwalk (encompassing Rowayton, South Norwalk and East Norwalk), as well as Westport, Wilton, New Canaan and Weston.

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

   The existing 0.2 Tesla MRI unit that is operating at the Applicant's Norwalk office needs to be replaced with the Fonar Tesla Stand-Up Open MRI scanner because the latter is of superior quality and will enable the Applicant to provide higher quality studies that the existing scanner is not capable of. Replacement of the existing equipment will also enable the Applicant to perform "position-imaging" scans thereby reducing patient pain, which could not be accomplished on the existing unit. Thus, replacing the existing equipment with the Fonar Tesla Stand-Up Open MRI will increase patient access to high quality MRI services.

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

   No. This would be a unique service in Fairfield County at this time.

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

Robert D. Russo, MD & Associates Radiology P.C.'s acquisition of the Fonar Tesla Stand-Up MRI System will provide unique MRI services to patients in the proposed geographic area, which will improve overall patient care. The Fonar Tesla Stand-Up Open MRI Scanner will produce high diagnostic quality images comparable to closed high field (1.5T) MRI. The implementation of the Fonar Stand-Up MRI System will enable the Applicant to perform high quality studies that traditional MRI scanners cannot. It will allow the Applicant's physicians the ability to scan patients, who cannot be scanned easily, including children frightened by MRI machines, as well as obese patients and patients with claustrophobia. The Fonar Stand-Up Open MRI Scanner also provides physicians with the ability to perform "position-imaging," in which patients can be scanned in a variety of positions, specifically those positions that reduce their pain. Furthermore, patients can be scanned in weigh-bearing positions that will provide the vital diagnostic information that is impossible to obtain by conventional MRI.

7. Who will be responsible for providing the service?

   Robert D. Russo, M.D. & Associates Radiology P.C.

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

Payers	Payer Mix
Government:	
Medicare	23
Medicaid	
TriCare (Champus)	
Total Government Payers	23
Non-Government Payers:	
Commercial Insurers	63
Self-Pay	9
Workers Compensation	3
Total Non-Government Payers	75
Uncompensated Care	2
TOTAL PAYER MIX	**100**

AFFIDAVIT

To be completed by each Applicant

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

Project Title: **Replacement of 0.2 Tesla Open MRI Unit with a Fonar Stand-Up Open MRI Unit at Norwalk Office Location.**

I, Robert D. Russo, M.D (Name), President & Owner (Position – CEO or CFO)

of Robert D. Russo, M.D. and Associates Radiology, P.C. 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 Robert D. Russo, M.D. and Associates Radiology, P.C. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 8/6/07 Date

Subscribed and sworn to before me on August 6, 2007

Carolyn D. Scafo, Notary Public
Notary Public/Commissioner of Superior Court

My commission expires: March 31, 2008

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

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

August 9, 2007
Via Facsimile (860) 418-7053
and First Class USPS Mail

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

Re: Robert D. Russo, M.D. & Associates Radiology P.C.
Letter of Intent – Form 2030
Replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-Up Open MRI Unit at Norwalk Office Location

Dear Commissioner Vogel:

Enclosed please find an original and five (5) copies of Robert D. Russo, M.D. & Associates Radiology P.C.'s Letter of Intent – Form 2030 regarding the replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-Up Open MRI Unit at 111 East Avenue, Suite 100 in Norwalk.

Thank you.

Very truly yours,

Michele M. Volpe

MMV:bt
Enclosures

F:\Doc\05 3101-3150\053147 Russo, Robert MD and Associates re General\LOI\OHCA (Comm Vogel) 8.09.07 (LOI).doc

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	Robert D. Russo, M.D. & Associates Radiology P.C.	
Doing Business As	East Avenue Radiology	
Name of Parent Corporation	Not Applicable	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	111 East Avenue, Suite 100 Norwalk, 06851	
What is the Applicant's Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes **No X**	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Robert D. Russo, M.D. President and Owner	Michele M. Volpe, Esq.
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	2660 Main Street, Suite 216, Bridgeport, CT 06606	105 Court Street 3rd Floor New Haven, CT 06511

Contact Person's Telephone Number	203-610-6805 ext 332	203-777-5800
Contact Person's Fax Number	203-610-6813	203-777-5806
Contact Person's e-mail Address	drrdrusso@aol.com	michelemvolpe@aol.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Replacement of 0.2 Tesla Open MRI Unit with a High Field Fonar Stand-UP Open MRI Unit at Norwalk Office Location

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.:

☐ New (F, S, Fnc) X 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

X Equipment Acquisition

☐ New X 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:

111 East Avenue, Suite 100, Norwalk, CT 06851

d. List each town this project is intended to serve:

The primary towns include Norwalk (encompassing Rowayton, South Norwalk and East Norwalk), as well as Westport, Wilton, New Canaan and Weston.

e. Estimated starting date for the project: **January 1, 2008**

f. Type of project: **19**
(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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$1,750,000.00**

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	$1,500,000.00
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$250,000.00
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$1,750,000.00**
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	**$1,750,000.00**

Total Project Cost	**$1,750,000.00**
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: **NA**

☐ 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
Open MRI	**Fonar**	**Indomitable Stand-UP MRI System**	**One (1)**	**$1,500,000.00**

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	**X**	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.

   Currently, the Applicant performs MRIs scanned in an open unit using its 0.2 Tesla unit.

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

   Replacing the older unit with new technology will allow the Applicant to better service the needs of its patients. Acquisition of the Fonar Tesla Stand-Up MRI System will allow the Applicant to provide unique multi-positional MRI services to its patients. The Stand-Up MRI is a multi-positional system that provides an unrestricted range of motion for flexion, extension, lateral bending and rotation studies of the cervical and lumbar spine. It can scan spines and joints in the weight-bearing state or in the conventional recumbent position.

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

   The target population to be served will be the same as the existing population being served by the current unit, including, but not limited to, patients from the towns of Norwalk (encompassing Rowayton, South Norwalk and East Norwalk), as well as Westport, Wilton, New Canaan and Weston.

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

   The existing 0.2 Tesla MRI unit that is operating at the Applicant's Norwalk office needs to be replaced with the Fonar Tesla Stand-Up Open MRI scanner because the latter is of superior quality and will enable the Applicant to provide higher quality studies that the existing scanner is not capable of. Replacement of the existing equipment will also enable the Applicant to perform "position-imaging" scans thereby reducing patient pain, which could not be accomplished on the existing unit. Thus, replacing the existing equipment with the Fonar Tesla Stand-Up Open MRI will increase patient access to high quality MRI services.

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

   No. This would be a unique service in Fairfield County at this time.

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

Robert D. Russo, MD & Associates Radiology P.C.'s acquisition of the Fonar Tesla Stand-Up MRI System will provide unique MRI services to patients in the proposed geographic area, which will improve overall patient care. The Fonar Tesla Stand-Up Open MRI Scanner will produce high diagnostic quality images comparable to closed high field (1.5T) MRI. The implementation of the Fonar Stand-Up MRI System will enable the Applicant to perform high quality studies that traditional MRI scanners cannot. It will allow the Applicant's physicians the ability to scan patients, who cannot be scanned easily, including children frightened by MRI machines, as well as obese patients and patients with claustrophobia. The Fonar Stand-Up Open MRI Scanner also provides physicians with the ability to perform "position-imaging," in which patients can be scanned in a variety of positions, specifically those positions that reduce their pain. Furthermore, patients can be scanned in weigh-bearing positions that will provide the vital diagnostic information that is impossible to obtain by conventional MRI.

7. Who will be responsible for providing the service?

   Robert D. Russo, M.D. & Associates Radiology P.C.

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

Payers	Payer Mix
Government:	
Medicare	23
Medicaid	
TriCare (Champus)	
Total Government Payers	23
Non-Government Payers:	
Commercial Insurers	63
Self-Pay	9
Workers Compensation	3
Total Non-Government Payers	75
Uncompensated Care	2
TOTAL PAYER MIX	**100**

AFFIDAVIT

To be completed by each Applicant

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

Project Title: **Replacement of 0.2 Tesla Open MRI Unit with a Fonar Stand-Up Open MRI Unit at Norwalk Office Location.**

I, Robert D. Russo, M.D (Name), President & Owner (Position – CEO or CFO)

of Robert D. Russo, M.D. and Associates Radiology, P.C. 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 Robert D. Russo, M.D. and Associates Radiology, P.C. complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 8/6/07

Subscribed and sworn to before me on August 6, 2007

Carolyn L. Scafo, Notary Public

Notary Public/Commissioner of Superior Court

My commission expires: March 21, 2008

RECEIVED
2007 AUG 10 A 11:12
OFFICE OF HEALTH CARE ACCESS

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

September 11, 2007

Michele Volpe, Esq.
105 Court Street
Third Floor
New Haven, CT 06511

Re: Letter of Intent, Docket Number 07-31025
Robert D. Russo, M.D. and Associates Radiology, PC
Acquisition of an MRI Unit at the Norwalk Office Location
Notice of Letter of Intent

Dear Attorney Volpe:

On August 10, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Robert D. Russo, M.D. and Associates Radiology, PC ("Applicant") for the Acquisition of an MRI Unit at the Norwalk Office Location, at a total capital expenditure of $1,750,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hour* pursuant to Section 19a-639 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly Martone /KRF

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

September 11, 2007

Requisition # HCA08-046
EMAIL: OBIT@TheHour.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 **Saturday, September 15, 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:AGF:lmg

c: Sandy Salus, OHCA

The Hour
Docket Number 07-31025

Letter of Intent
September 11, 2007

PLEASE INSERT THE FOLLOWING:

Statute References:	19a-639
Applicant:	Robert D. Russo, M.D. and Associates Radiology, PC
Town:	Norwalk
Docket Number:	07-31025
Proposal:	Acquisition of an MRI Unit at the Norwalk Office Location
Capital Expenditure:	$1,750,000

The Applicant may file its Certificate of Need application between October 9, 2007 and December 8, 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

September 11, 2007

Michele M. Volpe, Esq.
105 Court Street
3rd Floor
New Haven, CT 06511

RE: Certificate of Need Application Forms; Docket Number: 07-31025-CON
Robert D. Russo, M.D. & Associates Radiology P.C.
Replacement MRI Scanner

Dear Ms. Volpe:

Enclosed are the application forms for Robert D. Russo, M.D. & Associates Radiology P.C.'s Certificate of Need ("CON") proposal for the replacement of a MRI scanner with an associated capital expenditure of $1,750,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between October 9, 2007 and December 8, 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 Attachments and other data as appropriate be in MS Excel format.

The OHCA 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

Enclosure

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, an answer of "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 9, 2007, and may be submitted no later than December 8, 2007. The OHCA Analyst assigned to your application is Alexis G. Fedorjaczenko. She may be reached at the Office of Health Care Access by dialing (860) 418-7067.

Docket Number:	07-31025-CON
Applicant Name:	Robert D. Russo, M.D. & Associates Radiology P.C.
Contact Person:	Michele M. Volpe, Esq.
Contact Address:	105 Court Street 3rd Floor New Haven, CT 06511
Project Location:	Norwalk
Project Name:	Replacement of MRI Unit
Proposal Type:	Section 19a-638 and 19a-639, C.G.S.
Estimated Total Capital Expenditure:	$1,750,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposal 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) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The unit of service for the past three fiscal years by service area town.
   d) Describe the population to be served. Include demographic Information, as appropriate.
   e) Scheduling backlogs in service area.
   f) Travel distance from the office location to service area towns.
   g) Hours of operation of existing and proposed service.

ii) Provide the units of service projected for the first three years of operation of the service with the proposed new equipment. **Include the derivation/calculation.**

iii) Provide the current capacity of the existing MRI scanner showing the method used to calculate the annual volume of scans.

iv) Provide the anticipated capacity of the proposed MRI scanner showing the method used to calculate the annual volume of scans.

v) Identify the existing providers of the MRI services in your service area.

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

vii) Provide the information as outlined in the following table concerning the existing providers in the Applicant's PSA and SSA:

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

[1] Specify days of the week and start and end time for each day.
[2] Service volume performed 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) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

5. 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 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-Society Council for Radiation Oncology
☐ American College of Radiology
☐ Substance Abuse and Mental Health Services Administration

☐ Other: Specify _____

C. Describe in detail how the Applicant plans 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, technicians, etc., related to the proposal and a copy of their Curriculum Vitae.

E. 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]

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant 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 Applicant and/or any staff related to the proposal.

H. Provide a copy of the related Quality Assurance plan (as applicable):

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. Will this proposal result in any change to your teaching or research responsibilities?

☐ Yes ☐ No

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

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:

[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.

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

C. 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) Please identify the entity that will be billing for the 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 description of the proposed renovation including the related gross square feet of renovation.

B. Provide all schematic drawings related to the proposed floor plans.

C. Provide the following breakdown of the 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 renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for renovation:

Building Commencement Date	
Building Completion 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 basis for the projected payer mix.

A.3 Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

C. 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. **Please complete Financial Attachment 1, 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.

consideration of the Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development in the financial projections.

iii) 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.

iv) Please complete **Financial Attachment 2**, attached.

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

vi) Describe how this proposal is cost effective.

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)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) $_____.00 c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ 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)

13. 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.

13.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

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