RADIOLOGY ASSOCIATES, INC.

101 North Plains Industrial Road
Wallingford, CT 06492
(203) 949-2700

SHERWIN M. BORSUK, M.D.
LAURENCE M. WEISS, M.D.
GARY J. DEE, M.D.
LINDA S. DURHAN, M.D.
HARRY K. HAJEDEMOS, M.D.
JAMES W. CARROLL, M.D.
MARY B. FRIAR, M.D.
MICHAEL BISCEGLIA, M.D.
HOLLEY M. DEY, M.D.
GREGORY IAFRATE, M.D.

816 Broad Street
Meriden, CT 235-2577
50 South Main Street
Wallingford, CT 269-1485
680 South Main Street
Cheshire, CT 272-3595
97 Barnes Road
Wallingford, CT 294-2721
991 South Main Street
Plantsville, CT 620-9180

December 17, 2008

Commissioner Cristine A. Vogel
State of Connecticut
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Enclosed please find an original letter of intent as well as three copies from Meriden Imaging Center, Inc. d/b/a Radiology Associates, Inc. to upgrade the current 4-slice C.T. scanner at 97 Barnes Road – Wallingford, Connecticut to a 16-slice Siemens C.T. scanner at 863 North Main Street Extension - Wallingford, Connecticut 06492 Report Number 08-31272-DTR

Thank you in advance for your consideration of this project. If you have any questions, please call me at (203) 694-8405.

Sincerely,

Gary J. Dee, M.D., President
Radiology Associates, Inc.

GJD/mw
D: 12/17/08
T: 12/17/08

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 the Applicant(s), 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	Meriden Imaging Center, Inc.	
Doing Business As	Radiology Associates, Inc.	
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	101 No Plains Industrial Road-Wallingford, CT 06492	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Gary Dee, M.D., President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	101 No Plains Industrial Road-Wallingford, CT 06492	
Contact Person Telephone Number	203-679-8220	
Contact Person Fax Number	203-679-8282	
Contact Person e-mail Address	gdee@cox.net	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: _Replacement of current CAT scanner_____

b. Project Proposal: _Replace current 4 slice CAT scanner with 16 slice scanner_____

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☒ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☐ Yes ☒ No

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

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service
☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

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

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

863 North Main Street Extention – Wallingford, CT 06492

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

_Wallingford, Meriden, Cheshire, North Haven_____

h. Estimated starting date for the project: ___March 1, 2009_____

i. If the proposal includes change in the number of beds provide the following information: NO

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 395,000.00

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

Major Medical Equipment Purchases*	375,000.00
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	20,000.00
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	395,000.00
Major Medical Equipment – Fair Market Value of Leases 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	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
CAT Scan	SOMATOM Emotion 2007		1	375,000.00

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

e. 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

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: Radiology Associates

Project Title: Replacent of CAT Scan

I, Gary J. Dee MD (Name), President (Position – CEO or CFO)

of Radiology Associates INC being duly s worn, 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 Radiology Associates (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.

Gary Dee MD
Signature

12/17/08
Date

Subscribed and sworn to before me on December 17, 2008

Sandra L Frederick
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 2/28/2010

RADIOLOGY ASSOCIATES, INC.

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Wallingford, CT 06492
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December 17, 2008

Kimberly Martone
Certificate of Need Supervisor
State of Connecticut
Office of Health Care
410 Capitol Avenue MS#13HCA
Hartford, CT 06134-0308

Dear Kimberly,

Radiology Associates, Inc. is an existing provider of imaging services that currently operates at 97 Barnes Road, Wallingford, Connecticut. As of May 1, 2009, this office will be relocated to 890 North Colony Road, Wallingford, Connecticut. This was approved under CON determination 08-31152. Radiology Associates, Inc. is proposing to acquire a Siemens SOMATOM Emotion 2007 Configuration for at a total capital expenditure of $375,000.00 to replace the existing 4-slice C.T. scanner.

Radiology Associates, Inc. has provided CAT scanning service since 1987 to the communities of Meriden, Wallingford, Cheshire and North Haven. The existing leased unit is approximately 4-1/2 years old and performs approximately 4,500 scans per year. Radiology Associates, Inc. requests approval to acquire a Siemens 16-slice C.T. Scanner to improve image quality, reduce dosage and provide new services to our current patient population. New procedures such as C.T. colonography, C.T. pulmonary angiography and 3D imaging will be provided to our patients. Radiology Associates, Inc. will operate this scanner at the opening of our new office. This will preclude the movement of an old scanner at a cost of over $30,000 and reduce the time frame when the community will not have a scanner from 60 days down to 0 days.

Radiology Associates, Inc. feels that this upgrade will improve care to our current population without increasing cost of care in the State of Connecticut.

I hope this explains the project. If you have any questions, you may contact me at your earliest available time at (203) 694-8405.

Thank you.

Sincerely,

Gary J. Dee, M.D., President
Radiology Associates, Inc.

D: 12/17/08 T: 12/17/08

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 31, 2008

Gary Dee, M.D.
President
Radiology Associates
101 North Plains Industrial Road
Wallingford, CT 06492

Re: Letter of Intent, Docket Number 08-31292
Radiology Associates
Acquisition of a 16-Slice CT Scanner to Replace 4-Slice CT Scanner
Notice of Letter of Intent

Dear Mr. Dee:

On December 23, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Radiology Associates ("Applicant") for the acquisition of a 16-slice CT Scanner to replace 4-slice CT Scanner in Wallingford, with a capital expenditure of $395,000.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Record Journal* 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 R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 31, 2008

Requisition # HCA09-065
Fax (203) 317-2233

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

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, January 4, 2009.**

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

Record Journal
Docket Number 08-31292

Letter of Intent
December 31, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Radiology Associates
Town:	Wallingford
Docket Number:	08-31292-LOI
Proposal:	Acquisition of a 16-slice CT Scanner to replace 4-slice CT Scanner
Capital Expenditure:	$395,000

The Applicant may file its Certificate of Need application between February 21, 2009 and April 22, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

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

TRANSMISSION OK

TX/RX NO	4576
RECIPIENT ADDRESS	912033172233
DESTINATION ID	
ST. TIME	12/31 11:08
TIME USE	00'55
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 31, 2008

Requisition # HCA09-065
Fax (203) 317-2233

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

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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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 5, 2009

Gary Dee, M.D.
President
Radiology Associates
101 North Plains Industrial Road
Wallingford, CT 06492

Re: Letter of Intent, Docket Number 08-31292
Radiology Associates
Acquisition of a 16-Slice CT Scanner to Replace 4-Slice CT Scanner
Application Forms

Dear Dr. Dee:

Enclosed are the application forms for the acquisition by Radiology Associates ("Applicant") of a 16-slice CT Scanner to replace a 4-slice CT Scanner in Wallingford, with a capital expenditure of $395,000. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes the CON application may be filed between February 21, 2009, and April 22, 2009.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The OHCA analyst assigned to the CON application is Alexis 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, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than February 21, 2009 and may be submitted no later than April 22, 2009. The OHCA analyst assigned to your application is Alexis Fedorjaczenko. She may be reached at the Office of Health Care Access at (860) 418-7067.

Docket Number:	08-31292-CON
Applicant Name:	Meriden Imaging Center, Inc. d/b/a Radiology Associates
Contact Person:	Gary Dee, MD
Contact Title:	President
Contact Address:	101 No Plains Industrial Road Wallingford, CT 06492
Project Location:	Wallingford
Project Name:	Acquisition of a 16-Slice CT Scanner in Wallingford to Replace a 4-slice CT Scanner
Type of proposal:	Sections 19a-639, C.G.S.
Est. Capital Expenditure:	$395,000

1. **Imaging Service Consideration**

   What imaging services are currently offered at the facility that the proposal will augment or replace? Please list.

   Augment:

   Replace:

2. **State Health Plan**

   No questions at this time.

3. **Applicants' Long Range Plan**

   Is this application consistent with each Applicant's long-range plan?

   ☐ Yes ☐ No (If "No" is checked, please provide an explanation.)

4. **Clear Public Need**

   a. Explain how Radiology Associates determined there was a need for this proposal. Include the following:
      i. Explain how Radiology Associates determined there was a need for the existing 4-slice CT scanner.
      ii. Explain how Radiology Associates determined there was a need for the proposed 16-slice CT scanner.
      iii. Provide a copy of any needs assessment or need report produced in relationship to the proposal. If neither document was prepared, explain why this is the case.
      iv. Provide a copy of other studies or reports that support the acquisition of the acquisition of the proposed scanner.

   b. Provide the following information:
      i. The service's primary and secondary service area towns.
      ii. The rationale for choosing the proposed primary and secondary service area towns.
      iii. The population to be served, including the number of individuals to receive the proposed service. Include demographic information, as appropriate.
      iv. Hours of operation of the existing and proposed service.

   c. Provide the following information regarding the Applicant's existing CT scanners.
      i. Manufacturer;
      ii. Model;
      iii. Number of slices;
      iv. Age of the scanner;
      v. Date of installation;
      vi. General condition of the scanner;

vii. Add-ons or attachments to the base model CT scanner for specified imaging functions;
viii. Cost of acquiring the CT scanner;
ix. Anticipated date of replacement of the scanner;
x. Location and address of each scanner;
xi. OHCA approval date, and
xii. Total number of CT scanners.

d. Complete the following table to include actual scans per fiscal year ("FY"), scans per current fiscal year ("CFY") and projected scans per FY for the Applicants' existing and proposed CT. **Include all assumptions used in the derivation/calculation of your projections.**

Number of Procedures	**Actual Exam Volume (Last 3 *Completed* FYs)**			**CFY Volume***	**Projected Exam Volume (First 3 *Full* Operational FYs)****		
	FY_____	FY_____	FY_____	FY_____	FY_____	FY_____	FY_____
List each scanner on a separate line							
TOTAL							

Notes: *Please report the annualized number of CT scans, identifying the respective number of months of recorded activity in your response.
**If the first year of operation of the proposed CT scanner is only a partial year, the Applicant must provide the first partial year and then the first three full FYs.

e. Provide a table that segregates the number of scans by the town of origin for the last completed fiscal year.

f. Provide the capacity for the existing and the proposed MRI scanner in the table format provided below:

	Existing 4-Slice CT	**Proposed 16-Slice CT**
Number of CT Scanners		
Average # Hours/Week Scanner Operates		
Weeks/Year Operational**		
Targeted Utilization as % of Capacity		
Annual Total Capacity for Scans in Hours		
Average Scan Time in Hours		
Annual Capacity - # CT Scans/Scanner		
Actual & Projected/Actual # CT scans		
% Total CT Capacity	____%	____%

Note: Please include all related assumptions.

g. Complete the following information regarding existing providers.

i. Current operating information as outlined in the following table concerning other existing providers of CT services in the Applicant's primary service area.

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

Notes: 1 Provide a description of the equipment used by the provider, if know.
2 Specify days of the week and start and end time for each day.
3 Provide the number of procedures performed by Provider for the most recent 12 month period, if known.

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

h. Will the 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.

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

☐ Other: Specify _____

B. Describe how the Applicants plan to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Applicants' managing partners and physicians related to the proposal and a copy of their Curriculum Vitae.

Note: Please provide a list of hospitals that are served by the radiologists.

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

☐ 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]

E. Provide a copy of the related Quality Assurance plan

6. **Improvements to Productivity and Containment of Costs**

In the past year has the imaging center 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 the teaching or research responsibilities of the Applicants?

☐ Yes ☐ No

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

---

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

B. Are there any characteristics of the center's patient/physician mix that makes the proposal unique?

☐ Yes ☐ No

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

C. Provide the following licensing information:

i. If the imaging center is currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii. If not applicable, please explain why.

8. **Financial Information**

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

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

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

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

C. Provide the following financial information:

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

ii) Identify the entity that has been and 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/Renovation Information

A. Provide a description of the proposed building work, including the related gross square feet of new construction and/or renovation.

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

C. Provide an itemization of the proposed building costs as follows:

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 Cost			

D. Explain how the proposed building work will affect the delivery of patient care.

E. Provide the following information regarding the building work schedule:

Commencement Date	
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 the following information, 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. Description of the ownership interests in the LLC and in the PC.
v. Organizational chart of the LLC and PC.
vi. Lease agreement between the LLC and PC.

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 imaging center 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. Please complete Financial Attachment I. Note: *that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

ii) Please provide three years of projection of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. Please complete Financial Attachment II included in the forms package**.

iii) List 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.). Please 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 that result from the implementation and operation of the CON proposal.

v) Provide a copy of the rate schedule for the CT service with the new scanner.

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: _____	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 – 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, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____	$_____.00
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE:_____	$_____.00

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

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

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
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

*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.

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

Record-Journal

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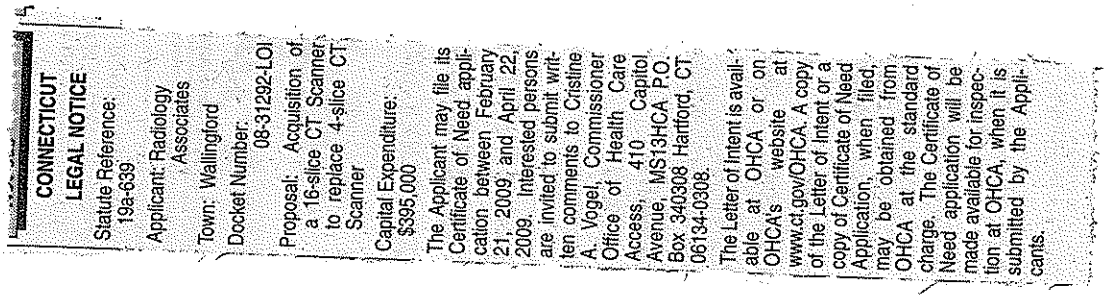
AFFIDAVIT OF PUBLICATION

THIS IS TO CERTIFY that the attached clipping is a true copy of a notice published in the RECORD-JOURNAL **JANUARY 3, 2009.**



CONNECTICUT
LEGAL NOTICE
Statute Reference: 19a-639
Applicant: Radiology Associates
Town: Wallingford
Docket Number: 08-31292-LOI
Proposal: Acquisition of a 16-slice CT Scanner to replace 4-slice CT Scanner
Capital Expenditure: $395,000
The Applicant may file its Certificate of Need application between February 21, 2009 and April 22, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

The Record-Journal Publishing Company

State of Connecticut

} SS. Meriden

Pam Adamski

Pam Adamski, Office Manager

County of New Haven r

The foregoing affidavit was signed and sworn
before me this 5 day
of JANUARY 2009.

Angela Grabiec

Angela Grabiec
Notary Public
My Commission Expires June 30, 2013