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

April 3, 2009
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

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

RECEIVED
2009 APR -3 P 2:21
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Re: Neurology Associates, LLC

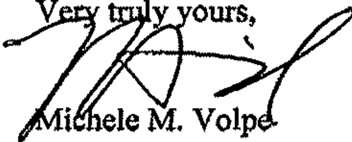
Dear Commissioner Vogel:

Enclosed please find an original and six (6) copies of a Letter of Intent / Form 2030 regarding Neurology Associates, LLC's proposal to expand the Practice's use of its existing 1.5 Tesla MRI scanner to benefit all patients.

Please do not hesitate to contact me if you have any questions or require additional information.

Thank you.

Very truly yours,



Michele M. Volpe

MMV/bt
Enclosure

F:\Doc\05 3251-3295\053263 Neurology Associates, LLC re CON Matter\CON 2009\Letters\OHCA (Letter of Intent) 4.03.09.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 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	Neurology Associates, LLC	
Doing Business As	N/A	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	One Towne Park Plaza Norwich, CT 06360	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	No	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	David J. Shiling, M.D. Member	Michele M. Volpe Attorney for Applicant
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Neurology Associates, LLC One Towne Park Plaza Norwich, CT 06360	105 Court Street Suite 304 New Haven, CT 06511
Contact Person Telephone Number	Phone: (860) 886-1433	(203) 777-5800
Contact Person Fax Number	Fax: (860) 886-4644	(203) 777-5806
Contact Person e-mail Address	dshiling@aol.com	Michelemvolpe@aol.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Expansion of Use of Existing 1.5 Tesla MRI Scanner

b. Project Proposal: To expand the Practice's use of its existing 1.5 Tesla MRI scanner to benefit all patients.

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:

One Towne Park Plaza, Norwich, Connecticut 06360

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

Norwich, Plainfield, Sprague, Lisbon, Canterbury, Preston, Ledyard, Salem, Oakdale, Montville and Colchester (the "Service Area")

h. Estimated starting date for the project: Upon OHCA approval.

i. If the proposal includes change in the number of beds provide the following information:

Not Applicable

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: $ -0-

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

Not Applicable

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:________	
Total Capital Expenditure	
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.

Not Applicable

☐ 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 **Not Applicable**

   ☐ 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). **Not Applicable**

d. Major Medical and/or Imaging Equipment Acquisition: **Not Applicable**

Equipment Type	Name	Model	Number of Units	Cost per unit

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): **Not Applicable**

- ☐ 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. **Please see attached.**

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.

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

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

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

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

8. Who will be responsible for providing the service?

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

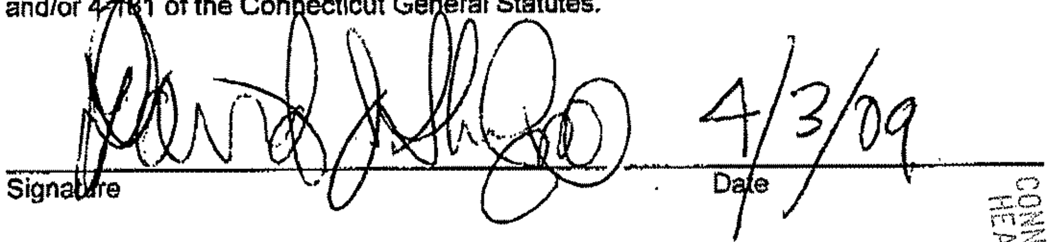
AFFIDAVIT

To be completed by each Applicant

Applicant: Neurology Associates, LLC

Project Title: Expansion of Use of Existing 1.5 Tesla MRI Scanner

I, David J. Shiling, M.D., Member of Neurology Associates, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent is true and accurate to the best of my knowledge, and that Neurology Associates, LLC 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

RECEIVED 2009 APR -3 P 2:21 CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on April 3, 2009

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2009

Section IV: Project Description

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.**

Neurology Associates (the "Practice") is a private physician practice specializing in neurology and radiology. The Practice is comprised of five (5) full-time neurologists and one on-site radiologist. The Practice has utilized radiology services since its inception in 1981. The radiologist maintains his own patient base that is not limited to patients with neurological conditions. The Practice has implemented and is in compliance with OHCA's Final Order in Docket Number 06-30674-CON (the "Order"), which authorized the Practice to acquire a replacement 1.5 Tesla high-field MRI scanner (the "Scanner") at its office in Norwich, Connecticut.

Since becoming operational on April 4, 2007, the Scanner has provided the Practice with the ability to offer superior MRI scanning capabilities compared to other providers of MRI services in the community. The Practice has the capability to perform more advanced scanning sequences. The Scanner provides patients access to additional types of scans, such as diffusion imaging, perfusion imaging and spectroscopy. In fact, OHCA found that the Practice's acquisition of the Scanner will improve both the accessibility and quality of MRI services for the patients of the Practice. (See the Order p. 9). In accordance with the Order, the Practice has limited its use of this high quality MRI Scanner only for its patients with neurological conditions.

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

No DPH licensure categories are required. Because the Practice already provides MRI services to patients, it does not seek to provide any new function or service with this proposal. Instead, the Practice is simply seeking OHCA approval to utilize its existing Scanner for the benefit of all patients requiring MRI services.

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

In accordance with the Order, the Practice is currently providing MRI services with the Scanner to its patients specifically for the diagnosis of neurological conditions. Upon OHCA approval, the population to be served will include all patients requiring MRI services regardless of their condition.

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

A need exists in the Service Area to justify approval of this request to expand the Practice's use of the Scanner for the benefit of all patients. This need is evidenced by the fact that the William W. Backus Hospital ("Backus") is presently seeking to acquire a new 1.2 open MRI unit. The Practice's radiologist maintains a patient base which encompasses patients with a myriad of conditions and which is not specific to patients with neurological conditions. However, in accordance with the Order, the Practice has been compelled to turn away patients without a neurological condition and deny them the same high-quality MRI services it is permitted to provide to the Practice's patients who present with a neurological condition.

The Practice currently maintains capacity on the Scanner. As such, the Practice can absorb and satisfy any "new" need in the Service Area upon OHCA's approval of use of the Scanner for all conditions. Any need can be satisfied without any capital expenditure. All stakeholders, including patients and payers, will be afforded the benefit of increased access to the highest quality MRI services available in the community without any additional associated cost to them. Approval of this proposal

will also prove to accommodate this need in the timeliest manner, as no equipment will have to be acquired or updated and it will allow the area's non-profit hospital to retain its valuable resources for other needed projects.

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

Backus Hospital is the only other provider in the Service Area. Backus Hospital presently operates a fixed site 1.5 Tesla Avanto MRI unit and a mobile 1.5 Tesla Avanto MRI unit.

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

Approval of this proposal will serve to benefit all patients in the Service Area by increasing their access to the highest quality MRI services without any associated cost to patients, providers, payers or other healthcare stakeholders.

7. Who will be responsible for providing the service?

The Practice will be responsible for providing the MRI services with the Scanner. All tests will be performed on-site and interpreted by American Registry of Radiologic Technologists (ARRT) and Connecticut state licensed technologists and a board certified Connecticut state licensed radiologist, who is capable of reading the full spectrum of scans. In addition, the Practice has complete radiology coverage from a large multidisciplinary radiology practice.

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

The current payers of the MRI services provided by the Practice include all government and private third party payers in the county. There are no anticipated payer changes upon this proposal becoming operational.

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

April 3, 2009
Via Facsimile (860) 418-7053
and USPS 1st Class Mail

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

RECEIVED
2009 APR -8 P 12: 10
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Re: Neurology Associates, LLC

Dear Commissioner Vogel:

Enclosed please find an original and six (6) copies of a Letter of Intent / Form 2030 regarding Neurology Associates, LLC's proposal to expand the Practice's use of its existing 1.5 Tesla MRI scanner to benefit all patients.

Please do not hesitate to contact me if you have any questions or require additional information.

Thank you.

Very truly yours,

Michele M. Volpe

MMV/bt
Enclosure

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by 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	Neurology Associates, LLC	
Doing Business As	N/A	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	One Towne Park Plaza Norwich, CT 06360	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	No	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	David J. Shiling, M.D. Member	Michele M. Volpe Attorney for Applicant
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Neurology Associates, LLC One Towne Park Plaza Norwich, CT 06360	105 Court Street Suite 304 New Haven, CT 06511
Contact Person Telephone Number	Phone: (860) 886-1433	(203) 777-5800
Contact Person Fax Number	Fax: (860) 886-4644	(203) 777-5806
Contact Person e-mail Address	dshiling@aol.com	Michelemvolpe@aol.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Expansion of Use of Existing 1.5 Tesla MRI Scanner

b. Project Proposal: To expand the Practice's use of its existing 1.5 Tesla MRI scanner to benefit all patients.

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:

One Towne Park Plaza, Norwich, Connecticut 06360

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

Norwich, Plainfield, Sprague, Lisbon, Canterbury, Preston, Ledyard, Salem, Oakdale, Montville and Colchester (the "Service Area")

h. Estimated starting date for the project: Upon OHCA approval.

i. If the proposal includes change in the number of beds provide the following information:

Not Applicable

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: $ **-0-**

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

Not Applicable

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:________	
Total Capital Expenditure	
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.

Not Applicable

☐ 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 **Not Applicable**

   ☐ 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). **Not Applicable**

d. Major Medical and/or Imaging Equipment Acquisition: **Not Applicable**

Equipment Type	Name	Model	Number of Units	Cost per unit

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): **Not Applicable**

- ☐ 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. **Please see attached.**

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.
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3.
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AFFIDAVIT

To be completed by each Applicant

Applicant: Neurology Associates, LLC

Project Title: Expansion of Use of Existing 1.5 Tesla MRI Scanner

I, David J. Shiling, M.D., Member of Neurology Associates, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent is true and accurate to the best of my knowledge, and that Neurology Associates, LLC 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: [signature] Date: 4/3/09

Subscribed and sworn to before me on April 3, 2009

[signature]
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2009

RECEIVED
2009 APR -8 P 12:10
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Section IV: Project Description

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