SHIPMAN & GOODWIN LLP.
COUNSELORS AT LAW

RECEIVED
2009 JUL 21 P 3:21
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 21, 2009

HAND DELIVERY

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

Re: Letter of Intent for Change of Ownership of Southeastern Connecticut Imaging Center, LLC.

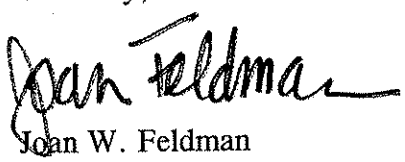
Dear Commissioner Vogel:

On September 22, 2006, the State of Connecticut Office of Health Care Access granted a Certificate of Need to L & M Systems, Inc. ("LMS") and Ocean Radiology Associates, P.C. ("ORA") to establish and operate a freestanding imaging center in Waterford, Connecticut to be known as Southeastern Connecticut Imaging Center, LLC ("SCIC"). See Docket Number 05-30661-CON.

We are writing on behalf of the applicants in the above referenced matter to submit the enclosed Letter of Intent in connection with a request to change the ownership of SCIC to permit LMS to become the owner of 100% of SCIC with a subsequent transfer of assets and liabilities to Lawrence & Memorial Hospital, Inc. (the "Hospital"). To accomplish this transfer, LMS plans to first purchase all of ORA's interest in SCIC for $275,000 (the "Purchase"). Immediately following the Purchase, LMS will dissolve SCIC and transfer its business and operating assets to the Hospital who shall then own, control and operate the imaging center as an outpatient department of the Hospital. Please note that Lawrence & Memorial Corporation is the parent of both LMS and the Hospital. There will be no change in the services provided, equipment used, or location of the imaging center. While there will be two consecutive transactions, we hope that not more than one approval process for this purpose will be necessary.

Thank you in advance for your assistance and prompt attention to this matter. If you have any further questions about the matter, please do not hesitate to contact me.

Sincerely,



Joan W. Feldman

Enc.

Cc: Maureen Anderson, Esq.
H. Kennedy Hudner, Esq.
Thomas J. Manning, M.D.
Ms. Crista Durand

1157658v3

SHIPMAN & GOODWIN LLP
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 21, 2009

VIA FIRST CLASS MAIL
The Honorable Cristine Vogel
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: CHANGE OF OWNERSHIP OF SOUTHEASTERN CONNECTICUT IMAGING CENTER, LLC

Dear Commissioner Vogel:

Enclosed please find the Notice of Appearance form regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Enclosure

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER RE: CHANGE OF OWNERSHIP OF SOUTHEASTERN CONNECTICUT IMAGING CENTER, LLC	: : : :	July 21, 2009

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of LRM Systems, Inc. in the proceeding captioned above.

Respectfully Submitted,

LRM Systems, Inc.

By: _____

Joan W. Feldman
jfeldman@goodwin.com
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5311
Its Attorney

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	L & M Systems, Inc.	Ocean Radiology Associates, P.C.
Doing Business As		
Name of Parent Corporation	Lawrence & Memorial Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	L&M Systems, Inc. c/o Lawrence & Memorial Hospital 365 Montauk Avenue New London, CT 06320	Ocean Radiology Associates, P.C. 365 Montauk Ave New London, CT 06320
Identify Applicant Status: P for Profit or NP for Nonprofit	P	P
Does the Applicant have Tax Exempt Status?	No	No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Crista Durand Vice President, Planning Lawrence & Memorial Hospital	Thomas J. Manning, M.D. President, Ocean Radiology Associates, P.C.
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Crista Durand 365 Montauk Avenue New London, CT 06320	Thomas J. Manning, M.D. 365 Montauk Avenue New London, CT 06320
Contact Person Telephone Number	(860) 442-0711 Ext. 2073	(860) 444-5151
Contact Person Fax Number	(860) 444-3716	
Contact Person e-mail Address	cdurand@lmhosp.org	tmanning@lmhosp.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Change of Ownership of Southeastern Connecticut Imaging Center, LLC ("SCIC")

b. Project Proposal: Change of Ownership in SCIC through liquidation of SCIC and transfer of 100% of SCIC's assets to Lawrence & Memorial Hospital

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
X 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 X 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 X 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:

Crossroads Professional Building, 196 Waterford Parkway South, Waterford, Connecticut 06385

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

The Primary and Secondary Service Areas are: East Lyme, Ledyard, Montville, North Stonington, Stonington, Norwich, Griswold, Preston, Colchester, Voluntown, Groton, Lyme, New London, Old Lyme, Waterford, Salem, Lisbon, Old Saybrook, Bozrah, and Franklin.

h. Estimated starting date for the project: Change of Ownership will occur immediately upon approval.

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

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: $ $275,000*

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

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	$275,000*
Capitalized Financing Costs (Informational Purpose Only)	

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

*L & M Systems, Inc. ("LMS") plans to purchase all of Ocean Radiology Associates, P.C.'s ("ORA's") interest in SCIC for $275,000, which is the value of ORA's capital account as of 12/31/2008. In addition, LMS engaged an independent consultant for a valuation analysis to confirm that the purchase price represents fair market value.

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: N/A

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):

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

*LMS will purchase ORA's 50% interest in SCIC.

SECTION IV. PROJECT DESCRIPTION Please see Attachment # IV.

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: L & M Systems, Inc.

Project Title: Change of Ownership of Southeastern Connecticut Imaging Center, LLC.

I, Bruce D. Cummings, President/CEO of L & M Systems, Inc. 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 L & M Systems, Inc. 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 7/17/09

Subscribed and sworn to before me on 7/19/09

Jacqueline E. Cooper
Notary Public/Commissioner of Superior Court

My commission expires: 6/30/13

JACQUELINE E. COOPER
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2013

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2009 JUL 21 P 3:22
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

AFFIDAVIT

To be completed by each Applicant

Applicant: Ocean Radiology Associates, P.C.

Project Title: Change of Ownership of Southeastern Connecticut Imaging Center, LLC.

I, Thomas J. Manning, President of Ocean Radiology Associates, 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 Ocean Radiology Associates, 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.

Thomas J. Manning — July 17, 2009
Signature — Date

Subscribed and sworn to before me on July 17, 2009

Margaret L. Inakas
Notary Public/~~Commissioner of Superior Court~~

My commission expires: Nov. 30, 2010

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2009 JUL 21 P 3:22
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

Attachment # IV Project Description

On September 22, 2006, the State of Connecticut Office of Health Care Access granted a Certificate of Need to L & M Systems, Inc. ("LMS") and Ocean Radiology Associates, P.C. ("ORA") to establish and operate a freestanding imaging center in Waterford, Connecticut to be known as Southeastern Connecticut Imaging Center, LLC ("SCIC" or "Imaging Center") and acquire a 16-slice CT Scanner at a total capital cost of $1,958,701. See Docket Number 05-30661-CON. LMS is a for-profit and wholly owned subsidiary of Lawrence & Memorial Corporation, which is also the parent corporation of Lawrence & Memorial Hospital (the "Hospital"). ORA is a professional corporation that provides radiology services to the Hospital and its various satellite imaging locations.

The Applicants believe that the Imaging Center can be more cost-effectively managed by having the Hospital provide the Imaging Services as an integrated service of the Hospital's existing radiology service lines. ORA is no longer interested in maintaining an ownership interest in the Imaging Center. Nevertheless, ORA remains fully committed to continuing to provide the professional radiology services for the Imaging Center.

The proposed transactions contemplate a change in the ownership of SCIC with the ultimate transfer of SCIC's assets to the Hospital. To accomplish this transfer, LMS plans to first purchase all of ORA's interest in SCIC for $275,000 so that LMS owns 100% of SCIC (the "Purchase Agreement"). Second and immediately following the execution of the Purchase Agreement, LMS will dissolve SCIC and transfer its business and operating assets to the Hospital. Upon the completion of the transfer, the Hospital will own, control and operate the Imaging Center as an integrated outpatient department of the Hospital.

Currently, SCIC provides CT Scanning, Diagnostic Radiography, Ultrasound, Mammography, and Bone Densitometry services (the "Imaging Services") for the following primary and secondary service areas: East Lyme, Ledyard, Montville, North Stonington, Stonington, Norwich, Griswold, Preston, Colchester, Voluntown, Groton, Lyme, New London, Old Lyme, Waterford, Salem, Lisbon, Old Saybrook, Bozrah, and Franklin. The current payers of this service include Medicare, Medicaid, TRICARE, commercial and self pay.

The Hospital is a full service general acute care hospital licensed for 280 beds and 31 bassinets with a main campus located at 365 Montauk Avenue, New London, Connecticut. Once the transfer is complete, the Hospital will provide, be responsible for, and bill for the Imaging Services as an outpatient department service of the Hospital. There will be no change in the services provided, equipment, location of the Imaging Center, payer mix, service areas, or target population as a result of this proposal.

In conclusion, there is no anticipated effect on the health care delivery system in the state of Connecticut as a result of this proposal.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 29, 2009

Crista Durand
Vice President, Planning
L&M Systems, Inc.
c/o Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Thomas J. Manning, M.D.
President
Ocean Radiology Associates, P.C.
c/o Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Re: Letter of Intent, Docket Number 09-31413
Change of Ownership of Southeastern CT Imaging Center, LLC
Notice of Letter of Intent

Dear Ms. Durand & Dr. Manning,

On July 21, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of L&M Systems, Inc. and Ocean Radiology Associates, P.C. ("Applicants") for the change of ownership of Southeastern CT Imaging Center, LLC in Waterford, with a total capital expenditure of $275,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Day Publishing Company* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 29, 2009

Requisition # HCA010-005
Email: Legal@Theday.com

The Day
47 Eugene O'Neil Drive
Box 1231
New London, CT 06360

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, August 2, 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 Steven Lazarus or Ronald Ciesones at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:RC;lmg

c: Marie Dempsey, OHCA

The Day
Docket Number 09-31413

Letter of Intent
July 29, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	L&M Systems Inc. and Ocean Radiology Associates, P.C.
Town:	Waterford
Docket Number:	09-31413-LOI
Proposal:	Change of ownership of Southeastern CT Imaging Center, LLC
Capital Expenditure:	$275,000

The Applicant may file its Certificate of Need application between September 19, 2009 and November 18, 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.

Greer, Leslie

Sent: Wednesday, July 29, 2009 4:38 PM

----IMA6b4b31e.4a70/pop.state.ct.us
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.
Unless the delivery fails, this will be the only delivery notification.

----IMA6b4b31e.4a70/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;Legal@theday.com
Action: relayed
Status: 2.0.0

----IMA6b4b31e.4a70/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-10.02) id A31D021C; Wed, 29 Jul 2009 16:37:49 -0400
Received: from 159.247.77.54 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Wed, 29 Jul 2009 16:45:51 -0400
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
X-MimeOLE: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Subject: Legal Ad 09-31413
Date: Wed, 29 Jul 2009 16:33:50 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD8B0@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach:
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31413
Thread-Index: AcoQi+HdYS7QunX0Seu2gJ5ysY0J2A==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: Legal@theday.com
cc: "Olejarz, Barbara" <Barbara.Olejarz@po.state.ct.us>
X-WSS-ID: 666E6B7525S4066448-02-01
Content-Type: multipart/alternative;
boundary="----_=_NextPart_001_01CA108B.E1D787E8"

----IMA6b4b31e.4a70/pop.state.ct.us--

Greer, Leslie

From: Foley, Melanie [M.Foley@theday.com]
Sent: Monday, August 03, 2009 10:41 AM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31413
Attachments: L-8289.doc

Hi Leslie,

Here is the proof/quote for the legal notice to run tomorrow, 8/4.
I apologize for not having it in yesterday for you.

Have a nice day, Melanie

Melanie Foley
Legal, Obituary & Milestone
Advertising Representative
The Day & The Times Community News Group
Phone (860) 701-4219 Fax (860) 442-5443
www.theday.com

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Monday, August 03, 2009 10:22 AM
To: Foley, Melanie
Subject: FW: Legal Ad 09-31413

Melanie,
Per our conversation attached is the legal ad to be published.

Thank you,

Leslie Greer
Office of Healthcare Access
(860) 418-7001

From: Foley, Melanie [mailto:M.Foley@theday.com]
Sent: Thursday, July 30, 2009 10:11 AM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31413

Hi Leslie,

There was no attachment, thanks! ☺

Melanie Foley
Legal, Obituary & Milestone
Advertising Representative
The Day & The Times Community News Group
Phone (860) 701-4219 Fax (860) 442-5443
www.theday.com

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Wednesday, July 29, 2009 4:34 PM
To: Legal
Cc: Olejarz, Barbara
Subject: Legal Ad 09-31413

Legal Ad,
Please run the attached public notice in your newspaper by August 2, 2009. Please notify me by email when this has been completed, if you have any questions or problems please contact Barbara Olejarz @ (860) 418-7001 or by email Barbara.Olejarz@ct.gov

Thank you,

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca

The Day

Receipt

Account Number: D1640
Order Number: d00207233

Salesperson: Melanie Foley | **Printed on:** 8/3/2009
Telephone: 860-701-4219 ext 4219 | **Fax:** (860) 442-5443

CT OFFICE OF HEALTH CARE
ACCESS MS#13HCA
PO BOX 340308
HARTFORD, CT 06134
860-418-7001

Title: The Day | **Class:** Public Notices 010
Start date: 8/4/2009 | **Stop date:** 8/4/2009 |
Insertions: 1 | **Lines:** 0 ag

Title: Day Website | **Class:** Public Notices 010
Start date: 8/4/2009 | **Stop date:** 8/4/2009 |
Insertions: 1 | **Lines:** 0 ag

Your Ad will appear below between the two solid lines.

8289

LEGAL NOTICE

Statute Reference: 19a-638
Applicants: L&M Systems Inc. and Ocean Radiology Associates, P.C.
Town: Waterford
Docket Number: 09-31413-LOI
Proposal: Change of ownership of Southeastern CT Imaging Center, LLC
Capital Expenditure: $275,000

The Applicant may file its Certificate of Need application between September 19, 2009 and November 18, 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.

Payment Information

Total Order Price: $165.30
Payment Type: Invoice Payments | **Exp:**

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 6, 2009

via fax and email only

Crista Durand
Vice President, Planning
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Thomas J. Manning, M.D.
President
Ocean Radiology Associates, P.C.
365 Montauk Avenue
New London, CT 06320

RE: Certificate of Need Application Forms, Docket Number 09-31413-CON
L&M Systems, Inc. and Ocean Radiology Associates, P.C.
Change of Ownership of Southeastern Connecticut Imaging Center, LLC

Dear Ms. Durand and Mr. Manning:

Enclosed are the application forms for L&M Systems and Ocean Radiology Associates, P.C. Certificate of Need ("CON") proposal for the Change of Ownership of Southeastern Connecticut Imaging Center, LLC with an associated capital expenditure of $275,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between September 19, 2009, and November 18, 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 analysts assigned to the CON application are Ronald Ciesones and Steven Lazarus. Please contact them at (860) 418-7001 if you have questions.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than September 19, 2009, and may be submitted no later than November 18, 2009. The Analysts assigned to your application are Ronald Ciesones and Steven Lazarus and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31413-CON

Applicants Name:	L&M Systems	Ocean Radiology Associates, P.C.
Contact Person:	Crista Durand	Thomas J. Manning, M.D.
Contact Title:	Vice President, Planning	President
Contact Address:	365 Montauk Avenue New London, CT 06320	365 Montauk Avenue New London, CT 06320

Project Location: Waterford

Project Name: Change of Ownership of Southeastern Connecticut Imaging Center, LLC

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $ 275,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.

e. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.

f. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

g. List all existing providers (name, address, services provided) of the services involved in this proposal in the towns served by the facility changing ownership or control, and in nearby towns.

h. Describe the effect of this proposal on existing providers.

i. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:

   i. Legal chart of corporate or entity structure including all affiliates.
   ii. List of owners and the % ownership and shares of each.

j. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

2. Actual and Projected Volume

a. Provide volumes for the most recently completed FY by town.

b. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for the facility/services changing ownership or control.

Table 1: Historical, Current, and Projected Volume

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Service***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service separately and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

3. Quality Measures

a. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i) If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii) If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

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 (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Patient Population Projections

a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 3: Patient Population Mix

	Current FY **	Year 1 FY **	Year 2 FY **	Year 3 FY **
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **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.) The projections must include the first three full fiscal years of the project.

c. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

d. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

e. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

f. Identify the entity that will be billing for the proposed service(s).

g. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

h. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

i. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

j. Describe how this proposal is cost effective.

7. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

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: _____

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: _____

L&M Systems, Inc.

12. C (i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: 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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$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.

Ocean Radiology Associates, P.C.

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

L&M Systems, Inc.										
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

Ocean Radiology Associates, P.C.										
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

****
*** TX REPORT ***
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FROM: RONALD CIESONES

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Comments: Docket 09-31413 CON Application

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