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Susan L. Davis, R.N., Ed.D.  
President and Chief Executive Officer  
(203) 576-5454  
sdavis@stvincents.org

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CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

March 26, 2010

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

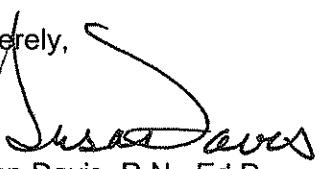
Re: St. Vincent's Medical Center  
Fairfield County Imaging, LLC  
Letter of Intent for Change of Ownership of Two Imaging Centers

Dear Commissioner Vogel:

On behalf of St. Vincent's Medical Center and Fairfield County Imaging, LLC ("FCI"), I am pleased to submit the Letter of Intent for a change in ownership of FCI's imaging centers in Bridgeport and Trumbull. The proposed change of ownership is part of an overall asset transfer agreement.

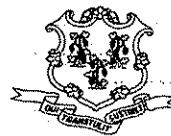
I look forward to working with you and your staff on this important project.

Sincerely,

  
Susan Davis, R.N., Ed.D.

President and Chief Executive Officer

Enclosures



**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	St. Vincent's Medical Center	Fairfield County Imaging, LLC
Doing Business As	N/A	N/A
Name of Parent Corporation	St. Vincent's Health Services Corporation	N/A
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2800 Main Street Bridgeport, CT 06606	Suite A -100 115 Technology Drive Trumbull, CT 06611
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	P
Does the Applicant have Tax Exempt Status?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Patricia Weitzman Attorney	John Del Negro Attorney
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Levett Rockwood P.C. 33 Riverside Avenue Westport, CT 06880	105 Court Street Suite 304 New Haven, CT 06511
Contact Person Telephone Number	(203) 222-0885	(203) 859-6228
Contact Person Fax Number	(203) 226-8025	(203) 777-5806

Contact Person e-mail Address	Applicant One	Applicant Two
	pweitzman@levettrockwo od.com	johndelnegro@gmail.com

## SECTION II. GENERAL APPLICATION INFORMATION

- Project Title: Change of ownership of two imaging centers from Fairfield County Imaging, LLC to St. Vincent's Medical Center.
- Project Proposal: St. Vincent's Medical Center and Fairfield County Imaging, LLC are requesting CON approval for the change of ownership of Fairfield County Imaging, LLC's two imaging centers to St. Vincent's Medical Center. This change of ownership is part of an overall Asset Transfer Agreement and change in radiology service provider at St. Vincent's.
- 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 Center

### 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:  
Specific street addresses for these locations are provided below.

**Bridgeport Location:**

3101 Main Street  
2<sup>nd</sup> Floor  
Bridgeport, CT 06606

CT scanner (CON Determination Report Number: 05-30438-DTR)

**Trumbull Location:**

115 Technology Drive  
Suite A-100  
Trumbull, CT 06611

CT and MRI scanners (CON Determination Report Number: 05-30437-DTR)

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

**Bridgeport, Easton, Fairfield, Monroe, Shelton, Stratford, Trumbull, and Westport**

h. Estimated starting date for the project: **July 1, 2010 or as soon as possible after CON 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: \$16,000

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

Major Medical Equipment Purchases*	\$0
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	\$0
Other (Non-Construction) Specify: _____	
<b>Total Capital Expenditure</b>	<b>\$0</b>
Major Medical Equipment – Fair Market Value of Leases Medical Equipment – Fair Market Value of Leases	\$16,000
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
<b>Total Capital Cost</b>	<b>\$16,000</b>
<b>Total Project Cost</b>	
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. N/A

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
MRI (Trumbull location)	GE	Signa, LX HighSpeed 1.0T	1	FMV at the time of acquisition was \$349,000 – Operating lease (CON Determination Report Number: 05-30437-DTR)
CT (Bridgeport location)	GE	Lightspeed QX/i	1	FMV at the time of acquisition was \$329,063 – Operating lease (CON Determination Report Number: 05-30438-DTR)
CT (Trumbull location)	GE	Lightspeed QX/i	1	FMV at the time of acquisition was \$345,000 – Operating lease (CON Determination Report Number: 05-30437-DTR)

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

Copies of the CON Determinations noted above are included in *Attachment I*.

e. Type of financing or funding source (more than one can be checked): N/A

<input checked="" type="checkbox"/> Applicant's Equity	<input type="checkbox"/> Capital Lease	<input type="checkbox"/> Conventional Loan
<input type="checkbox"/> Charitable Contributions	<input type="checkbox"/> Operating Lease	<input type="checkbox"/> CHEFA Financing
<input type="checkbox"/> Funded Depreciation	<input type="checkbox"/> Grant Funding	
<input type="checkbox"/> 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.

##### Project Overview

This Letter of Intent is being submitted as part of an Asset Transfer Agreement between Fairfield County Imaging, LLC ("FCI"), Fairfield County Radiology Associates, LLC ("FCRA") and FCRA Realty Associates, LLC ("Realty"), and St. Vincent's Medical Center ("SVMC"). This Letter of Intent is being filed pursuant to Section 19a-638 of the Connecticut General Statutes as

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Form 2030

Revised 10/2007

the proposed asset transfer will result in a change of ownership of two imaging centers owned and operated by FCI.

The Applicants seek to consolidate radiology services in the service area and improve the efficiency of such services. Specifically, the Asset Transfer Agreement is being pursued for the following reasons:

- FCRA radiologists intend to integrate into Advanced Radiology Consultants, LLC.
- Advanced Radiology Consultants, LLC will provide professional radiology services for SVMC beginning May 1, 2010.
- The transfer to SVMC will enhance access to imaging services for Medicaid, under- and un-insured residents of the service area.

FCI currently operates two imaging centers, one in Bridgeport and one in Trumbull. The services provided at each site are noted below:

**FCI Bridgeport:**

- CT
- Image guided procedures
- Endovascular laser therapy
- Ultrasound

**FCI Trumbull:**

- Bone Densitometry
- CT
- Mammography
- MRI
- Ultrasound
- X-Ray/Fluoroscopy

As part of the Applicants' desire to consolidate radiology services, following the closing of the Asset Transfer Agreement, SVMC plans to close the FCI Bridgeport location. FCI is currently negotiating with the facility's landlord as the current lease expires in May, 2010 and an extension will be necessary for the completion of this Certificate of Need application. A six month extension may be necessary which would permit SVMC to close the site no later than November, 2010. Access to the services provided can be continued and enhanced by offering the same services at the main Hospital campus. FCI's Bridgeport equipment will be moved to SVMC's main radiology department. In the case of CT scanning services, SVMC will continue to operate two CT scanners at its main campus. The Hospital currently operates a 16-slice CT scanner and a 32-slice CT scanner. Following a careful review of FCI's Bridgeport CT scanner in comparison to the two in operation at the hospital, one scanner will be removed from service and two will continue to remain in use.

SVMC intends that the Trumbull location will remain open for up to 18 months and then the equipment will be moved to a new Bridgeport location. The new Bridgeport location will serve the same population as the existing Trumbull office. SVMC is currently evaluating possible locations with the goal of establishing a location which can be easily accessed by residents of northern Bridgeport and Trumbull as well as surrounding communities.

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.

The types of services that pertain to this Letter of Intent include MRI, CT, Mammography, Ultrasound, Bone Densitometry and X-Ray services. SVMC is licensed as an acute care hospital by the Department of Public Health and a copy of SVMC's license is included in **Attachment II**. Fairfield County Imaging, LLC does not require DPH facility licensure since its services are provided by a private physician practice, however all individual physicians are licensed by DPH.

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

As noted above, this Letter of Intent pertains to SVMC's acquisition of FCI's two imaging center sites through an Asset Transfer Agreement.

The services to be offered include MRI, CT, Mammography, Ultrasound, Bone Densitometry and X-Ray services. Following the asset transfer, all imaging services will be provided by SVMC under its existing DPH license.

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

The current and target population will remain the same and include patients who live in the respective service area and require imaging services.

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

As previously noted, this proposal is being pursued to consolidate radiology services, and improve access to imaging services for the service area.

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

Other radiology providers in the proposed geographic area are listed below:

**Bridgeport**

- Bridgeport Hospital
- Advanced Radiology Consultants (MRI Center at Bridgeport Hospital)
- Robert D. Russo M.D. & Associates (general imaging, CT, bone densitometry, mammography, (PET/CT at 2660 Main Street location))

**Easton**

- none known

**Fairfield**

- Advanced Radiology Consultants (general imaging, MRI)
- Robert D. Russo M.D. & Associates (general imaging, CT, bone densitometry, mammography)

**Monroe**

- none known

**Shelton**

- Advanced Radiology Consultants (general imaging, MRI)
- Robert D. Russo M.D. & Associates (Open MRI)

**Stratford**

- Advanced Radiology Consultants (general imaging, MRI, nuclear medicine, and interventional Radiology Center)
- Robert D. Russo M.D. & Associates (MRI at 2595 Main Street and general imaging, CT, bone densitometry, and mammography at 2909 Main Street)

**Trumbull**

- Advanced Radiology Consultants (general imaging, MRI, nuclear medicine, women's imaging center)

**Westport**

- none known

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

**The anticipated effect of this proposal on the health care delivery system in the State of Connecticut will be positive. Following completion of the Asset Transfer Agreement, two radiology practices intend to integrate into one larger practice. The larger practice can offer more efficient and convenient services. Access to imaging services will also be improved for the Medicaid and under- and un-insured populations with SVMC operating the imaging equipment in the service area.**

7. Who will be responsible for providing the service?

**SVMC will be responsible for providing the imaging services. Advanced Radiology Consultants, LLC will provide the professional services.**

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

**Current payers for imaging services include Medicare, Medicaid, and commercial health insurance. The applicants do not anticipate any payer changes.**

## AFFIDAVIT

To be completed by each Applicant

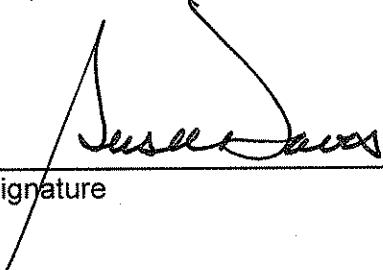
Applicant: St. Vincent's Medical Center

Project Title: Change of ownership of two imaging centers from Fairfield County Imaging, LLC to St. Vincent's Medical Center

I, Susan L. Davis, CEO  
(Name) (Position – CEO or CFO)

of St. Vincent's Medical Center being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that St. Vincent's Medical Center complies with the (Facility Name)

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 3-25-10

Subscribed and sworn to before me on: March 25, 2010

  
\_\_\_\_\_  
Dolores M. Miele

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2011

## AFFIDAVIT

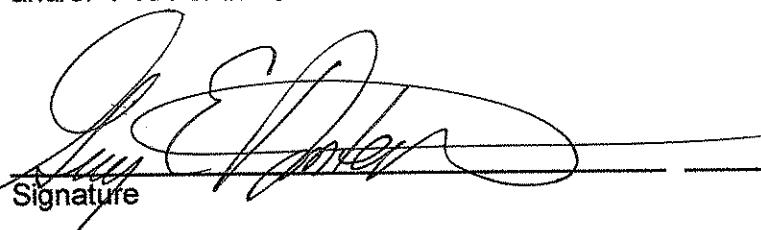
To be completed by each Applicant

Applicant: Fairfield County Imaging, LLC

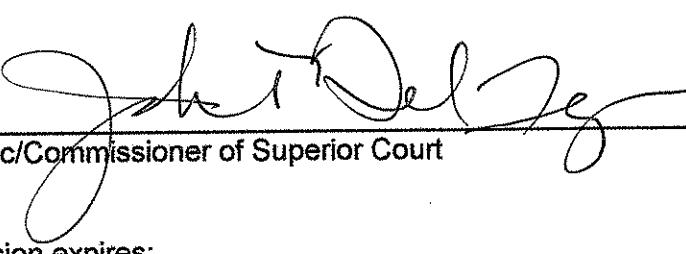
Project Title: Change of ownership of two imaging centers from Fairfield County Imaging, LLC to St. Vincent's Medical Center

I, Guy E. Torstenson, MD \_\_\_\_\_ President  
(Name) \_\_\_\_\_ (Position – CEO or CFO)

of Fairfield County Imaging, LLC 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 Fairfield County Imaging, LLC complies with the appropriate and (Facility Name) 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 3/24/10

Subscribed and sworn to before me on 3/24/10

  
\_\_\_\_\_  
Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_

## **Attachment I**



**STATE OF CONNECTICUT**  
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL  
GOVERNOR

CRISTINE A. VOGEL  
COMMISSIONER

February 15, 2005

Guy E. Torstenson, M.D.  
President, Main Street Imaging Center, LLC  
d/b/a Fairfield County Radiology Associates, LLC  
c/o St. Vincent's Medical Center  
2800 Main Street  
Bridgeport, CT 06606

*Re: Certificate of Need Determination Request; Report Number: 05-30438-DTR*  
Acquisition and Installation of a CT Scanning System to be located in a  
Diagnostic Imaging Center in Bridgeport

Dear Dr. Torstenson:

On February 8, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of Main Street Imaging Center, LLC, d/b/a Fairfield County Radiology Associates, LLC, to acquire and install a computed tomography scanning system for its diagnostic imaging center to be located at 3101 Main Street, in Bridgeport, at an estimated total capital cost of \$329,063. OHCA has reviewed the information contained in your CON Determination request letter and makes the following findings.

1. Main Street Imaging Center, LLC, d/b/a Fairfield County Radiology Associates, LLC, ("FCRA") is a private physician practice that is presently comprised of eight radiologists.
2. FCRA is the sole provider of radiology services for St. Vincent's Medical Center located at 2800 Main Street in Bridgeport.
3. Main Street Imaging Center, LLC, d/b/a FCRA is proposing to acquire and install a General Electric Lightspeed computed tomography ("CT") scanning system.
4. The CT scanning system will be located at the Main Street Imaging Center, LLC's diagnostic imaging center to be located at 3101 Main Street, Bridgeport, CT.
5. The imaging center is anticipated to become operational in April 2005.

*An Equal Opportunity Employer*  
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688  
Fax: (860) 418-7053

6. The service area of FCRA consists of Fairfield County, including Bridgeport, and possesses a total population of over three hundred thousand individuals.
7. Main Street Imaging Center, LLC, is owned by FCRA Holdings, LLC. The members of FCRA Holdings are the same as those of FCRA. There are no outside owners of FCRA Holdings.
8. The only radiologists providing services at the diagnostic imaging center will be those radiologists who are either owners or employees of FCRA.
9. The project's total capital cost of \$329,063 consists of the following components:
  - the fair market value associated with the proposed system's lease acquisition is \$303,833; and
  - the associated implementation costs (i.e. delivery, installation and sales tax) totals \$25,230.

Based on the above findings, OHCA determines that Main Street Imaging Center, LLC, d/b/a/ Fairfield County Radiology Associates, LLC's proposal to acquire a CT scanning system to be located at the 300 Main Street diagnostic imaging center in Bridgeport will not require CON approval from OHCA pursuant to Section 19a-639 of the Connecticut General Statutes.

Thank you for providing information to OHCA regarding this proposal. If you have any questions concerning this letter, please contact Jack Huber at (860) 418-7034.

Sincerely,

Signed by Cristine A. Vogel  
Commissioner

CAV:jah



**STATE OF CONNECTICUT**  
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL  
GOVERNOR

CRISTINE A. VOGEL  
COMMISSIONER

February 24, 2005

Guy E. Torstenson, M.D.  
President, Main Street Imaging Center, LLC  
d/b/a Fairfield County Radiology Associates, LLC  
c/o St. Vincent's Medical Center  
2800 Main Street  
Bridgeport, CT 06606

Re: Certificate of Need Determination Request; Report Number: 05-30437-DTR  
Main Street Imaging Center, LLC d/b/a Fairfield County Radiology Associates, LLC  
Acquire and Install Imaging Equipment in the Trumbull Imaging Center

Dear Dr. Torstenson:

On February 8, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of Main Street Imaging Center, LLC, d/b/a Fairfield County Radiology Associates, LLC, to acquire and install imaging equipment at its diagnostic imaging center to be located at 115 Technological Drive, in Trumbull. OHCA has reviewed the information contained in your CON Determination request letter and makes the following findings.

1. Main Street Imaging Center, LLC, d/b/a Fairfield County Radiology Associates, LLC, ("FCRA" or "Applicant") is a private physician practice that is presently comprised of eight radiologists.
2. F CRA is the sole provider of radiology services for St. Vincent's Medical Center located at 2800 Main Street in Bridgeport.
3. F CRA is proposing to acquire and install the following pieces of imaging equipment at its Trumbull imaging center: a magnetic resonance imaging ("MRI") system, a computed tomography ("CT") scanning system, a computed radiography unit, a digital mammography unit, a CAD mammography unit and a bone densitometry unit.

*An Equal Opportunity Employer*  
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688  
Fax: (860) 418-7053

4. The Applicant has investigated acquiring the following specified make and model of imaging equipment:

<u>Equipment</u>	<u>Vendor</u>	<u>Model</u>	<u>Unit(s)</u>
a. MRI System	GE	Signa, LX HiSpeed, 1.0 T	1
b. CT System	GE	Lightspeed QX/i	1
c. Computed Radiography	Konica	Xpress, CR System	1
d. Digital Mammography	GE	Senographe 2000D	1
e. CAD Mammography	GE	S30321LR	1
f. Bone Densitometer	GE	Prodigy Advanced	1
			6

5.F. CRA's Trumbull imaging center will house the proposed equipment. The center will be located at 115 Technological Drive and will become operational in late spring or early summer of 2005.

6. The service area of FCRA consists of Fairfield County, including Trumbull, and possesses a total population of over three hundred thousand individuals.

7. Main Street Imaging Center, LLC, is owned by FCRA Holdings, LLC. The members of FCRA Holdings, LLC, are the same as those of FCRA. There are no outside owners of FCRA Holdings, LLC.

8. The only radiologists who anticipate providing services at the Trumbull imaging center will be those radiologists who are either owners or employees of FCRA.

9. The Applicant's equipment cost estimates were verified through receipt of a vendor price quotation received for each piece of imaging equipment. An itemization of the costs associated with the proposed acquisition and installation is as follows:

<u>Equipment</u>	<u>Fair Market Value</u>	<u>Implementation Costs<sup>1</sup></u>	<u>Total Capital Cost</u>
a. MRI System	\$349,000	\$25,940	\$374,940
b. CT System	\$345,000	\$25,700	\$370,700
c. C. Radiography	\$193,500	\$11,610	\$205,110
d. D. Mammography	\$287,940	\$17,276	\$305,216
e. CAD Mammography	\$ 95,000	\$ 5,700	\$100,700
f. Bone Densitometer	\$ 75,000	\$ 4,500	\$ 79,500
g. Project Totals	\$1,345,440	\$90,726	\$1,436,166

<sup>1</sup> The implementation cost estimates associated with the equipment acquisitions include delivery fees, installation costs and sale tax expenses.

10. With the exception of the proposed bone densitometer unit, which will be purchased with a conventional loan, all remaining pieces of imaging equipment will be acquired through lease financing.

Based on the above findings, OHCA determines that each individual piece of imaging equipment to be acquired by Main Street Imaging Center, LLC, represents a capital expenditure that is less than \$400,000. Therefore, Main Street Imaging Center, LLC, d/b/a/ Fairfield County Radiology Associates, LLC's proposal to acquire and install imaging equipment at its diagnostic imaging center to be located at 115 Technology Drive in Trumbull will not require CON approval from OHCA pursuant to Section 19a-639 of the Connecticut General Statutes. Please be advised, however, that if the Applicant changes the scope of services to be provided at this location or incurs a total capital cost equal to or greater than \$400,000 for each individual piece of imaging equipment, Certificate of Need approval from OHCA would then be required.

Thank you for providing information to OHCA regarding this proposal. If you have any questions concerning this letter, please contact Jack Huber at (860) 418-7034.

Sincerely,

Signed by Cristine A. Vogel  
Commissioner

CC: Rose McLellan, Licensing Examination Assistant, DHSR, DPH  
John T. Del Negro, Esq., Del Negro & Feldman, LLC, on behalf of FCRA, LLC

CAV:jah

## **Attachment II**

# STATE OF CONNECTICUT

## Department of Public Health

### LICENSE

**License No. 0057**

#### **General Hospital**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

St. Vincent's Medical Center of Bridgeport, CT, d/b/a St. Vincent's Medical Center is hereby licensed to maintain and operate a General Hospital.

**St. Vincent's Medical Center** is located at 2800 Main Street, Bridgeport, CT 06606

The maximum number of beds shall not exceed at any time:

47 Bassinets

473 General Hospital beds

This license expires **September 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2009.

#### **Satellites**

St. Vincent's Immediate Health Care, 4600 Main Street, Bridgeport, CT

St. Vincent's Immediate Health Care, 1055 Post Road, Fairfield, CT

St. Vincent's Immediate Health Care, 2 Trap Falls Road, Shelton, CT

St. Vincent's Medical Center, Neighborhood at St. Joseph's Center, 43 Madison Avenue, Bridgeport, CT

Family Health Center, 760-762 Lindley Street, Bridgeport, CT

St. Vincent's Immediate Health Care, 401 Monroe Turnpike, Monroe, CT

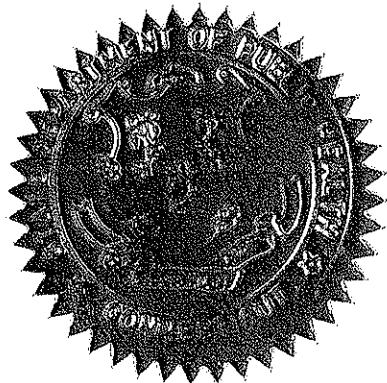
St. Vincent's Family Practice, 2595 Main Street, Stratford, CT

The St. Vincent's Center for Wound Healing, 115 Technology Drive, Trumbull, CT

St. Vincent's Behavioral Health Center-Westport, 47 Long Lots Road, Westport, CT

St. Vincent's Outpatient Behavioral Health-Bridgeport, 2400 Main Street, Bridgeport, CT

St. Vincent's Outpatient Behavioral Health-Norwalk, 1 Lois Street, Norwalk, CT

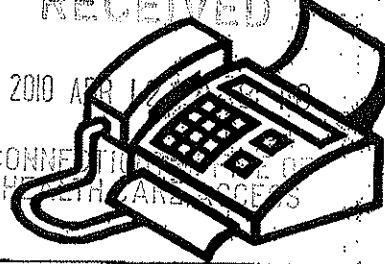


*J. Robert Galvin MD, MPH, MBA*

J. Robert Galvin, MD, MPH, MBA,  
Commissioner

RECEIVED

2010 APR 12 10:00 AM

CONNECTIONS, INC. DE  
HEALTH CARE ACCESS

To: Ronald Clesones, OHCA  
Fax number: 860-418-7053

Date: 4/11/2010

A facsimile from

kmb consulting, llc

OPTIMIZE YOUR HEALTH CARE PLANNING RESOURCES

Karen M. Banoff  
(203) 459-1601

Regarding: Revised first two pages of Letter of Intent: St. Vincent's Medical Center and Fairfield County Imaging, LLC

**Comments:**

Revised contacts for each applicant. Replacement pages attached. Please let me know if you require any additional information. Karen Banoff



RECEIVED

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

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

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	St. Vincent's Medical Center	Fairfield County Imaging, LLC
Doing Business As	N/A	N/A
Name of Parent Corporation	St. Vincent's Health Services Corporation	N/A
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2800 Main Street Bridgeport, CT 06606	Suite A-100 115 Technology Drive Trumbull, CT 06611
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	P
Does the Applicant have Tax Exempt Status?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Contact Person, Including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Rachel Gillotti Administrative Director	Peter Steenbergen, MD
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	St. Vincent's Medical Center 2800 Main Street Bridgeport, CT 06606	Fairfield County Imaging, LLC 115 Technology Drive Suite A-100 Trumbull, CT 06611
Contact Person Telephone Number	(203) 576-6370	(203) 459-2442
Contact Person Fax Number	(203) 581-6537	(203) 777-5806 c/o John DelNegro

Page 2 of 8

Contact Person e-mail Address	Applicant One	Applicant Two
	rgillotti@stvincents.org	pschoenberger@stvincents.org

## SECTION II: GENERAL APPLICATION INFORMATION

- Project Title: Change of ownership of two imaging centers from Fairfield County Imaging, LLC to St. Vincent's Medical Center.
- Project Proposal: St. Vincent's Medical Center and Fairfield County Imaging, LLC are requesting CON approval for the change of ownership of Fairfield County Imaging, LLC's two imaging centers to St. Vincent's Medical Center. This change of ownership is part of an overall Asset Transfer Agreement and change in radiology service provider at St. Vincent's.
- Type of Project/Proposal, please check all that apply.

### Inpatient Service(s):

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

Maternity

### Outpatient Service(s):

Ambulatory Surgery Center       Primary Care  
 New Hospital Satellite Facility       Emergency  
 Rehabilitation (specify type) \_\_\_\_\_  
 Behavioral Health (Psychiatric and/or Substance Abuse Services)  
 Other Outpatient (specify) Imaging Center

Oncology  
 Urgent Care  
 Central Services Facility

### Imaging:

MRI       CT Scanner  
 CT Simulator       PET/CT Scanner  
 Cineangiography Equipment       New Technology: \_\_\_\_\_

PET Scanner  
 Linear Accelerator

### 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: \_\_\_\_\_

**Greer, Leslie**

---

**From:** Ciesones, Ron  
**Sent:** Thursday, April 15, 2010 3:23 PM  
**To:** Greer, Leslie  
**Cc:** Lazarus, Steven  
**Subject:** FW: CON Application #10-31578-CON

**Attachments:** 10-31578-CON Application.doc; 10-31578 Cover Letter.doc; Financial Attachment\_St\_Vincents.xls; CON Affidavit-Fairfield County Imaging.doc; CON Affidavit-St. Vincents Medical Center.doc; Financial Attachment II\_Fairfield County.xls; Financial Attachment II\_St\_Vincents.xls; Financial Attachment\_Fairfield County.xls

Leslie, this is the application and related documents that were sent out.

---

**From:** Ciesones, Ron  
**Sent:** Wednesday, April 14, 2010 1:28 PM  
**To:** Rachel Giliotti (rgiliotti@stvincents.org); Peter Steenbergen (psteenbergen@stvincents.org)  
**Cc:** Fedorjaczenko, Alexis; Carney, Brian  
**Subject:** CON Application #10-31578-CON

Ms. Giliotti and Dr. Steenbergen,

Please see the attached CON Application forms for the Change of Ownership of two imaging centers owned by Fairfield County Imaging, LLC. If you have any questions please contact OHCA at (860) 418-7001.

**Ronald A. Ciesones**  
**Associate Health Care Analyst**  
Department of Public Health  
Division of Office of Health Care Access  
410 Capitol Avenue  
MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308  
phone (direct line) (860)-418-7023  
fax (primary line) (860)-418-7053  
website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

April 20, 2010

Facsimile Only

Rachel Giliotti  
Administrative Director  
St. Vincent's Medical Center  
2800 Main Street  
Bridgeport, CT 06606

Peter Steenbergen, MD  
Fairfield County Imaging, LLC  
115 Technology Drive  
Suite A-100  
Trumbull, CT 06611

Re: Letter of Intent; Docket Number: 10-31578  
Acquisition of Two CT Scanners: One Located in Bridgeport and One Located in Trumbull, Relocating the Acquired CT Scanners to Bridgeport, and Terminating a CT Scanner.

Dear Ms. Giliotti and Dr. Steenbergen:

On March 30, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of St. Vincent's Medical Center and Fairfield County Imaging, LLC ("Applicants") for the acquisition of two CT Scanners: one located in Bridgeport and one located in Trumbull, relocating the acquired CT Scanners to Bridgeport, and terminating a CT Scanner, with no capital expenditure.

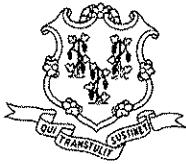
A notice to the public regarding OHCA's receipt of a LOI was published in *The Connecticut Post* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

*Kimberly Martone* (KRM)

Kimberly R. Martone  
Director of Operations

KRM:lmg



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

April 20, 2010

Requisition # 31112

Connecticut Post  
410 State Street  
Bridgeport, CT 06604-4560

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 **Wednesday, April 21, 2010**.

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 Ronald Ciesones or Brian Carney at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly Martone   
Kimberly R. Martone  
Director of Operations

Attachment

KRM:RC:BC:Img

c: Danielle Pare, DPH

**PLEASE INSERT THE FOLLOWING:**

Statute Reference: 19a-638  
Applicant(s): St. Vincent's Medical Center and Fairfield County Imaging, LLC  
Town(s): Bridgeport & Trumbull  
Docket Number: 10-31578-LOI  
Proposal: Acquisition of two CT Scanners: one located in Bridgeport and one located in Trumbull, relocating the acquired CT Scanners to Bridgeport, and terminating a CT Scanner.  
Capital Expenditure: \$0

The Applicant may file its Certificate of Need application between May 29, 2010 and July 28, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 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](http://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 Applicant.

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

TX/RX NO 1485  
RECIPIENT ADDRESS 912035816537  
DESTINATION ID  
ST. TIME 04/21 14:38  
TIME USE 00 '48  
PAGES SENT 4  
RESULT OK



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*OFFICE OF HEALTH CARE ACCESS*

**FAX SHEET**

TO: RACHEL GILIOTTI

FAX: (203) 581-6537

AGENCY: ST. VINCENT'S MEDICAL CENTER

FROM: RONALD CIESONES

DATE: 4/21/10 TIME: \_\_\_\_\_

NUMBER OF PAGES: 4  
(including transmittal sheet)

~~~~~

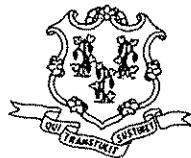
Comments: Docket 10-31578

***PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.***

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

TX/RX NO 1486  
RECIPIENT ADDRESS 912037775806  
DESTINATION ID  
ST. TIME 04/21 14:40  
TIME USE 01 ' 33  
PAGES SENT 4  
RESULT OK



**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS**

**FAX SHEET**

TO: JOHN DELNEGRO, ESQ.  
FAX: (203) 777-5806  
AGENCY: FAIRFIELD COUNTY IMAGING, LLC  
FROM: RONALD CIESONES  
DATE: 4/21/10 TIME: \_\_\_\_\_  
NUMBER OF PAGES: 4  
(including transmittal sheet)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: Docket 10-31578

**PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.**

**Greer, Leslie**

---

**From:** ads [ads@graystoneadv.com]  
**Sent:** Tuesday, April 20, 2010 3:48 PM  
**To:** Greer, Leslie  
**Subject:** Re: Legal Ads 10-31578 & 10-31596

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061  
E-mail: ads@graystoneadv.com  
<http://www.graystoneadv.com/>

On 4/20/10 3:46 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

*To Whom It May Concern,*  
Please run the attached newspaper notices in The Connecticut Post by April 21, 2010. For billing  
refer to requisition 31112 for both notices, if you have any questions feel free to call me.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
A Division of Department of Public Health  
State of Connecticut  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca) <<http://www.ct.gov/ohca>>

 Please consider the environment before printing this message

**Greer, Leslie**

---

**From:** Laurie [Laurie@graystoneadv.com]  
**Sent:** Tuesday, April 20, 2010 4:48 PM  
**To:** Greer, Leslie  
**Subject:** Re: Legal Ads 10-31578 & 10-31596

Thanks!

Your legal notices are all set to run as follows:

CT Post, 4/21 issue - 10-31578 - \$263.03 and 10-31596 - \$245.26

Thanks,  
Laurie Miller

Graystone Group Advertising  
2710 North Ave., Ste 200, Bridgeport, CT 06604  
Ph: 203-549-0060, Fax: 203-549-0061  
email: [laurie@graystoneadv.com](mailto:laurie@graystoneadv.com)  
[www.graystoneadv.com](http://www.graystoneadv.com)

On 4/20/10 4:19 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

You are the BEST ☺  
Thank you  
Leslie

---

**From:** Laurie [mailto:[Laurie@graystoneadv.com](mailto:Laurie@graystoneadv.com)]  
**Sent:** Tuesday, April 20, 2010 3:55 PM  
**To:** Greer, Leslie  
**Subject:** FW: Legal Ads 10-31578 & 10-31596

They said they would run them on 4/21, I will get the costs to you after I get them...

Thanks,  
Laurie

Graystone Group Advertising  
2710 North Ave., Ste 200, Bridgeport, CT 06604  
Ph: 203-549-0060, Fax: 203-549-0061  
email: [laurie@graystoneadv.com](mailto:laurie@graystoneadv.com)  
[www.graystoneadv.com](http://www.graystoneadv.com)

----- Forwarded Message  
**From:** "Greer, Leslie" <Leslie.Greer@ct.gov>  
**Date:** Tue, 20 Apr 2010 15:46:44 -0400  
**To:** ads <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>

**Conversation:** Legal Ads 10-31578 & 10-31596  
**Subject:** Legal Ads 10-31578 & 10-31596

To Whom It May Concern,

Please run the attached newspaper notices in The Connecticut Post by April 21, 2010. For billing refer to requisition 31112 for both notices, if you have any questions feel free to call me.

Thank you,

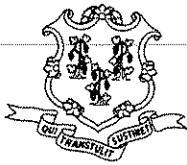
Leslie M. Greer &  
Office of Health Care Access  
A Division of Department of Public Health  
State of Connecticut  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca) [<http://www.ct.gov/ohca>](http://www.ct.gov/ohca)



Please consider the environment before printing this message

----- End of Forwarded Message

----- End of Forwarded Message



## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

May 6, 2010

via fax and email only

Rachel Giliotti  
Administrative Director  
St Vincent's Medical Center  
2800 Main Street  
Bridgeport, CT 06606

Peter Steenbergen, MD  
Fairfield County Imaging, LLC  
115 Technology Drive  
Suite A-100  
Trumbull, CT 06611

RE: Certificate of Need **Revised** Application Forms, Docket Number 10-31578-CON  
St. Vincent's Medical Center and Fairfield County Imaging, LLC  
Acquisition of a CT scanner and MRI scanner and Relocation of both from  
Trumbull to Bridgeport

Dear Ms. Giliotti and Dr. Steenbergen:

Enclosed are the **REVISED** application forms for St. Vincent's Medical Center and Fairfield County Imaging, LLC's Certificate of Need ("CON") proposal for Acquisition of a CT scanner and MRI scanner and relocation of both from Trumbull to Bridgeport, with no associated capital expenditure. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between May 29, 2010 and July 28, 2010.

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.

An Equal Opportunity Employer

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688

Fax: (860) 418-7053

---

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

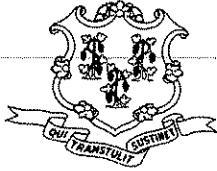
The analyst assigned to the CON application is Carmen Cotto. Please contact her at (860) 418-7001 if you have questions.

Sincerely,



Kaila Riggott  
Planning Specialist

Enclosures



**State of Connecticut  
Department of Public Health  
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 May 29, 2010, and may be submitted no later than Wednesday, July 28, 2010. The Analyst assigned to your application is Carmen Cotto; she may be reached at the Office of Health Care Access at (860) 418-7001.

**NOTE: This application replaces the forms previously sent under the same docket number.**

**Docket Number:** 10-31578-CON

|                         |                                          |                                   |
|-------------------------|------------------------------------------|-----------------------------------|
| <b>Applicants Name:</b> | Rachel Giliotti                          | Peter Steenbergen, MD             |
| <b>Contact Person:</b>  | Administrative Director                  | Fairfield County Imaging, LLC     |
| <b>Contact Title:</b>   | St Vincent's Medical Center              | 115 Technology Drive              |
| <b>Contact Address:</b> | 2800 Main Street<br>Bridgeport, CT 06606 | Suite A-100<br>Trumbull, CT 06611 |

**Project Location:** Bridgeport and Trumbull

**Project Name:** Acquisition of a CT scanner and MRI scanner and  
Relocation of both from Trumbull to Bridgeport

**Type proposal:** Section 19a-639, C.G.S.

**Est. Capital Expenditure:** \$ 0

**Please clearly identify how responses pertain to each scanner involved in this proposal.**

**1) Project Description and Need**

- a) Provide a narrative detailing the proposal.
- b) Provide a timeline describing the process of equipment purchase and identification of a new site, and identify the anticipated date upon which the equipment will be relocated.
- c) Provide the Manufacturer, Model, Number of slices/tesla strength of each proposed scanner (as appropriate to each equipment).
- d) List each of the Applicant's sites and the imaging modalities and other services currently offered by location.
- e) Complete **Table 1** for each scanner (of the type proposed) currently operated by the Applicant at each of the Applicant's sites.

**Table 1: Existing Scanners Operated by the Applicant**

| Provider Name<br>Street Address<br>Town, Zip Code | Description of<br>Service * | Hours/Days of<br>Operation ** | Utilization *** |
|---------------------------------------------------|-----------------------------|-------------------------------|-----------------|
|                                                   |                             |                               |                 |
|                                                   |                             |                               |                 |
|                                                   |                             |                               |                 |

\* Include equipment strength (e.g. slices, tesla strength), whether scanner is open or closed (for MRI)

\*\* Days of the week scanner is operational, and start and end time for each day; and

\*\*\* Number of scans performed on each scanner for the most recent 12-month period (identify period).

- f) Provide the following regarding the proposal's location:

- i) The specific address and a description of the new location where the imaging equipment will be located;
- ii) A description of any medical services currently, or that will be provided at the proposed location (i.e. types of physician practices, the types of imaging equipment, etc);
- iii) The rationale for locating the proposed equipment at the proposed site;
- iv) The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;
- v) How and where the proposed patient population is currently being served;

- vi) All existing providers (name, address) of the proposed service in the towns listed above and in nearby towns;
- vii) The effect of the proposal on existing providers; and
- viii) If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

## 2) Actual and Projected Volume

- a) Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed scanners (of the type proposed, at the proposed location only). In Table 2a, report the units of service by scanner, and in Table 2b, report the units of service by type of scan (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

**Table 2a: Historical, Current, and Projected Volume, by Scanner**

|              | Actual Volume<br>(Last 3 Completed FYs) |         |         | CFY<br>Volume* | Projected Volume<br>(First 3 Full Operational<br>FYs)** |        |        |
|--------------|-----------------------------------------|---------|---------|----------------|---------------------------------------------------------|--------|--------|
|              | FY ****                                 | FY **** | FY **** |                | FY ****                                                 | FY *** | FY *** |
| Scanner***   |                                         |         |         |                |                                                         |        |        |
|              |                                         |         |         |                |                                                         |        |        |
|              |                                         |         |         |                |                                                         |        |        |
|              |                                         |         |         |                |                                                         |        |        |
| <b>Total</b> |                                         |         |         |                |                                                         |        |        |

\* 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 scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.

\*\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

**Table 2b: Historical, Current, and Projected Volume, by Type of Scan**

|                    | Actual Volume<br>(Last 3 Completed FYs) |         |        | CFY<br>Volume* | Projected Volume<br>(First 3 Full Operational<br>FYs)** |        |        |
|--------------------|-----------------------------------------|---------|--------|----------------|---------------------------------------------------------|--------|--------|
|                    | FY ****                                 | FY **** | FY *** |                | FY ****                                                 | FY *** | FY *** |
| Service<br>type*** |                                         |         |        |                |                                                         |        |        |
|                    |                                         |         |        |                |                                                         |        |        |
|                    |                                         |         |        |                |                                                         |        |        |
|                    |                                         |         |        |                |                                                         |        |        |

| 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 type of scan (e.g. orthopedic, neurosurgery or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners) and add lines as necessary.

\*\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

- b) Provide a breakdown, by town, of the volumes provided in Table 2a for the most recently completed full FY.
- 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 by scanner and scan type.
- e) Provide a copy of any articles, studies, or reports that support the need to acquire the proposed scanner, along with a brief explanation regarding the relevance of the selected articles.

### **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 3: Proposed Capital Expenditures/Costs**

|                                                          |           |
|----------------------------------------------------------|-----------|
| Medical Equipment Purchase                               | \$        |
| Imaging Equipment Purchase                               |           |
| Non-Medical Equipment Purchase                           |           |
| Land/Building Purchase *                                 |           |
| Construction/Renovation **                               |           |
| Other Non-Construction (Specify)                         |           |
| <b>Total Capital Expenditure</b>                         | <b>\$</b> |
| Medical Equipment Lease (Fair Market Value) ***          | \$        |
| Imaging Equipment Lease (Fair Market Value) ***          |           |
| Non-Medical Equipment Lease (Fair Market Value) ***      |           |
| Fair Market Value of Space ***                           |           |
| <b>Total Capital Cost</b>                                | <b>\$</b> |
| Capitalized Financing Costs (Informational Purpose Only) |           |
| <b>Total Capital Expenditure with Cap. Fin. Costs</b>    | <b>\$</b> |

\* 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) with the CON proposal for EACH proposed scanner, separately.

**Table 4: Patient Population Mix**

|                             | <b>Current**<br/>FY ***</b> | <b>Year 1<br/>FY ***</b> | <b>Year 2<br/>FY ***</b> | <b>Year 3<br/>FY ***</b> |
|-----------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| Medicare*                   |                             |                          |                          |                          |
| Medicaid*                   |                             |                          |                          |                          |
| CHAMPUS & TriCare           |                             |                          |                          |                          |
| <b>Total Government</b>     |                             |                          |                          |                          |
| Commercial Insurers*        |                             |                          |                          |                          |
| Uninsured                   |                             |                          |                          |                          |
| Workers Compensation        |                             |                          |                          |                          |
| <b>Total Non-Government</b> |                             |                          |                          |                          |
| <b>Total Payer Mix</b>      |                             |                          |                          |                          |

\* Includes managed care activity.

\*\* New programs may leave the "current" column blank.

\*\*\* 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.

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

c. 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.).

d. 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).

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

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

g. 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: \_\_\_\_\_

## HOSPITAL AFFIDAVIT

Applicant: \_\_\_\_\_

Project Title: \_\_\_\_\_

of \_\_\_\_\_ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of \$15,000,000.  
 Yes       No
  
2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.  
 Yes       No

---

**Signature**

Date

Subscribed and sworn to before me on

**Notary Public/Commissioner of Superior Court**

My commission expires:





**Fairfield County Imaging, LLC**

**6A. 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:**

| <u>Total Facility:</u><br><u>Description</u> | <u>FY<br/>Actual<br/>Results</u> | <u>FY<br/>Projected<br/>W/out Project</u> | <u>FY<br/>Projected<br/>Incremental</u> | <u>FY<br/>Projected<br/>With Project</u> | <u>FY<br/>Projected<br/>W/out Project</u> | <u>FY<br/>Projected<br/>Incremental</u> | <u>FY<br/>Projected<br/>With Project</u> | <u>FY<br/>Projected<br/>W/out Project</u> | <u>FY<br/>Projected<br/>Incremental</u> | <u>FY<br/>Projected<br/>With Project</u> |
|----------------------------------------------|----------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|
| Revenue from Operations                      |                                  |                                           |                                         |                                          |                                           |                                         |                                          |                                           |                                         |                                          |
| Non-Operating Revenue                        |                                  |                                           |                                         |                                          |                                           |                                         |                                          |                                           |                                         |                                          |
| Total Revenue:                               | \$0                              | \$0                                       | \$0                                     | \$0                                      | \$0                                       | \$0                                     | \$0                                      | \$0                                       | \$0                                     | \$0                                      |
| Total Operating Expenses                     |                                  |                                           |                                         |                                          |                                           |                                         |                                          |                                           |                                         |                                          |
| 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         |                                  |                                           |                                         |                                          |                                           |                                         |                                          |                                           |                                         |                                          |
| 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.

**St. Vincent's Medical Center**

**6A.** 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:

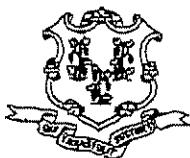
| Total Facility:                       | FY<br>Actual<br>Results | FY<br>Projected<br>W/out CON | FY<br>Projected<br>Incremental | FY<br>Projected<br>With CON | FY<br>Projected<br>W/out CON | FY<br>Projected<br>Incremental | FY<br>Projected<br>With CON | FY<br>Projected<br>W/out CON | FY<br>Projected<br>Incremental | FY<br>Projected<br>With CON |
|---------------------------------------|-------------------------|------------------------------|--------------------------------|-----------------------------|------------------------------|--------------------------------|-----------------------------|------------------------------|--------------------------------|-----------------------------|
| <b>NET PATIENT REVENUE</b>            |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Non-Government                        |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Medicare                              |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Medicaid and Other Medical Assistance |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Other Government                      |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| 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                         |
| <b>OPERATING EXPENSES</b>             |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Salaries and Fringe Benefits          |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Professional / Contracted Services    |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Supplies and Drugs                    |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Bad Debts                             |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Other Operating Expense               |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Subtotal                              | \$0                     | \$0                          | \$0                            | \$0                         | \$0                          | \$0                            | \$0                         | \$0                          | \$0                            | \$0                         |
| Depreciation/Amortization             |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Interest Expense                      |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Lease Expense                         |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| 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           |                         |                              |                                |                             |                              |                                |                             |                              |                                |                             |
| Revenue Over/(Under) Expense          | \$0                     | \$0                          | \$0                            | \$0                         | \$0                          | \$0                            | \$0                         | \$0                          | \$0                            | \$0                         |
| FTEs                                  |                         |                              |                                |                             | 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.

\*\*\*\*\*  
\*\* TX REPORT \*\*  
\*\*\*\*\*

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FAX SHEET

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FAX: 203-581-6537 203-777-5806  
AGENCY:  
FROM: Alexis Fedorjacek or Steven Lazars  
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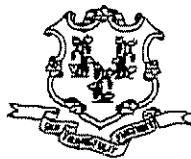
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OFFICE OF HEALTH CARE ACCESS

**FAX SHEET**

TO: Rachel Gillotti / Peter Steenbergen, MD

FAX: 203-581-6537 203-777-5806

AGENCY: \_\_\_\_\_

FROM: Alexis Feduniaczenko + Steven Lazarus

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Comments:

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**Greer, Leslie**

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**From:** Fedorjaczenko, Alexis  
**Sent:** Thursday, May 06, 2010 2:29 PM  
**To:** Greer, Leslie  
**Subject:** FW: New Forms, Docket Number 10-31578  
**Attachments:** CON Affidavit-St. Vincents Medical Center.doc; 10-31578-CON Application NEW.doc; 10-31578 Cover Letter.doc; Financial Attachment II\_St Vincents.xls; Financial Attachment II\_Fairfield County.xls; Financial Attachment\_St. Vincents.xls; Financial Attachment\_Fairfield County.xls; CON Affidavit-Fairfield County Imaging.doc

This goes in the record with the fax I left in your box.

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**From:** Fedorjaczenko, Alexis  
**Sent:** Thursday, May 06, 2010 2:18 PM  
**To:** 'kbanoff@kmbconsult.com'; rgiliotti@stvincents.org; psteenbergen@stvincents.org  
**Cc:** Lazarus, Steven; Martone, Kim  
**Subject:** New Forms, Docket Number 10-31578

As discussed, attached please find the revised forms for Docket Number 10-31578.

Let us know if you have any questions.

Alexis G. Fedorjaczenko, MPH  
Health Care Analyst  
DPH Office of Health Care Access  
860.418.7017

