

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

RECEIVED
2009 AUG 28 P 12:10
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

VIA Fax 860-418-7053

Re: Request for CON Determination for acquisition and operation of an MRI by a private physician practice in 2005.

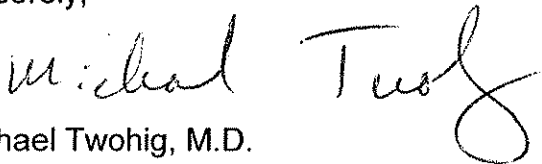
Dear Ms. Vogel:

We are filing a completed form 2020, as a request for a CON Determination for approval of a previous acquisition in 2005 of an MRI 1.0 Tesla mobile unit in Glastonbury, Connecticut by Radiology Associates of Hartford, P.C. and its operation.

We are submitting the original and required four copies by mail, as well.

If you have any questions concerning these responses, please feel free to contact Bernadette Jensen at our office, 714-7121.

Sincerely,



Michael Twohig, M.D.
President



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Radiology Associates of Hartford, P.C.	
Doing Business As	Radiology Associates of Hartford, P.C.	
Name of Parent Corporation	Radiology Associates of Hartford, P.C.	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	1000 Asylum Avenue Suite 3201E Hartford, CT 06105	
What is the Petitioner's Status: P for profit and NP for Nonprofit	P	

Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Michael Twohig, M.D., President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	1000 Asylum Avenue Suite 3201E Hartford, CT 06105	
Contact Person's Telephone Number	860-714-5285	
Contact Person's Fax Number	860-714-8808	
Contact Person's e-mail Address	mtwohig@stfranciscare.org	

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Determination for prior acquisition and operation of an MRI by a private physician practice.
- b. Location of proposal, identifying Street Address, Town and Zip Code: 31 Sycamore St., Glastonbury, CT 06033
- c. List each town this project is intended to serve: Glastonbury, East Hartford, Wethersfield, Manchester, Rocky Hill, Newington, South Windsor, Hebron, Colchester, South Glastonbury, Vernon Rockville, Windsor, Cromwell, Marlborough, Bolton, East Hampton, and Middletown.
- d. Estimated starting date for the project: Contract was executed and payment made on June 31, 2005, see copy of check attached.
- e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P	E	P	E	P
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute Care Hospital		Imaging Center		Cancer Center	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Provider		Ambulatory Surgery Center		Primary Care Clinic	
<input type="checkbox"/>	<input type="checkbox"/>	x <input type="checkbox"/> Other (specify): <u>Private physician practice</u>			
Hospital Affiliate					

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: \$ 374,000.

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify: _____	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	\$374,000.
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space –Capital Leases Only	
Total Capital Cost	
Total Project Cost	\$374,000.
Capitalized Financing Costs (Informational Purpose Only)	

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
MRI	Siemens	Harmony, 1.0 T	1	\$374,000

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

- | | | |
|---|---|---|
| <input type="checkbox"/> Petitioner's Equity | <input checked="" 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. PROPOSAL DESCRIPTION

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

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

Radiology Associates of Hartford, P.C. has provided outpatient and inpatient diagnostic and interventional imaging services for over three decades in Connecticut.

All of our radiologists are board certified by the American Board of Radiology and American Osteopathic Board of Radiology. RAH radiologists are widely published in peer-reviewed literature, have authored books and actively lecture at local and national meetings. Our sub-specialty radiologists have advanced fellowship training in:

- CT
- MRI
- Breast Imaging
- Breast Biopsies
- Musculoskeletal
- Nuclear Medicine
- Neuroradiology
- Minimally Invasive / Interventional Radiology
- Vascular / Interventional Radiology
- Cardiovascular Imaging

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

No new services are proposed nor were any introduced with the 2005 acquisition of the MRI scanner.

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

RAH Glastonbury patient base has remained consistent from first use of the MRI equipment and this is the intended services area. It is made up of the towns listed in the response to prior question in Section IIc.

4. Identify the entity that will be providing the service(s).

RAH provides MRI services directly.

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

RAH bills for the MRI services.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service.

RAH leases the office space for the MRI scanner.

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

Not applicable.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

RAH is the sole applicant involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

RAH is a group of 19 physicians and does not have a organizational chart.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

Not applicable as RAH is the only entity involved.

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

The service serves Medicare, Medicaid, and third party insurance payers, as well as providing free care. These will continue to be the payer sources. (See attachment 3 for first patient bill.)

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Radiology Associates of Hartford, P.C.

Project Title: Determination for prior acquisition and operation of a MRI by a private physician practice

I, Michael Twohig, M.D., President
(Name) (Position – CEO or CFO)

of Radiology Associates of Hartford, PC being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Radiology Associates of Hartford, PC complies with the appropriate
(Facility Name)

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.

Michael Twohig 8-27-2009
Signature Date

Subscribed and sworn to before me on 08-27-2009

Bernadette Jensen
Notary Public/Commissioner of Superior Court

My commission expires: 04-30-2012

Attachment 1 – Vendor Contract

SIEMENS

May 25, 2005

Bernadette Jensen, CCP
Administrator
Radiology Associates of Hartford, P.C.
100 Asylum Avenue
Suite 2201-E
Hartford, CT 06105

Dear Ms. Jensen:

Siemens Medical Solutions USA, Inc. (hereinafter referred to as "Siemens" or "Lessor") is pleased to inform you that we herein commit to enter into an equipment lease/financing transaction with Radiology Associates of Hartford, P.C. (hereinafter referred to as "Lessee"), subject to the terms of this letter.

Lessor: Siemens Medical Solutions USA, Inc., its affiliates, assigns or nominees.
("Siemens")

Lessee: Radiology Associates of Hartford, P.C.

Guarantor				
Equipment Description / And Payments:	<u>EQUIPMENT</u>	<u>QUOTE #</u>	<u>PRICE</u>	<u>Mo 01 - 60</u>
	Used Harmony	80T-SXZ	\$374,000	\$7,362
	Used Harmony	1-3W5SFS	\$374,000	\$7,362
CT units include monthly cost of equipment	CT Emotion 6	1-435147	\$375,990	\$8,720
\$5,340+ monthly construction of \$1,380	CT Emotion 6	1-44N3FV	\$375,990	\$8,720
	CT Emotion 6	6WA-JC7	\$375,990	\$8,720

Equipment Locations: 31 Sycamore Commons, Glastonbury, CT
9 Cranbrook Boulevard, Enfield, CT
35 Nod Road, Avon, CT

Total Equipment Cost: It is anticipated that the Total Equipment Cost will not exceed the price set forth above.

Lease Term: 60 months.

Adjustments to Lease Payments: The above lease payments have been calculated on the basis of the Total Equipment Cost and the yield to maturity of the 5 year Treasury Note of 3.81% as published in the Wall Street Journal on 5/18/05 (the "Reference Date"). If there is a change in either the Total Equipment Cost or an increase in the Treasury Note rate between the Reference Date and the date the Lease commences, the lease payments will be adjusted accordingly.

End of Lease Term Options:

1. Renew the Lease at Fair Market Value.
2. Purchase the Equipment at Fair Market Value.
3. Return the Equipment.

CT Units:
End of Lease Option: Purchase The Equipment for \$1.00
MR Units:

Insurance:	Lessee, at its cost and expense, must provide evidence of satisfactory insurance coverages, which shall include physical damage, business interruption, and general liability in amounts and from carriers satisfactory to Siemens. Siemens, its successors and assigns, must be named on the appropriate policies as loss payee or additional insured, as its interest may appear, and a Certificate of Insurance, in form and substance acceptable to Siemens, is to be provided to Siemens prior to closing of the transaction.
Events of Default:	Customary events of default for a transaction of this type, as determined by Siemens.
Net Lease:	This will be a non-cancelable net lease transaction, whereby all costs for documentation, insurance, maintenance, filing, registration, search fees and taxes relating to the purchase, lease, ownership, possession and use of the Equipment and to the transaction, and all items of a similar nature, will be for Lessee's account.
Collateral:	Lessor shall have either an ownership interest in or first lien on all Equipment and other collateral, if any, securing the Lessee's obligations.
Documentation:	All documentation will be provided by Siemens. The standard documentation includes, but is not limited to, the following: <ol style="list-style-type: none"> 1. Master Equipment Lease Agreement 2. Leasing Schedule(s), Rider(s) and Addenda, as applicable 3. Guaranties, if required 4. UCC Financing Statement 5. Certificate(s) of Insurance 6. Secretary's Certificate 7. Landlord/Mortgagee Waiver 8. Siemens Debt Subordination Agreement 9. All other documents required by Siemens and its counsel. <p>Siemens may, at its discretion, order UCC, judgment, tax and similar searches against Lessee, at Lessee's cost and expense. Additional documentation and/or information may be required based upon the results of those searches.</p>
Credit Approval	You have been formally credit approved by Siemens, subject to the following conditions that are required to fulfil this commitment: <ol style="list-style-type: none"> 1. Non Refundable advance lease payment in the amount of \$34,884 due with return of signed Commitment Letter. Payment to be applied to the first lease payment due. <p>Lessee will subordinate all payments of dividends, distributions, management fees, or other compensation to any of the Lessee's shareholder-owners or members, if there is a default under the lease.</p>
Commitment Fee:	With your execution and return of this commitment letter, you shall pay to Siemens a non-refundable Commitment Fee equal to \$34,884.00. This amount will be applied to the last first Lease payment when the lease documents are executed.
Confidentiality:	This letter is delivered to you with the understanding that neither this letter nor its substance shall be disclosed by the Lessee to any third party except those who are in a confidential relationship with you, such as your legal counsel or accountants.
Acceptance:	Siemens must receive this commitment letter executed by Lessee on or before June 3, 2015 along with the non-refundable Commitment Fee, or this commitment shall expire and will no longer be effective unless extended in writing by Siemens.

The terms and conditions outlined herein are not all inclusive but rather constitute the principal business terms of our leasing commitment. Closing of this proposed transaction will be subject to, among other things, there having occurred no material adverse change in the Lessee's or any Guarantor's financial condition, business operations, business prospects or to the economic and regulatory conditions existing prior to the closing and, subject further, to the execution by Lessee, Guarantors and Siemens and delivery to Siemens of all documents required by Siemens, all in form and substance acceptable to Siemens. This commitment letter may be withdrawn or modified by Siemens at any time prior to Siemens' receipt of this commitment letter executed by Lessee and payment of the applicable Commitment Fee. Siemens shall have the sole right of assignability of this commitment letter or any lease between Lessee and Siemens. The provisions hereof supersede all prior and contemporaneous discussions, proposals or other correspondence with respect to the specific transaction described herein. All rates stated herein are based upon current money cost, tax rates and tax law assumptions. Should any changes occur, the rates may be adjusted in our discretion. Any changes or agreements between Siemens and the Lessee subsequent to the signing of this document must be in writing.

Please contact me if you have any questions or would like to discuss this commitment letter in greater detail. Upon our receipt of a properly countersigned copy of this commitment letter and the Commitment Fee, we shall promptly begin to prepare all documentation necessary to finalize the transaction.

Sincerely,

Tim Kehoe

Regional Finance Manager

ACKNOWLEDGMENT OF ACCEPTANCE:

The undersigned agrees to the terms and conditions of this commitment letter as set forth herein. Siemens and Lessee agree that if Lessee fails to have executed and delivered all documentation required by Siemens, that Siemens shall have no further obligation to Lessee with respect to the transaction described herein.

Agreed to and Accepted this 1 day of June, 2009

Lessee: <u>Radiology Associates of Hartford</u>	Siemens Medical Solutions USA, Inc.
By: <u>[Signature]</u>	By: <u>[Signature]</u>
Printed Name: <u>Jonathan Getz, M.D.</u>	Printed Name: <u>Mark Gallahan</u>
Title: <u>Treasurer</u>	Title: <u>P.R. - Risk Management</u>

Attachment 3 – Copy of redacted patient bill demonstrating when equipment was put in use.

1500 Restart # (1) Form (PRI) UNITED HEALTH CARE
030 PO BOX 740800
HEALTH INSURANCE CLAIM FORM ATLANTA, GA 30374

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA Line (HP)		Sta []		PICA []	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA SECLAW OTHER		1a. INSURED'S I.D. NUMBER (For Program Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)	
CITY STATE ZIP CODE TELEPHONE (include Area Code)		8. PATIENT STATUS		CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR REGA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. EMPLOYMENT? (Current or Former)		14. INSURED'S DATE OF BIRTH SEX	
15. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. AUTO ACCIDENT? PLACE (Street) ID		17. EMPLOYER'S NAME OR SCHOOL NAME	
16. SPINELLA ANTHONY MD		17. OTHER ACCIDENT? YES NO		18. INSURANCE PLAN NAME OR PROGRAM NAME	
17. LG B38468		18. RESERVED FOR LOCAL USE		19. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
18. 1508941584		19. YES NO If yes, return to and complete Item 9 d-d		20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
19. RESERVED FOR LOCAL USE		20. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (NPI)		21. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
20. 844.9		21. 17. ICD 9 B38468		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
21. 17. NPI 1508941584		22. FROM TO		23. OUTSIDE LAB? \$ CHARGES	
22. FROM TO		23. YES NO		24. MEDICARE RESUBMISSION CODE ORIGINAL REF NO	
23. FROM TO		24. YES NO		25. PRIOR AUTHORIZATION NUMBER	
24. FROM TO		25. YES NO		26. FEDERAL TAX I.D. NUMBER	
25. FROM TO		26. YES NO		27. PATIENT'S ACCOUNT NO	
26. FROM TO		27. YES NO		28. ADJURY ASSIGNMENT? YES NO	
27. FROM TO		28. YES NO		29. TOTAL CHARGE	
28. FROM TO		29. YES NO		30. AMOUNT PAID	
29. FROM TO		30. YES NO		31. BALANCE DUE	
30. FROM TO		31. YES NO		32. SIGNATURE OF PHYSICIAN OR SUPPLIER	
31. FROM TO		32. YES NO		33. SERVICE FACILITY LOCATION INFORMATION	
32. FROM TO		33. YES NO		34. BILLING PROVIDER INFO & PH #	
33. FROM TO		34. YES NO		35. SIGNATURE OF PHYSICIAN OR SUPPLIER	
34. FROM TO		35. YES NO		36. DATE	
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37. FROM TO		38. YES NO		39. DATE	
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185. FROM TO		186. YES NO		187. DATE	
186. FROM TO		187. YES NO		188. DATE	
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192. FROM TO		193. YES NO		194. DATE	
193. FROM TO		194. YES NO		195. DATE	
194. FROM TO		195. YES NO		196. DATE	
195. FROM TO		196. YES NO		197. DATE	
196. FROM TO		197. YES NO		198. DATE	
197. FROM TO		198. YES NO		199. DATE	
198. FROM TO		199. YES NO		200. DATE	
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200. FROM TO		201. YES NO		202. DATE	
201. FROM TO		202. YES NO		203. DATE	
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203. FROM TO		204. YES NO		205. DATE	
204. FROM TO		205. YES NO		206. DATE	
205. FROM TO		206. YES NO		207. DATE	
206. FROM TO		207. YES NO		208. DATE	
207. FROM TO		208. YES NO		209. DATE	
208. FROM TO		209. YES NO		210. DATE	
209. FROM TO		210. YES NO		211. DATE	
210. FROM TO		211. YES NO		212. DATE	
211. FROM TO		212. YES NO		213. DATE	
212. FROM TO		213. YES NO		214. DATE	
213. FROM TO		214. YES NO		215. DATE	
214. FROM TO		215. YES NO		216. DATE	
215. FROM TO		216. YES NO		217. DATE	
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240. FROM TO		241. YES NO		242. DATE	
241. FROM TO		242. YES NO		243. DATE	
242. FROM TO		243. YES NO		244. DATE	

RAH
RADIOLOGY ASSOCIATES OF HARTFORD, P.C.

1000 Asylum Avenue
Suite 3201E
Hartford, CT 06105
Phone: (860) 525-3322
Fax: (860) 714-8808

RECEIVED

2009 AUG 27 P 2: 13

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Fax

To: Cristine Vogel, Commissioner	From: Bernadette Jensen
Fax: 860-418-7053	Date: 08-27-2009
Phone: 860-418-7001	Pages: 13
Re: Letter of Determination	CC:

Urgent For Review Please Comment Please Reply Please Recycle

Comments:

Please see attached request for Letter of Determination

The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination or copy of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return all documents received to us at the address above via the U.S. Postal Service.

Thank you.

Radiology Associates of Hartford, P.C.

August 27, 2009

Page 1 of 12

RECEIVED

2009 AUG 27 P 2:13

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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

VIA Fax 860-418-7053

Re: Request for CON Determination for acquisition and operation of an MRI by a private physician practice in 2005.

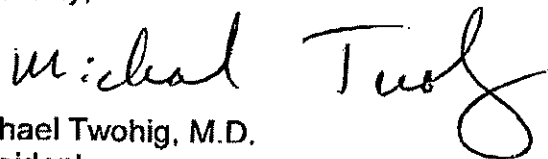
Dear Ms. Vogel:

We are filing a completed form 2020, as a request for a CON Determination for approval of a previous acquisition in 2005 of an MRI 1.0 Tesla mobile unit in Glastonbury, Connecticut by Radiology Associates of Hartford, P.C. and its operation.

We are submitting the original and required four copies by mail, as well.

If you have any questions concerning these responses, please feel free to contact Bernadette Jensen at our office, 714-7121.

Sincerely,



Michael Twohig, M.D.
President

Radiology Associates of Hartford, P.C.

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8/27/09



State of Connecticut Office of Health Care Access CON Determination Form Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Radiology Associates of Hartford, P.C.	
Doing Business As	Radiology Associates of Hartford, P.C.	
Name of Parent Corporation	Radiology Associates of Hartford, P.C.	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	1000 Asylum Avenue Suite 3201E Hartford, CT 06105	
What is the Petitioner's Status: P for profit and NP for Nonprofit	P	

Radiology Associates of Hartford, P.C.

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Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Michael Twohig, M.D., President	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	1000 Asylum Avenue Suite 3201E Hartford, CT 06105	
Contact Person's Telephone Number	860-714-5285	
Contact Person's Fax Number	860-714-8808	
Contact Person's e-mail Address	mtwohig@stfran ciscare.org	

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Determination for prior acquisition and operation of an MRI by a private physician practice.
- b. Location of proposal, identifying Street Address, Town and Zip Code: 31 Sycamore St., Glastonbury, CT 06033
- c. List each town this project is intended to serve: Glastonbury, East Hartford, Wethersfield, Manchester, Rocky Hill, Newington, South Windsor, Hebron, Colchester, South Glastonbury, Vernon Rockville, Windsor, Cromwell, Marlborough, Bolton, East Hampton, and Middletown.
- d. Estimated starting date for the project: Contract was executed and payment made on June 31, 2005, see copy of check attached.
- e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

<input type="checkbox"/> <input type="checkbox"/> Acute Care Hospital	<input type="checkbox"/> <input type="checkbox"/> Imaging Center	<input type="checkbox"/> <input type="checkbox"/> Cancer Center
<input type="checkbox"/> <input type="checkbox"/> Behavioral Health Provider	<input type="checkbox"/> <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> <input type="checkbox"/> Primary Care Clinic
<input type="checkbox"/> <input type="checkbox"/> Hospital Affiliate	x <input type="checkbox"/> Other (specify): <u>Private physician practice</u>	

Radiology Associates of Hartford, P.C.

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SECTION III. EXPENDITURE INFORMATION

- a. Estimated Total Project Cost: \$ 374,000.
- b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	\$374,000.
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space -Capital Leases Only	
Total Capital Cost	
Total Project Cost	\$374,000.
Capitalized Financing Costs (Informational Purpose Only)	

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
MRI	Siemens	Harmony, 1.0 T	1	\$374,000

Note: Provide copy of the vendor contract or quotation for the medical equipment.

- c. Check each applicable financing method or funding source to be used for the proposal:

<input type="checkbox"/> Petitioner's Equity	<input checked="" 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): _____

Radiology Associates of Hartford, P.C.

Page 5 of 12
8/27/09**SECTION IV. PROPOSAL DESCRIPTION**

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

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

Radiology Associates of Hartford, P.C. has provided outpatient and inpatient diagnostic and interventional imaging services for over three decades in Connecticut.

All of our radiologists are board certified by the American Board of Radiology and American Osteopathic Board of Radiology. RAH radiologists are widely published in peer-reviewed literature, have authored books and actively lecture at local and national meetings. Our sub-specialty radiologists have advanced fellowship training in:

- CT
- MRI
- Breast Imaging
- Breast Biopsies
- Musculoskeletal
- Nuclear Medicine
- Neuroradiology
- Minimally Invasive / Interventional Radiology
- Vascular / Interventional Radiology
- Cardiovascular Imaging

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

No new services are proposed nor were any introduced with the 2005 acquisition of the MRI scanner.

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

RAH Glastonbury patient base has remained consistent from first use of the MRI equipment and this is the intended services area. It is made up of the towns listed in the response to prior question in Section IIc.

4. Identify the entity that will be providing the service(s).

RAH provides MRI services directly.

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

RAH bills for the MRI services.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service.

RAH leases the office space for the MRI scanner.

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

Radiology Associates of Hartford, P.C.

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Not applicable.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

RAH is the sole applicant involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

RAH is a group of 19 physicians and does not have a organizational chart.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

Not applicable as RAH is the only entity involved.

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

The service serves Medicare, Medicaid, and third party insurance payers, as well as providing free care. These will continue to be the payer sources. (See attachment 3 for first patient bill.)

Radiology Associates of Hartford, P.C.

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SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Radiology Associates of Hartford, P.C.

Project Title: Determination for prior acquisition and operation of a MRI by a private physician practice

I, Michael Twohig, M.D. President
(Name) (Position – CEO or CFO)

of Radiology Associates of Hartford, PC being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my
knowledge, and that Radiology Associates of Hartford, PC complies with the appropriate
(Facility Name)

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.

Michael Twohig 8.27.2009
Signature Date

Subscribed and sworn to before me on 08-27-2009

Bernadette Jensen
Notary Public/Commissioner of Superior Court

My commission expires: 04-30-2012

Radiology Associates of Hartford, P.C.

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Attachment 1 – Vendor Contract

SIEMENS

May 25, 2005

Benedetto Jensen, CCP
Administrator
Radiology Associates of Hartford, P.C.
100 Asylum Avenue
Suite 3201-E
Hartford, CT 06105

Dear Ms. Jensen:

Siemens Medical Solutions USA, Inc. (hereinafter referred to as "Siemens" or "Lessor") is pleased to inform you that we herein commit to enter into an equipment lease/financing transaction with Radiology Associates of Hartford, P.C. (hereinafter referred to as "Lessee"), subject to the terms of this letter.

Lessor: Siemens Medical Solutions USA, Inc., its affiliates, assigns or nominees.
(“Siemens”)

Lessee: Radiology Associates of Hartford, P.C.

Guarantor:

**Equipment Description /
And Payments:**

CT units include monthly
cost of equipment
\$5,340+ monthly
construction of \$1,300

<u>EQUIPMENT</u>	<u>QUOTE#</u>	<u>PRICE</u>	<u>Mo 01 - 60</u>
Used Harmony	80T-8XZ	\$374,000	\$7,362
Used Harmony	1-3W5SFS	\$374,000	\$7,362
CT Emotion 6	1-435147	\$375,000	\$8,720
CT Emotion 6	1-44N8FV	\$375,000	\$8,720
CT Emotion 6	8WA-KC7	\$375,000	\$8,720

Equipment Locations: 31 Sycamore Commons, Glastonbury, CT
9 Cranbrook Boulevard, Enfield, CT
35 Rod Road, Avon, CT

Total Equipment Cost: It is anticipated that the Total Equipment Cost will not exceed the price set forth above.

Lease Term: 60 months.

**Adjustments to Lease
Payments:**

The above lease payments have been calculated on the basis of the Total Equipment Cost and the yield to maturity of the 5 year Treasury Note of 3.81% as published in the Wall Street Journal on 5/18/05 (the "Reference Date"). If there is a change in either the Total Equipment Cost or an increase in the Treasury Note rate between the Reference Date and the date the Lease commences, the lease payments will be adjusted accordingly.

**End of Lease Term
Options:**

1. Renew the Lease at Fair Market Value.
2. Purchase the Equipment at Fair Market Value.
3. Return the Equipment.

**CT Units:
End of Lease Option
MR Units:**

Purchase The Equipment for \$1.00

Radiology Associates of Hartford, P.C.

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8/27/09

Insurance:	Lessee, at its cost and expense, must provide evidence of satisfactory insurance coverages, which shall include physical damage, business interruption, and general liability in amounts and from carriers satisfactory to Siemens. Siemens, its successors and assigns, must be named on the appropriate policies as loss payee or additional insured, as its interest may appear, and a Certificate of Insurance, in form and substance acceptable to Siemens, is to be provided to Siemens prior to closing of the transaction.
Events of Default:	Customary events of default for a transaction of this type, as determined by Siemens.
Net Lease:	This will be a non-cancelable net lease transaction, whereby all costs for documentation, insurance, maintenance, filing, registration, search fees and taxes relating to the purchase, lease, ownership, possession and use of the Equipment and to the transaction, and all items of a similar nature, will be for Lessee's account.
Collateral:	Lessor shall have either an ownership interest in or first lien on all Equipment and other collateral, if any, securing the Lessee's obligations.
Documentation:	All documentation will be provided by Siemens. The standard documentation includes, but is not limited to, the following: <ol style="list-style-type: none"> 1. Master Equipment Lease Agreement 2. Leasing Schedule(s), Rider(s) and Addenda, as applicable 3. Guarantees, if required 4. UCC Financing Statement 5. Certificate(s) of Insurance 6. Secretary's Certificate 7. Lessor/Mortgagee Waiver 8. Siemens Debt Subordination Agreement 9. All other documents required by Siemens and its counsel. <p>Siemens may, at its discretion, order UCC, judgment, tax and similar searches against Lessee, at Lessee's cost and expense. Additional documentation and/or information may be required based upon the results of those searches.</p>
Credit Approval:	You have been formally credit approved by Siemens, subject to the following conditions that are required to fulfil this commitment: <ol style="list-style-type: none"> 1. Non Refundable advance lease payment in the amount of \$34,884 due with return of signed Commitment Letter. Payment to be applied to the first lease payment due. <p>Lessee will subordinate all payments of dividends, distributions, management fees, or other compensation to any of the Lessee's shareholder-owners or members, if there is a default under the lease.</p>
Commitment Fee:	With your execution and return of this commitment letter, you shall pay to Siemens a non-refundable Commitment Fee equal to \$34,884.00. This amount will be applied to the first Lease payment when the lease documents are executed.
Confidentiality:	This letter is delivered to you with the understanding that neither this letter nor its substance shall be disclosed by the Lessee to any third party except those who are in a confidential relationship with you, such as your legal counsel or accountants.
Acceptance:	Siemens must receive this commitment letter executed by Lessee on or before June 3, 2005 along with the non-refundable Commitment Fee, or this commitment shall expire and will no longer be effective unless extended in writing by Siemens.

Radiology Associates of Hartford, P.C.

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8/27/09

The terms and conditions outlined herein are not all inclusive but rather constitute the principal business terms of our leasing commitment. Closing of this proposed transaction will be subject to, among other things, there having occurred no material adverse change in the Lessee's or any Guarantor's financial condition, business operations, business prospects or in the economic and regulatory conditions existing prior to the closing and, subject further, to the execution by Lessee, Guarantors and Siemens and delivery to Siemens of all documents required by Siemens, all in form and substance acceptable to Siemens. This commitment letter may be withdrawn or modified by Siemens at any time prior to Siemens' receipt of this commitment letter executed by Lessee and payment of the applicable Commitment Fee. Siemens shall have the sole right of assignability of this commitment letter or any lease between Lessee and Siemens. The provisions hereof supersede all prior and contemporaneous discussions, proposals or other correspondence with respect to the specific transaction described herein. All rates stated herein are based upon current money cost, tax rates and tax law assumptions. Should any changes occur, the rates may be adjusted in our discretion. Any changes or agreements between Siemens and the Lessee subsequent to the signing of this document must be in writing.

Please contact me if you have any questions or would like to discuss this commitment letter in greater detail. Upon our receipt of a properly countersigned copy of this commitment letter and the Commitment Fee, we shall promptly begin to prepare all documentation necessary to finalize the transaction.

Sincerely,

Tim Kehoe

Regional Finance Manager

ACKNOWLEDGMENT OF ACCEPTANCE:

The undersigned agrees to the terms and conditions of this commitment letter as set forth herein. Siemens and Lessee agree that if Lessee fails to have executed and delivered all documentation required by Siemens, that Siemens shall have no further obligation to Lessee with respect to the transaction described herein.

Agreed to and Accepted this 1 day of June, 2005

Lessee: <u>Radiology Associates of Hartford</u>	Siemens Medical Solutions USA, Inc. <u>Mark Galbach</u>
By: <u>[Signature]</u>	By: <u>Mark Galbach</u>
Printed Name: <u>Jonathan Getz, MD</u>	Printed Name: _____
Title: <u>Treasurer</u>	Title: <u>PIR - Risk Management</u>

Radiology Associates of Hartford, P.C.

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8/27/09

Attachment 3 – Copy of redacted patient bill demonstrating when equipment was put in use.

1500 Restart # (1) Form (PRI) UNITED HEALTH CARE
030) PO BOX 740800
HEALTH INSURANCE CLAIM FORM ATLANTA, GA 30374
APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE DEMO

Line (EP) Sta [] PISA []

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX
 4. INSURED'S ID NUMBER (First Program in Part 1)
 5. INSURED'S NAME (Last Name, First Name, Middle Initial)
 6. PATIENT RELATIONSHIP TO INSURED
 7. INSURED'S ADDRESS (No. Street)
 8. PATIENT'S ADDRESS (No., Street)
 9. PATIENT STATUS
 10. IS PATIENT'S CONDITION RELATED TO:
 11. INSURED'S POLICY BACK OR PICA NUMBER
 12. INSURED'S DATE OF BIRTH
 13. EMPLOYER'S NAME OR SCHOOL NAME
 14. INSURED'S POLICY OR GROUP NUMBER
 15. EMPLOYER'S NAME OR SCHOOL NAME
 16. OTHER INSURED'S DATE OF BIRTH
 17. OTHER ACCIDENT? PLACE (State)
 18. EMPLOYER'S NAME OR SCHOOL NAME
 19. OTHER ACCIDENT?
 20. RESERVED FOR LOCAL USE
 21. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized person's signature is required for medical services to the insured person or member for services described below.)
 23. SIGNATURE ON FILE
 24. DATE OF CURRENT ILLNESS (From MM/YY To MM/YY) (Indicate if from previous or future illness)
 25. DATE PATIENT BECAME UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/YY TO MM/YY
 26. SIGNATURE ON FILE
 27. NAME OF REFERRING PHYSICIAN OR OTHER LICENSED PROVIDER (Last Name, First Name, Middle Initial)
 28. IDENTIFICATION NUMBER RELATED TO CURRENT REFERRAL FROM MM/YY TO MM/YY
 29. OUTSIDE LAB? YES NO
 30. ORIGINAL REF. NO.
 31. AUTHORIZATION NUMBER
 32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to ICD-9-CM, 4th Edition, Vol. 1)
 33. A. DATE(S) OF SERVICE FROM MM/YY TO MM/YY B. PROCESSED SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIER (Report Unusual Circumstances) E. DIAGNOSIS POINTS
 34. FEDERAL TAX ID NUMBER SSN EIN 35. PATIENT'S ACCOUNT NO. 36. ADJUSTMENT YES NO 37. TOTAL CHARGE 38. AMOUNT PAID 39. BALANCE DUE
 40. BILLING PROVIDER INFO & PIA (860) 525-3332
 41. SERVICE FACILITY LOCATION INFORMATION
 42. BILLING PROVIDER INFO & PIA (860) 525-3332
 43. SIGNATURE OF PHYSICIAN OR SUPPLIER (Indicate if the date is not the coverage end date and attach separate invoice.)
 44. RADIOLOGY ASSOC GLASTONBU
 31 SYCAMORE STREET
 GLASTONBURY, CT 06333
 45. BILLING PROVIDER INFO & PIA (860) 525-3332
 P O BOX 30893
 HARTFORD, CT 06150-
 46. SIGNATURE DATE
 47. A-1942234893

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0930-0901 FORM OMS-1500 (09-05)

Form 2020
Revised 11/08



STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 23, 2009

VIA FACSIMILE ONLY

Michael Twohig, M.D.
President
Radiology Associates of Hartford, P.C.
1000 Asylum Avenue
Suite 3201E
Hartford, CT06105

Re: CON Determination Report Number 09-31451-DTR
Radiology Associates of Hartford, P.C. - Glastonbury
Acquisition and operation of a 1.0 Tesla Mobile MRI Scanner by a private
physician practice in 2005.

Dear Dr. Twohig:

On August 28, 2009, the Office of Health Care Access ("OHCA") received a CON Determination Form 2020 regarding Radiology Associates of Hartford, P.C. ("Applicant") the acquisition and operation of a 1.0 Tesla Mobile MRI Scanner in 2005. OHCA has reviewed your request and makes the following findings:

1. Radiology Associates of Hartford, P.C. ("Applicant") is a for-profit entity that provides outpatient and inpatient diagnostic and interventional imaging services in Connecticut.
2. The Applicant currently operates the 1.0 Tesla Mobile MRI Scanner at 31 Sycamore Street, in Glastonbury, Connecticut.
3. On June 1, 2005, the Applicant agreed to and accepted the conditions of a lease commitment letter with Siemens Medical Solutions USA, Inc. ("Vendor") to acquire the 1.0 Tesla Mobile MRI Scanner at a cost of \$374,000.
4. The aforementioned lease included 4 other pieces of imaging equipment for the Applicant's other office locations.
5. The Applicant provided a copy of a check dated May 31, 2005 paid to the Vendor for the first lease payment due in the amount of \$34,884, out of which \$7,362 was applied toward the acquisition of the 1.0 Tesla Mobile MRI Scanner.

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 Applicant provided evidence demonstrating that a patient was scanned at its Glastonbury location with the 1.0 Tesla Mobile MRI Scanner on November 1, 2005.

Based on these findings, OHCA has determined that Certificate of Need approval is not required for the acquisition and operation of the 1.0 Tesla Mobile MRI Scanner because certain binding commitments were made prior to the implementation of Public Act 05-93 and the equipment was in operation prior to July 1, 2006.

If you have any questions concerning this letter, please contact Carmen Cotto at (860) 418-7001.

Sincerely,

A handwritten signature in cursive script, appearing to read "Cristine A. Vogel".

Cristine A. Vogel
Commissioner

CAV: cc

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO 0705
RECIPIENT ADDRESS 97148808
DESTINATION ID
ST. TIME 09/23 15:34
TIME USE 00'30
PAGES SENT 3
RESULT OK



STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MICHAEL TWOHIG, M.D. PRESIDENT
FAX: 714-8808
AGENCY: RADIOLOGY ASSOCIATES OF HARTFORD, P.C.
FROM: CARMEN COTTO
9/23/09
DATE: _____ TIME: _____
NUMBER OF PAGES: 3
(including transmittal sheet)

Comments: Docket 09-31451-DTR

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.