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

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 Assoicates of Hartford, P.C.	
Doing Business As	Radiology Assoicates of Hartford, P.C.	
Name of Parent Corporation	Radiology Assoicates 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	
☐☐	Acute Care Hospital	☐☐	Imaging Center	☐☐	Cancer Center
☐☐	Behavioral Health Provider	☐☐	Ambulatory Surgery Center	☐☐	Primary Care Clinic
☐☐	Hospital Affiliate	x☐	Other (specify): Private physician practice		

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.o 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:

☐	Petitioner's Equity	x	Capital Lease	☐	Conventional Loan
☐	Charitable Contributions	☐	Operating Lease	☐	CHEFA Financing
☐	Funded Depreciation	☐	Grant Funding	☐	Other (specify): _____

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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**

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

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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.

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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.

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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 (Name), President (Position – CEO or CFO)

of Radiology Associates of Hartford, PC (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Radiology Associates of Hartford, PC (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Michael Twohig
Signature

8-27-2009
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 26, 2005

Bernadette 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:

EQUIPMENT	QUOTE #	PRICE	Mo 01 - 60
Used Harmony	80T-8XZ	$374,000	$7,362
Used Harmony	1-3W5SFS	$374,000	$7,362
CT Emotion 6	1-435I47	$375,990	$6,720
CT Emotion 6	1-44N3FV	$375,990	$6,720
CT Emotion 6	6WA-JC7	$375,990	$6,720

CT units include monthly cost of equipment $5,340+ monthly construction of $1,380

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
MR Units: Purchase The Equipment for $1.00

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: 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. 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.
Credit Approval	You have been formally credit approved by Siemens, subject to the following conditions that are required to fulfill this commitment: 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. 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.
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, 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.

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: Radiology Associates of Hartford	Siemens Medical Solutions USA, Inc.
By:	By: Mark Gallagher
Printed Name: Jonathan Getz M.D.	Printed Name:
Title: Treasurer	Title: PR - Risk Management

Attachment 2 - Copy of Check for lease dated 5.31.05

RADIOLOGY ASSOCIATES OF HARTFORD
1000 ASYLUM AVENUE, SUITE 3201-E
HARTFORD, CT 06105
(860) 525-3322

FLEET NATIONAL BANK
HARTFORD, CT 06115
61-44/110

15900

5/31/2005

PAY TO THE ORDER OF Siemens Medical Solutions USA, Inc. $ **34,884.00

Thirty-Four Thousand Eight Hundred Eighty-Four and 00/100********** DOLLARS

Siemens Medical Solutions USA, Inc.
51 Valley Stream Pkwy.
Malvern, PA 19355

VOID AFTER 180 DAYS

MEMO

⑈015900⑈ ⑆011900445⑆ 93981 94183⑈

RADIOLOGY ASSOCIATES OF HARTFORD 15900

Siemens Medical Solutions USA, Inc.		5/31/2005	
Security Deposits	Commitment Fee (MRI+CT units)		34,884.00

Bank of America 34,884.00

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

1500 Restart # (1) Form (PRI)
030)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED HEALTH CARE
PO BOX 740800
ATLANTA, GA 30374

PICA Line (HP) Sta [ ] PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE SEX F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street)

CITY STATE | 8. PATIENT STATUS Single Married Other | CITY STATE

ZIP CODE TELEPHONE (Include Area Code) | Employed Full-Time Student Part-Time Student | 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 FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | b. AUTO ACCIDENT? YES NO PLACE (State) | b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 11/01/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SPINELLA ANTHONY MD | 17a. 1G B38468 | 17b. NPI 1508941584 | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 844.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 01 05	11 01 05	11		73721	LT	1	1045.00	1		NPI	1619963857
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]: 06-0935472 | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? YES NO | 28. TOTAL CHARGE $ 1045.00 | 29. AMOUNT PAID $ 0.00 | 30. BALANCE DUE $ 1045.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JONATHAN D GETZ MD

SIGNED 11/01/2005 DATE

32. SERVICE FACILITY LOCATION INFORMATION

RADIOLOGY ASSOC GLASTONBU
31 SYCAMORE STREET
GLASTONBURY, CT 06333

33. BILLING PROVIDER INFO & PH # (860) 525-3322

RADIOLOGY ASSOCIATES OF HARTF
P O BOX 30893
HARTFORD, CT 06150-
a. 1942234893

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

RAH
RADIOLOGY ASSOCIATES OF HARTFORD, P.C.
1000 Asylum Avenue
Suite 3201E
Hartford, CT 06105
Phone: (860) 525-3322
Fax: (860) 714-8808

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

Radiology Associates of Hartford, P.C.

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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 (Name), President (Position – CEO or CFO)

of Radiology Associates of Hartford, PC (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Radiology Associates of Hartford, PC (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Michael Twohig
Signature

8.27.2009
Date

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

Bernadette Johnson
Notary Public/Commissioner of Superior Court

My commission expires: 04-30-2012

Form 2020
Revised 11/08

Attachment 1 – Vendor Contract

SIEMENS

May 25, 2005

Bernadette 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 $1,350

EQUIPMENT	QUOTE #	PRICE	Mo 01 - 60
Used Harmony	80T-8XZ	$374,000	$7,352
Used Harmony	1-3W5SFS	$374,000	$7,352
CT Emotion 6	1-435I47	$375,990	$8,720
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** **MR Units:**	Purchase The Equipment for $1.00

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:

1. Master Equipment Lease Agreement
2. Leasing Schedule(s), Rider(s) and Addenda, as applicable
3. Guarantee, 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.

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.

Credit Approval: You have been formally credit approved by Siemens, subject to the following conditions that are required to fulfill this commitment:

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.

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.

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, 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.

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 liens 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: Radiology Associates of Hartford

By: _____

Printed Name: Jonathan Getz, M.D.

Title: Treasurer

Siemens Medical Solutions USA, Inc.

By: Mark Gallagher

Printed Name: Mark Gallagher

Title: Risk Management

Attachment 2 - Copy of Check for lease dated 5.31.05

RADIOLOGY ASSOCIATES OF HARTFORD
1000 ASYLUM AVENUE, SUITE 3201-G
HARTFORD, CT 06105
(860) 525-3322

FIRST NATIONAL BANK
HARTFORD, CT 06116
61-447/119

15900

5/31/2005

PAY TO THE ORDER OF Siemens Medical Solutions USA, Inc. $ **34,554.00

Thirty-Four Thousand Eight Hundred Eighty-Four and 00/100********** DOLLARS

Siemens Medical Solutions USA, Inc.
51 Valley Stream Pkwy.
Malvern, PA 19355

VOID AFTER 180 DAYS

MEMO

⑈015900⑈ ⑆011900445⑆ 93981 94183⑈

RADIOLOGY ASSOCIATES OF HARTFORD			15900
Siemens Medical Solutions USA, Inc.		5/31/2005	
Security Deposits	Commitment Fee (MRI+CT units)		34,554.00

Bank of America 34,554.00

Form 2020
Revised 11/08

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

1500 Restart # (030) 1) Form (PRI)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA Line (PP) Sta [ ]

UNITED HEALTH CARE
PO BOX 740800
ATLANTA, GA 30374

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in 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 Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

Employed Full-Time Student Part-Time Student

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 FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, return to and complete item 9 a-d.)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 11/01/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SPINELLA ANTHONY MD

17a. LG 538468

17b. NPI 1508941584

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 844.9

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 01 05	11 01 05	11		73721	LT	1	1045.00	1		NPI	1619963857
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 06-0935472 X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 1045.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 1045.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JONATHAN D GETZ MD 11/01/2005

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

RADIOLOGY ASSOC GLASTONBU
31 SYCAMORE STREET
GLASTONBURY, CT 06333

a.

b.

33. BILLING PROVIDER INFO & PH # (860) 525-3322

RADIOLOGY ASSOCIATES OF HARTF
P O BOX 30893
HARTFORD, CT 06150-

a. 1942234893 b.

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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.

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,

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

DATE: 9/23/09 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Docket 09-31451-DTR

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 Fax: (860) 418-7053