Connecticut Children's
MEDICAL CENTER

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

27 August, 2007

Dear Commissioner Vogel: Re: CCMC Farmington Radiology Satellite

Enclosed is a CON Letter of Intent Form 2030 for the above named project. Based upon your office's response to our Request for CON Determination for a similar project in Glastonbury, I was advised by Ms. Martone to submit a LOI for this one.

We look forward to your request for a full Certificate of Need application.

I will be the contact for this proposal. Please call me (860-545-9339) or email (Lbanco@ccmckids.org) if you have any questions or need further information.

Regards,

Leonard Banco MD.

Leonard Banco, MD
Vice President,
Regional Development

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 an Applicant, 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	Connecticut Children's Medical Center	RECEIVED 2001 AUG 29 A 11:30 OFFICE OF HEALTH CARE ACCESS
Doing Business As	Same	
Name of Parent Corporation	Connecticut Children's Medical Center Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	282 Washington Street Hartford, CT 06106	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	**Yes** No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Leonard Banco, MD VP, Regional Development	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	282 Washington Street Hartford, CT 06106	
Contact Person's Telephone Number	860-545-9339	
Contact Person's Fax Number	860-545-8558	
Contact Person's e-mail Address	Lbanco@ccmckids.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

CCMC Farmington Radiology Satellite

b. Type of Proposal, please check all that apply:

Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

New (F, S, Fnc)	Replacement	Additional (F, S, Fnc)
Expansion (F, S, Fnc)	Relocation	Service Termination
Bed Addition'	Bed Reduction	Change in Ownership/Control

Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

Project expenditure/cost cost greater than $ 3,000,000

Equipment Acquisition

New	Replacement	Major Medical (> $3,000,000)
Imaging	Linear Accelerator	

Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

399 Farmington Avenue, Farmington 06032

d. List each town this project is intended to serve: Avon, Farmington, Simsbury, Granby, Canton, West Hartford, Bristol, Burlington, Southington, Torrington, and to a lesser degree towns situated in proximity to Routes 44/202 and I-84 west of Hartford.

e. Estimated starting date for the project: October 15, 2007.

f. Type of project: 23
(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
DNA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 207,414

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

Medical Equipment Purchases	$	$ 39,833
Major Medical Equipment Purchases		$ 164,581
Non-Medical Equipment Purchases*		$ 3,000
Land/Building Purchases		-0-
Construction/Renovation		-0-
Other (Non-Construction) Specify:		-0-
Total Capital Expenditure	**$**	**$ 207,414**
Medical Equipment – Fair Market Value of Leases	$	-0-
Major Medical Equipment – Fair Market Value of Leases		-0-
Non-Medical Equipment – Fair Market Value of Leases*		-0-
Fair Market Value of Space – Capital Leases Only		-0-
Total Capital Cost	**$**	**$ 207,414**
Total Project Cost		**$ 207,414**

Capitalized Financing Costs (Informational Purpose Only)	$	-0-

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

Radiology Tables, aprons, shielding items

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows: **DNA**

No Yes

If you checked "Yes" above, please check the appropriate box below:

Energy Fire Safety Code Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Radiographic system	Shimadzu	Radspeed RSP-H-65kW	1	$78,650
Computed radiography	Konica	IQUE CR	1	$85,931

Note: Provide a copy of the vendor contract or quotation for the major medical/imaging equipment. **(Attached)**

d. Type of financing or funding source (more than one can be checked):

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

SECTION IV. PROJECT 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 items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services are being proposed and what DPH licensure categories will be

sought, if applicable.

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: Connecticut Children's Medical Center

Project Title: CCMC Farmington Radiology Satellite

I, Martin J. Gavin (Name), CEO (Position – CEO or CFO)

of Connecticut Children'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 Connecticut Children's Medical Center (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.

Martin J Gavin
Signature

August 15, 2007
Date

Subscribed and sworn to before me on August 15, 2007

R J Phillips
Notary Public/~~Commissioner of Superior~~ Court

Rebecca J. Phillips

My commission expires: 10/31/2011

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

30. Facility Development
31. Non-Medical Equipment
32. Land and Building Acquisitions
33. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
34. Renovations
35. Other Non-Clinical

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. **List the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.** Connecticut Children's Medical Center (CCMC) is licensed as a pediatric hospital and provides a full array of primary, secondary and tertiary care pediatric services. (Copy of license attached). Among those, it provides a full range of radiographic services for infants, children and adolescents, both as inpatients and outpatients. In FY06, approximately 52,000 studies and procedures were performed.

2. **List the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?** CCMC is proposing to establish a satellite ambulatory radiology center in Farmington that will provide diagnostic radiology services for infants, children and adolescents. Neither CT nor MRI services will be provided at this site. This center will support selected pediatric specialty services (Provided by CCMC Faculty Practice Plan), physical therapy services and services provided by the center for motion analysis within the same building. We do not anticipate seeking any new DPH licensure as part of this proposal, but will confirm that plan with DPH.

3. **Identify the current population served and the target population to be served**. CCMC currently provides services to children who reside in all of Connecticut's 169 towns. The Farmington site is projected to serve the pediatric population that lives primarily in Avon, Farmington, Simsbury, Granby, Canton, West Hartford, Bristol, Burlington, Southington and, Torrington, as well as a smaller number of patients from other towns proximate to Route 44/202 and I-84 West of Hartford. It is possible that children from towns outside of those areas will use the facility on an appointment-available basis.

4. **Identify any unmet need and describe how this project will fulfill that need.** At present, there are no radiology services specifically for children in the Farmington Valley or west of that area. Infants and children requiring radiographic studies must either travel to Hartford or have them performed by adult facilities. This project will provide equipment and materials appropriate to perform pediatric radiologic studies. The radiologic equipment will employ digital PACS technology, and will be linked to our system at CCMC in Hartford, facilitating comparison to films previously obtained as part of inpatient admissions and other ambulatory evaluations. Co-locating pediatric medical and surgical specialty services with pediatric radiology services allows a comprehensive evaluation to be performed in one visit, removing the need to schedule a separate appoint for an X-ray at a different site.

5. **Are there any similar existing service providers in the proposed geographic area?** There are no providers of pediatric radiology services in the proposed geographic area. University of Connecticut Health Center provides radiologic support for its NICU and Emergency Department, but does not support ambulatory pediatric studies. There are also private radiology offices distributed in and west of the Farmington Valley, but none provide pediatric radiology services primarily.

6. **Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.** As Connecticut's only free-standing children's hospital, CCMC is committed to providing the most appropriate level of care as close to where children live as possible. By establishing selected satellite locations for basic pediatric radiologic studies around greater Hartford, we hope to provide easier access for children and their families.

This distribution of service will also help relieve increasingly challenging parking and entry for ambulatory studies at our main Hartford site.

7. **Who will be responsible for providing the service(s).** CCMC will own the equipment and staff of CCMC will provide the diagnostic procedures. Depending upon the specific radiologic study, either surgical specialists or a radiology group whose physicians are members of the CCMC medical staff will provide professional services.

8. **Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?** At present, the major payers for services provided by CCMC are the various Medicaid Managed Care entities as well as Anthem/Blue Cross-Blue Shield, Connecticare and Aetna. We do not anticipate any payer changes after the proposed project becomes operational.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 2-CH

Children's Hospital

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

Connecticut Children's Medical Center of Hartford, CT, d/b/a Connecticut Children's Medical Center is hereby licensed to maintain and operate a Children's Hospital.

Connecticut Children's Medical Center is located at 282 Washington Street, Hartford, CT 06106

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

103 Licensed Bed
32 Bassinet

This license expires **December 31, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006.

License revised to reflect:
*Corrected bed capacity

Satellites

Neo-Natal Intensive Care Unit, North Building, Hartford Hospital

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

SourceOne
Healthcare Technologies
A Subsidiary of Merry X-Ray Corporation

MXR MERRY X-RAY
ELECTRONIC IMAGING DIVISION

Name	Diane Jay	**Quote #**	020107-04 Rev 9
Customer	Connecticut Children's Medical Center - Farmington	**Date**	04/19/07
Address	282 Washington Street	**Cust #**	24429865
City, State, Zip	Hartford, CT 06106	**Phone #**	860-545-9104

Merry X-Ray/SourceOne Healthcare Technologies is pleased to submit the following quotation and offers to sell the products described at the prices below, subject to your acceptance of the terms and conditions.

This quotation is valid for 60 days.

Catalog Number	Description	Qty	Unit Price	Extended Price

Service is our only product.

5900502	**Konica IQue CR Special Edition – Ultra Package** Computed Radiography System designed to meet the specific requirements of areas with more moderate image volumes. IQue CR Special Edition combines innovative systems' intelligence and unparalleled ease of use with the same reliable, proven reader platform used in higher volume areas. - REGIUS Model 190 High Capacity, Dual Bay Computed Radiography Reader o 62 Plates / Hour (14 x 17) o 58 Seconds Cycle Time o 12-bit Grayscale Output o Auto-Sensing 100/1000 mbps Network Interface o Uninterruptible Power Supply (UPS) - IQue Control Station w/ Uninterruptible Power Supply **Minimum configuration:** o Pentium IV, 2.16 GHz, 1GB RAM, CD-R, 15 LCD with 160 degree Viewing Angle o 80 GB HD **Includes:** o Automatic Exam View Recognition Feature o Self-Learning Image Processing Feature o Protocol Name o Reject Reason Tracking and Data Export o Free Text Annotation o Automatic and Manual Masking o Image Zoom o Equalization, Frequency, and Gradation Processing and Hybrid Processing o HIPPA compliance features (Audit trail, Auto log-out) **Also Includes** o DICOM Modality Worklist o DICOM Store (One connection) o Installation and Applications Training o (2) 14 x 17 Cassettes / Plates o (2) 10 x 12 Cassettes / Plates	1	$47,118.00	$47,118.00
5901021	**IQue Stitching Promotion 14x42** ▪ 14x42 Cassette/Plate Kit (5907342) ▪ Image Stitching Software XP – 1st CS (5900713) ▪ Mobile Cassette Holder (5071052)	1	$15,281.00	$15,281.00
414611	**DICOM Print – IQue**	1	$1,559.00	$1,559.00

Service is our only product.

5900183	**Barcode Reader – Plate Registration**	1	$656.00	$656.00
410573	**Xpress/IQue Cassette & Plate 10x12**	2	$655.00	$1,310.00
401505	**Xpress/IQue Cassette & Plate 8x10**	4	$561.00	$2,244.00
410574	**Xpress/IQue Cassette & Plate 14x17**	1	$679.00	$679.00
410453	**14x42 Cassette/Plate Kit (5907342)**	1	$5,736.00	$5,736.00
417172	**14x51 Cassette/Plate Kit (5907351)** One 14x51 Cassette Three 14x17 Cassettes Three 14x17 Image Plates Compatible with: Cassette Holder Wall Mount 14x51 (with 38" traveling distance) Mobile Cassette Holder Mount 14x51 (with 38" traveling distance)	1	$6,672.00	$6,672.00
5907336	**10x36 Stitching Cassette/Plate Kit**	1	$4,676.00	$4,676.00
		Total		**$85,931.00**

This does not include any applicable state or local taxes.

Please choose one of the following:

Funding Source: ☐ **Capital Funds** ☐ **Operating Funds** ☐ **Line of Credit**

☐ **Lease*** **Lessor:** _____

☐ **Bank Loan** **Name of Bank:** _____

* If order is being leased, a Leasing Company's Purchase Order is required.

Payment Terms: **20% down payment, 70% due upon delivery, 10% due upon availability of first clinical use. If customer order is less than $100,000.00, payment terms default to net 30 days from date of invoice. A down payment may be required pending a credit evaluation.**

Freight: **FOB Origin, freight charges are prepaid by Merry/SourceOne and will be added to your invoice for payment.**

Estimated Delivery: **90 days from receipt of order**

Service is our only product.

Installation: **Included in above price performed by Konica.**

Warranty: **One-year Parts, Labor and Applicable Preventative Maintenance**
4 Hours On-Site targeted response time
1 Hour Phone targeted response time
KMI rates for Service and Professional Services support:
Standard Rates Apply (8:30 am – 5:00 pm, Monday-Friday during non-holidays and those observed by KMI). Special rates apply for hours and holiday support

All orders are subject to credit approval.
Payment terms on purchase order must reflect those on the quote.

Note: A dedicated phone line or Secure VPN access is mandatory on all products that are capable of remote diagnostics. It is the customers responsibility both physically and financially to install or have installed and maintain such access. The customer understands that such access is secured by means of login ids and passwords and that all Merry/SourceOne personnel with such access have signed a letter of HIPAA compliance ensuring patient confidentiality.

Thank you for giving Merry X-Ray/SourceOne Healthcare Technologies an opportunity to quote these products. Please visit our Website at www.sourceonehealth.com. If you have any questions, please feel free to contact me.

CUSTOMER ACCEPTANCE AS QUOTED

Signature: _____

Date: 6/18/07

REQUESTED DELIVERY DATE

Date: _____

Mike Maynard
Merry X-Ray/SourceOne Healthcare Technologies
Account Executive
800-866-8509
michael.maynard@merryxray.com
Prepared by: L. Connors

Please fax your signed quotation and purchase order to 440-701-1413.

Service is our only product.

Merry X-Ray/SourceOne Healthcare Technologies' Service Contract Offerings

CR, Laser, ICAD, and Vidar Systems

☐ **Extended Full Service:** **(Labor, Parts, & Preventative Maintenance)**
(24 hours a day, 7 days a week, 365 days per year, including Holidays)

Coverage includes:
- All emergency and remedial labor and travel during contract hours.
- Preventative maintenance inspections during contract hours as per manufacturer's specifications.
- All replacement parts required to maintain system to manufacturer's specifications.
- Software updates as provided by manufacturer (not including hardware required to run the software updates).
- Priority dispatching.

Exclusions:
- Sub-assemblies and consumable items such as batteries, film, belts, chemistry, Optics units, and racks.
- Thermal print heads.

☐ **Full Service:** **(Labor, Parts, & Preventative Maintenance)**
(8:00am – 5:00pm, Monday-Friday, excludes weekends/ MXR/ MXR/S1 observed Holidays)

Coverage includes:
- All emergency and remedial labor and travel during contract hours.
- Preventative maintenance inspections during contract hours as per manufacturer's specifications.
- All replacement parts required to maintain system to manufacturer's specifications.
- Software updates as provided by manufacturer (not including hardware required to run the software updates).
- Priority dispatching.

Exclusions:
- Sub-assemblies and consumable items such as batteries, film, belts, chemistry, Optics units, and racks.
- Thermal print heads.

☐ **Preventative Maintenance:**
(8:00am – 5:00pm, Monday-Friday, excludes weekends/ MXR/S1 observed Holidays)

Coverage includes:
- All preventative maintenance labor and travel during contract hours.
- Preventative maintenance inspections during contract hours as per manufacturer's specifications.
- Software updates as provided by manufacturer (not including hardware required to run the software updates).

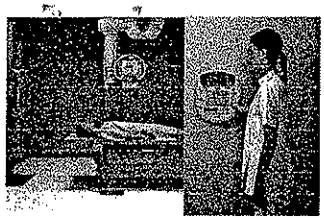
*** Service outside contract hours is subject to the prevailing overtime rates with a 4-hour minimum charge.**

- The start date of the agreement will go into effect 1-year after Customer Acceptance Date or First Clinical Use, whichever comes first.

In the future, our Service Specialist will contact you to discuss our point of sales offerings and work with you to design the right solution for your needs.

Please do not hesitate to contact us with any questions or concerns that you have regarding this or any other topics.

Thank you once again for considering Merry/SourceOne as your Business partner and supplier.



SHIMADZU

1

Quote Valid For 60 Days

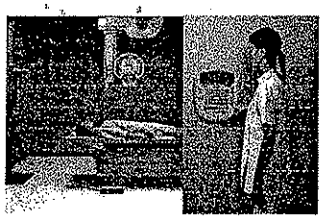
Config 6 RadSpeed Manual-H-50kw

Customer:	**CCMC Farmington Office**	**Office: MIS**
Attention:	Diane Jay	**Account Executive: Randy D. Lester**
		Specialist:
Quotation #	**L-07-101Rev 1**	**Code:**

This quotation is valid for (60) days.

Date of Quotation: _N/A_____

CUSTOMER ACCEPTANCE, AS QUOTED: THIS QUATATION IS SUBJECT TO ALL PROVISIONS AND CONDITIONS REFERENCED IN THE ATTACHED EXHIBITS A,B AND C. Customer Requested Delivery Date: _____ Name: _____ Title: _____ Signature: _____ Date: _____	BY: **MEDICAL IMAGING SYSTEMS, INC.** NAME: RANDY D. LESTER TITLE: PRESIDENT SIGNATURE: _____ DATE: 1-8-07
Comments: This proposal represents the modified system configurations for CCMC's Farminton facility.	



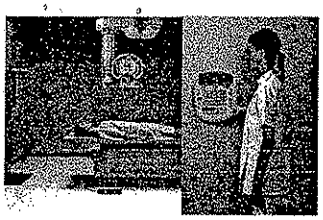
SHIMADZU

2

Quote Valid For 60 Days

Config 6 RadSpeed Manual-H-50kw

MODEL NUMBER AND QUANTITY	DESCRIPTION	Pricing
	SHIMADZU RadSpeed™ RSP(Manual)-H- 65kW Elevating Table Radiographic System	
Basic System Configuration	**Config 5 RadSpeed Manual-H-65kw**	
	RadSpeed Elevating Radiographic Table • Horizontal, elevating radiographic table • Vertical table Travel: – From 54 cm to 85 cm (21.25" to 33.5") • 4-way floating top – From 115 cm longitudinal Travel, and +/-12.5 cm transverse – Flat table top construction – **Maximum patient load of 295 kg (650 lbs.)** • 200/(208)/220/230/240V 1 kVA Single-phase incoming line • Permanent Electromagnetic locks; Locked without power. • Table Top Collision Protection Sensor • Small pedestal footprint • Standard Aluminum Grid (10:1 Ratio; 40 lines / cm; 40" focal distance) • Convenient and safe foot controls for elevation and locks • Designed to meet UL • Bucky Travel 40 cm. • Bucky with Photo timer; 3 field • Bucky tray accepts cassettes up to 14" by 17".	
BK-200		**Included**
UD150V-40	**RadSpeed 65 kW Generator:** • Three Phase High Frequency inverter, • 65 kW Rating, Three Phase • 380/400/415/440/480 Vac 3 Phase input power 75 KVA. • Color LCD Touch Screen Display • Large Readout for Ease of Viewing • Jog Dials for Manual Selection • Up / Down Buttons for Fine Manual Selection • kV mA, mAs and time adjusted with both up/down or dial.	**Included**

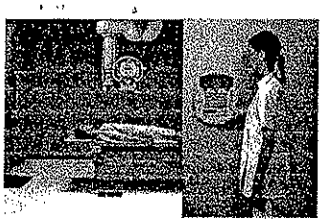


SHIMADZU

Quote Valid For 60 Days

Config 6 RadSpeed Manual-H-50kw

	• Easy View "Ready-Up" and Exposure Status Lamps on Generator and Handswitch • Micro Processor Controlled • Automatic Exposure Control • kV Range: 40-150 kV in 1kV increments. • mA Range: 10-800 mA (12 presets per Focal Spot) • mAs: .5-800 mAs; 500 mAs max with AEC. • Time Settings: 0.001 – 10 seconds • Anatomical Programmed Radiography (APR) • High Speed Starter • Self Diagnostic function with display of error codes • Wall Mounting Bracket	
CH200-M	**RadSpeed CH-200M Ceiling Tube Mount (Front Mount))** • 200/(208)/220/230/240V 1 kVA Single-phase incoming line • Large / Clear Digital Display • V/H (Vertical / Horizontal) angle display conversion • Eight programmable switches for locks (user customizable) • Easy-to-clean surfaces • Positive touch release operation handles for quick positioning • One-button full-way motion release • 3 way lock release, Vertical lock Release and collimator light switches on Rear of Tube Suspension • Spring balanced for easy movement • Reliable locking system allows any angulation to be held in position • Over Table X-Ray Tube; 400 KHU; (12 degree, 0.6 X 1.2 Focal) Vertical Travel – 160 cm (5' 3")	**Included**
2.6 X 4.0 Rails	**4.0 Meter Ceiling Rails** • Longitudinal rails 4.0 meters (13 ft. 1 inch) • Longitudinal Travel – 295 cm (9 ft. 8 inch) (286 cm w / Tomo) • Transverse Rails –260 cm (8'6") • Transverse Travel –200 cm (6'7")	**Included**
BR-120M	**RadSpeed BR-120M RadSpeed Wall Bucky Stand** • Extensive Vertical Travel to accommodate all patient ranges and studies	**Included**



SHIMADZU

Quote Valid For 60 Days

Config 6 RadSpeed Manual-H-50kw

	• Vertical travel: from 62.7 cm to 214.7 cm (24.68 to 84.5 inch) • Manual, electromagnetic locking system • Three-Field AEC Sensor System Standard Aluminum Grid; 10:1, 40 line/cm, 48-72" focal distance • Wall Stand Mounting Bracket	
	SHIMADZU RadSpeed™ RSP(Manual)-H- 65kW Elevating Table Radiographic System **List Price .....** **Customer Price Net Price .....**	**$114,600** **$75,900**
	SHIMADZU RadSpeed™ RSP(Manual)-H- 65kW Elevating Table Radiographic System Options	
	Table Options	
Auto-C	**Automatic Collimation Price.....**	**$ 2,750.00** YES
503-51628	**Table Patient Handgrip Price .....**	**$ 975.00** NO
501-23092-07	**Compression Band; Table Price .....**	**$1,295.00** NO
	Total	$ 78,650

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 4, 2007

Leonard Banco M.D.
Vice President, Regional Development
Connecticut Children's Medical Center
282 Washington St.
Hartford, CT 06106

RE: Certificate of Need Application Forms; Docket Number 07-31026-CON
Connecticut Children's Medical Center
Proposal to Establish a Radiology Satellite in Farmington

Dear Dr. Banco:

Enclosed are the application forms for Connecticut Children's Medical Center's Certificate of Need ("CON") proposal to establish a radiology satellite in Farmington with an associated capital expenditure of $207,414. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between October 28, 2007, and December 27, 2007.

When submitting your CON application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The OHCA analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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

Please complete all questions. If any question is not relevant to your project, a response of "Not Applicable" may be an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than October 28, 2007, and may be submitted no later than December 27, 2007. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number:	07-31026-CON
Applicant Name:	Connecticut Children's Medical Center
Contact Person:	Leonard Banco M.D.
Contact Title:	Vice President, Strategy & Regional Development
Contact Address:	Connecticut Children's Medical Center 282 Washington St. Hartford, CT 06106
Project Location:	Farmington
Project Name:	Proposal to Establish a Radiology Satellite in Farmington for Infants, Children and Adolescence
Proposal Type:	Section 19a-638, C.G.S.
Estimated Capital Expenditure:	$207,414

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

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: _____

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The unit of service for the past three fiscal years by service area town.
   d) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
   e) Scheduling backlogs in service area.
   f) Travel distance from the proposed site to service area towns.
   g) Hours of operation of existing and the proposed service.

ii) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

iii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Provide the units of service projected for the first three years of operation of the proposed service. Include the derivation/calculation.

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology
☐ National Committee for Quality Assurance
☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers
☐ American College of Obstetricians & Gynecologists
☐ American College of Surgeons
☐ Report of the Inter-Society Council for Radiation Oncology
☐ American College of Radiology
☐ Substance Abuse and Mental Health Services Administration
☐ Other: Specify _____

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

D. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH
☐ JCAHO
☐ Fire Marshall Report
☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC
☐ AAAASF
☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital, its physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, its physicians working at the Hospital and/or any staff related to the proposal.

G. Provide a copy of the related Quality Assurance plan.

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide a copy of the State of Connecticut Department of Public Health license currently held.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) 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 Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Capitalized Financing Costs	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

10. Construction/Renovation Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	___ Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	Please submit a schedule of depreciation for the purchased equipment as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

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12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:

i. Letter of interest from the lending institution.

ii. Letter of interest from CHEFA.

iii. Amortization schedule (if not level amortization payments).

iv. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please complete Financial Attachment I enclosed.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Please complete **Financial Attachment II**.

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.). *Note: Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

vii) Provide a copy of any "turn-around" plan which the Hospital may have in place concerning the Applicant/Hospital current financial position.

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

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

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

13.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:
# of Months in Operation

Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0