

Supplemental CON Application Form  
**Acquisition of Equipment**  
Conn. Gen. Stat. § 19a-638(a)(10),(11)

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**Applicant:**

**Project Name:**

## **Affidavit**

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

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

I, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Position – CEO or CFO)

of \_\_\_\_\_ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486, of the Connecticut General Statutes, and that all facts contained in this Certificate of Need application are true and correct to the best of my knowledge.

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Signature

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Date

Subscribed and sworn to before me on \_\_\_\_\_

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

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

## 1. Project Description: Acquisition of Equipment

- a. Provide the name of the legal entity that will acquire/own the equipment.
- b. Provide the name of the legal entity that will bill for imaging services performed on the new equipment.
- c. Will the acquired equipment be new or refurbished? Provide the age (if refurbished), manufacturer, model and number of slices/tesla strength of the proposed equipment.
- d. Will the acquired equipment be leased or purchased? Please describe the terms of the lease/purchase agreement.
- e. List each of the applicant's service sites and the imaging modalities currently offered by location.

## 2. Clear Public Need

- a. For new equipment, where are the patients in the proposed service area currently being served?
- b. Describe the benefits (e.g., clinical uses, technological advancements, etc.) of the equipment you are acquiring compared to your existing machines.
- c. Provide scholarly articles to validate the advantages of the proposed equipment.
- d. Complete **Table A** for each piece of equipment of the type proposed and currently operated at each of the applicant's service sites. Provide the name/address, equipment strength (e.g. slices, tesla strength) and state whether the unit is open or closed (for MRI), the days of the week the unit is operational, the start and end time for each day and the number of scans/exams performed on each unit for the most recently **completed** fiscal year. Identify the fiscal year months and type of volume (e.g., scans) being reported.

**TABLE A**  
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Equipment Description	Days/Hours of Operation	Utilization FY ____

- e. Provide the rationale for locating the proposed equipment at the service location.

### 3. Actual and Projected Volume

- a. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the applicant's existing and proposed pieces of **equipment** (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment.

In completing these tables, please adhere to the following:

- i) Identify each scanner or service and add lines as necessary. Break out inpatient/outpatient/ED volumes if applicable and **label** what the **volumes represent** (e.g., MRI scans) and the **fiscal year** reflected in the table.
- ii) For CFY periods greater than 6 months, report annualized volume and identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months.
- iii) If the first year of the proposal is only a partial year, provide the partial year and indicate the months included and then provide projections for the first three complete FYs - add columns as necessary.
- iv) Table B totals should match OHS Tables 4 and 6 from the CON Main Form.

**TABLE B**  
HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment	Actual <i>[Indicate Volume Type]</i> (Last 3 Completed FYs)			CFY Volume	Projected <i>[Indicate Volume Type]</i> (First 3 Full Operational FYs)		
	FY ____	FY ____	FY ____	FY ____ *	FY ____	FY ____	FY ____
<b>Total</b>							

\*Months include \_\_\_\_\_

- b. Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHS Table B.
- c. Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volumes by equipment.

#### 4. Cost Effectiveness

- a. How will the equipment acquisition improve the cost effectiveness of health care delivery in the region?
- b. How will patient costs for imaging services at the proposed service location be affected by the acquisition of the new equipment?
- c. In **Table C**, provide the historical and projected patient cost for imaging scans per commercially insured patient. Provide a detailed explanation of all assumptions used in the derivation/calculation and explain any increases or decreases that occur between FYs.

**TABLE C**  
**AVERAGE COST<sup>1</sup> OF SCAN PER COMMERCIALLY-INSURED PATIENT**

Historical		Projected	
FY _____	FY _____	FY _____	FY _____

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<sup>1</sup> Cost is defined as the total dollar amount paid by the insurer plus patient out-of-pocket costs (e.g., deductibles, co-pays)