LAWRENCE & MEMORIAL HOSPITAL

February 2, 2011

Kimberly R. Martone
Director of Operations
State of Connecticut
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Application to Acquire and Operate a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT

Dear Ms. Martone:

On January 28, 2011, we received your letter regarding the Certificate of Need Application for the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT.

According to the letter, as pursuant to section 19a-639a, applicants must file notice that an application is to be submitted not later than 20 days prior to submitting the CON application. Therefore, we could not submit our CON application and filing fee until February 2, 2011.

Attached to this letter is our resubmitted filing fee of $500.00. Please do not hesitate to contact me at (860) 442-0711, extension 2073, if you have any questions.

Sincerely,

Crista Durand
Vice President, Strategic Planning, Marketing, and Business Development

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☐ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 11-31682- **Check No.:** 252204
OHCA Verified by: **Date:** 2/4/11

☐ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 428-7053, at the time of the publication)***

☐ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☐ **Attached are completed Financial Attachments I and II.**

☐ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: **A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to the following email addresses: steven.lazarus@ct.gov and leslie.greer@ct.gov.**

Important: **For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.**

☐ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 25, 2011

Crista Durand, Vice President
Strategic Planning, Marketing, Business Development
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Certified Mail: 7005 0390 0001 3507 0859

RE: Certificate of Need Application Forms; Docket Number: 11-31681-CON
Lawrence & Memorial Hospital
Acquire and Operate a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT
Filing fee

Dear Ms. Durand:

On January 24, 2011, we received your Certificate of Need Application along with your check in the amount of $500.00. We are returning the check, as pursuant to section 19a-639a (b) the applicant must file notice that an application is to be submitted not later than 20 days prior to submitting the Certificate of Need Application. In light of the fact that the notice was published on 1/11, 1/12 and 1/13/11, you may not submit your CON application until February 2, 2011 or any date thereafter.

Please feel free to contact me if your have any questions at (860) 418-7001.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:SWL:lmg

Attachment: Check# 252204

DATE: 01/14/11

LAWRENCE & MEMORIAL HOSPITAL

L001817 CHECK NO: 252204

INVOICE NO.	DATE	DESCRIPTION	GROSS AMT.	DISCOUNT	NET AMOUNT
MRI CON	01/11/11		500.00	0.00	500.00

RECEIVED
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

VENDOR NO: L001817 ACCOUNTS PAYABLE

	GROSS AMT.	DISCOUNT	NET AMOUNT
TOTALS	500.00	0.00	500.00

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

LAWRENCE & MEMORIAL HOSPITAL
New London, CT 06320

51-57
119

DATE 01/14/11 CHECK NUMBER 252204

AMOUNT *****$500.00

VOID OVER 60 DAYS

PAY FIVE HUNDRED 00/100

TO THE ORDER OF TREASURER, STATE OF CONNECTICUT

AUTHORIZED SIGNATURE

CITIZENS BANK

⑈252204⑈ ⑆211170114⑆ 2202493780⑈

LAWRENCE & MEMORIAL HOSPITAL

January 14, 2011

Norma D. Gyle, R.N., Ph.D
Deputy Commissioner
State of Connecticut
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134

RE: Certificate of Need Application to Acquire and Operate a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT

Dear Deputy Commissioner Gyle,

Enclosed is the original Certificate of Need Application for the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT. Also enclosed are four copies of the application and a CD of the scanned application and documents in MS format.

I look forward to working with you and your staff during the review process.

Please do not hesitate to contact me at (860) 442-0711, extension 5185, if you have any questions regarding this application.

Sincerely,

Crista Durand, Vice President
Strategic Planning, Marketing, Business Development

cc: Shraddha Patel, Director of Business Development & Planning

LAWRENCE & MEMORIAL

Certificate of Need Application

Acquisition and Operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT

Lawrence & Memorial Hospital
365 Montauk Avenue, New London, CT 06320

Acquisition and Operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT

Table of Contents

Lawrence & Memorial Hospital
365 Montauk Avenue, New London, CT 06320

Acquisition and Operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT

Table of Contents (continued)

Acquisition of Equipment
Application Checklist

☐ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

OHCA Verified by:_____ Date:_____

☐ **Attached is evidence demonstrating that proper public notice has been published in a suitable newspaper that relates to the location of the proposal.**

☐ **Attached is a completed affidavit, signed and notarized by the appropriate individuals.**

☐ **Submitted is a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.**

☐ **Submitted is an electronic copy of the documents on CD in MS Word format with financial attachments and other data as appropriate in MS Excel format.**

☐ **Attached are completed Financial Attachments I and II.**

☐ **Submitted CON application materials, including cover letter and all attachments, have been paginated in their entirety.**

☐ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

CON Application Filing Fee

DATE: 01/14/11

LAWRENCE & MEMORIAL HOSPITAL

L001817 CHECK NO: 252204

INVOICE NO.	DATE	DESCRIPTION	GROSS AMT.	DISCOUNT	NET AMOUNT
MRI CON	01/11/11		500.00	0.00	500.00
VENDOR NO: L001817	ACCOUNTS PAYABLE	TOTALS	500.00	0.00	500.00

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

51-57
119

ANTI-FRAUD PROTECTION - PATENTS 5,197,765; 5,340,159

LAWRENCE & MEMORIAL HOSPITAL

New London, CT 06320

DATE 01/14/11

CHECK NUMBER 252204

AMOUNT *****$500.00

VOID OVER 60 DAYS

PAY FIVE HUNDRED 00/100

TO THE ORDER OF TREASURER, STATE OF CONNECTICUT

AUTHORIZED SIGNATURE

CITIZENS BANK

11CC (11-07) PRINTED BY STANDARD REGISTER U.S.A. IMAGE SEAL® Pat.

Details on back. Security Features Included

⑈252204⑈ ⑆211170114⑆ 2202493780⑈

The Day
47 Eugene O'Neill Drive
New London, CT 06320
860-442-2200
www.theday.com

Receipt

Account Number: D785
Order Number: d00297834

Salesperson: Mary Labasi | **Printed on:** 1/10/2011
Telephone: 860-701-4292 ext 4292 | **Fax:** (860) 442-5443
Email: m.labasi@theday.com

L&M HOSPITAL
ACCOUNTS PAYABLE
365 MONTAUK AVENUE
NEW LONDON, CT 06320
860-442-0711

Title: The Day | **Class:** Public Notices 010
Start date: 1/11/2011 | **Stop date:** 1/13/2011 |
Insertions: 3 | **Lines:** 0 ag

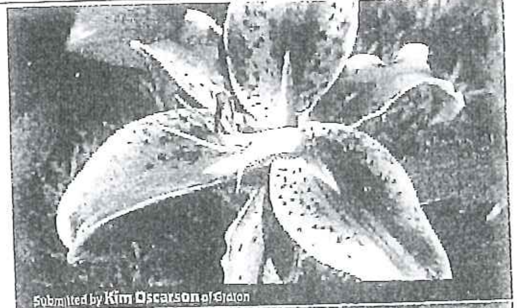
Title: Day Website | **Class:** Public Notices 010
Start date: 1/11/2011 | **Stop date:** 1/13/2011 |
Insertions: 3 | **Lines:** 0 ag

A preview of your ad will appear between the two solid lines.

10998
Legal Notice

Lawrence & Memorial Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statutes. The proposal includes the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads located at 196 Parkway South, Waterford, CT 06385. The total capital expenditure for the project is $ 3,250,210.

Payment Information
Total Order Price: $179.00
Payment Type: Invoice Payments | **Exp:**


Submitted by Kim Oscarson of Groton

READER PHOTO SUBMISSIONS: To have your photo appear here, email it to classphotos@theday.com

announcements | automotive | employment | financial | merchandise | rentals | real estate | animal/pets | boats/marinas

Public Notices

10977
Zoning Board of Appeals
Notice of Hearing

The City of Groton Zoning Board of Appeals will hold a Public Hearing on January 25, 2011, at 7:30 p.m. at the Municipal Building, 295 Meridian Street, Groton, to hear and act on the following matter:

ZBA Application #479, Applicants: Richard Hurne and Bethany Shippee, Property owner: Richard Foltz, property located at: 84 Poquonnock Road, are seeking to approve location of gasoline station and motor vehicle, per Section: 6.21e; To approve the location of gasoline stations, motor vehicle dealerships, and motor vehicle repair garages, as defined by State statutes, subject to prior Special Permit and Site Plan approval by the Planning and Zoning Commission and to the location requirements of Section 4.12 herein. PIN#168807581076

A copy of the application is on file for public inspection at the Office of the Zoning and Building Department, 295 Meridian Street, Groton, CT.

Dated at Groton, Connecticut, this 11th and 18th day of January 2011.

Zoning Board of Appeals
Dwaine Rugh, Chairperson

10992
ORDER OF NOTICE
STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS

NOTICE TO RONNIE RODGERS Formerly of New London, CT and presently of parts unknown
A petition has been filed seeking: Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.
The petition, whereby the court's decision can effect your parental rights, if any, regarding minor child(ren) will be heard on 3/1/11 @ 3:00 pm at the Superior Court, Juvenile Matters, 978 Hartford Tpke., Waterford, CT 06385
Hearing on an Order of

Public Notices

10994
TOWN OF SALEM
INLAND WETLANDS & WATERCOURSES COMMISSION
LEGAL NOTICE

The Town of Salem Inland and Wetlands & Watercourses Commission, through its authorized agent pursuant to §12.1 of the Town of Salem Inland Wetlands & Watercourses Regulations, took the following action on January 4, 2011:
#IWBUF#11-01-01 - Jon-Christopher Desautels owner, for property at 14 Rathbun Hill Rd. Regulated activity within 75' of a wetlands/watercourse for the purpose of installation of a 1000 gallon propane tank on a 2' x 2' platform. APPROVED W/ CONDITIONS
Respectfully submitted,
Jon C. Desautels
Property Owner

10996
TOWN OF LEDYARD
Notice

Pursuant to Section 7-394 of the Connecticut General Statutes, notice is hereby given that the Auditor's Report of the Town of Ledyard for the Fiscal Year Ending June 2005 has been received and is on file in the Office of the Town Clerk, 741 Colonel Ledyard Highway, and is available for public inspection during normal business hours.

Dated at Ledyard, Connecticut, this 4th day of January, 2006.

s/Calvin K. Brouwer, CMC/CCTC
Town Clerk

10998
Legal Notice

Lawrence & Memorial Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statutes. The proposal includes the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads located at 196 Parkway South, Waterford, CT 06385. The total capital expenditure for the project is $ 3,250,210.

P5777
Court of Probate, District of New London. Notice to

Public Notices

P5778
Court of Probate, District of New London. Notice to Creditors. ESTATE OF Martin K. Dirrane (11-0007) The Hon. Mathew H. Greene, Judge of the Court of Probate, District of New London, by decree dated January 6, 2011, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Eileen Bagwell, Assistant Clerk. The fiduciary is: Pauline Wyatt, 92 Butlertown Road, Waterford, CT 06385

P5779
Court of Probate, District of New London. Notice to Creditors. ESTATE OF Carol J. Lishing, AKA Carol J. Johnson (10-0463) The Hon. Mathew H. Greene, Judge of the Court of Probate, District of New London, by decree dated January 6, 2011, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Eileen Bagwell, Assistant Clerk. The fiduciary is: Frank Lishing, 75 Swan Avenue, Old Lyme, CT 06371

announcements

Notes of Interest

CT SCRAP: Will buy your scrap steel, copper & aluminum. 33 Pequot Rd, Uncasville 860-848-3366

automotive

Auto Parts & Accessories

ALLOY RIMS — SET OF 4

Automobiles

Audi A4 — 2004 Sedan AWD. Gray/Gray Lthr. 6-CD, Dual-Climate, Htd Seats, Dlr Serviced & Clean. Hwy Miles. $9750 Call 860-912-0570.

Dodge Dakota — 1987. 4X4, V6 Truck runs good has many new parts. To many to list. $999. Firm. Call 860-876-7186.

Dodge Stratus — 2006 white with gray interior. auto trans, cd, power everything, runs great 90k $5500 obo. w/warr. Call Al @ 860-625-5884

Ford Contour — 1999 Sedan.Green. Keyless Entry. Moonroof. 6-cyl. Auto. 101k $2000, 860-389-6329

JAGUAR X TYPE — 2007 Sport, GPS system, loaded, sunroof, leather. $16,999. 860-434-7197, 836-9386

NISSAN ALTIMA - 2002, 4DR, AT, 102K, CD, NICE! $5600. Call 860-514-0347

Saab 9-5 — 2005 wagon. Gray w/gray interior. AM/FM/CD player. Alarm system. 102000miles Runs great! Heated seats. $9200.00 860-536-4490

VOLVO 960 WAGON - 1995, 4DR, AT, 140K, Excellent! $2300. Call 860-514-0347

VOLVO S60 — 2006, excellent condition, 76K, light green, tan leather, sun roof, all extras, garaged $12,500, 941-893-7326

VW CABRIO-2001. GLS Convertible, 2DR, 5 SPD, 90K, Mint! $4500. 860-514-0347

Four Wheel Drive

Jeep Cherokee — Sport 2001 SUV. 6-cyl. Opt. 4-wheel dr. Black w/black interior. Tinted windows. AM/FM/CD player. Front/rear air cond. Dual airbags. Keyless entry. Sport package. Alloy wheels. Full pwr. 148,000 Excellent condition. $3900 860-235-4567 Rick

Trucks

Wanted Automotive

WE BUY CARS, TRUCKS & SUV'S All Makes & Models. Ask For Pete Sabo At: Bob Valenti Auto Mall. 860-536-4931.

employment

Automotive

Auto Tech: Experienced in diagnostics and emissions repairs. Precision Motors, Inc. Call 860-536-9235

Drivers

Clean CDL Class A
Frameless dump trailer and rolloff experience. Full time with benefits. Apply in person ONLY, Calamari Recycling, 20 Town Dump Rd., Essex. www.calamarirecycling.com

HARRY'S TAXI DRIVERS WANTED CASH DAILY
Call: 860-625-8773

Education

Cable Installation Technicians Needed
Must live within 30 mile radius of office, possess valid driver's license and pass pre-employment testing. Careers@ftsusa.net

General Help

HEAVY EQUIPMENT OPERATOR
Experience in a scrap yard pref'd, full time w/ benefits. Apply in person ONLY, 20 Town Dump Rd., Essex www.calamarirecycling.com

RETAIL — Full time Work in an upscale Lingerie Boutique. Apply at Zoe & Co., 69 High St, Westerly, RI.

Hotel / Restaurant / Food

WAIT STAFF & SOUS CHEF
Experience Required
Apply in Person:
Dev's On Bank
345 Bank St., New London

animal/pets

Dogs

ALL BREED PUPPIES
I-95, EXIT 42, ORANGE, CT
STATEWIDEPETS.COM
1-800-245-PETS

Chihuahuas — 2, 9 weeks, Female. Raised in w/kids. Ready for a home. $400. call 860-514-2042

ENGLISH SPRINGER SPANIEL PUPS - AKC Females,$650, Males, $550 Ready to Go! 860-889-3130

GERMAN SHEPHERD PUPS — AKC. Black/Tan. 1st shots, wormed, parents on site. $650. 401-624-6803

GOLDEN RETRIEVER PUPS: AKC, OFA hip certified, very calm, family raised, 9F, 3M, 1st shots, $900. Call 860-604-2117 or 860-871-4922. Ready to Go, February 5th.

Yorkshire Terrier Puppies — ADORABLE. Wormed and Shots. $800.00 each. Griswold. Chris (401) 742-4300

boats/marinas

Boats

Grady — 21 foot White Cuddy cabin lap streak 1974 Power boat. Excellent stability. Needs TLC. FREE YOU REMOVE CALL 860-443-6808

Supplies - Marine

Garelick Sport/Diver — 3 step ladder. White, 400lb cap. 38"x 13". Mounting hardware. $ 225.00. 860-884-3014

Golight Stryker — series 2-remote spotlight. New. $ 300.00. 860-884-3014

Raymarine SR50 — Weather & Sirius receiver. New - $ 250.00. 860-884-3014

Antiques/ Collectibles /Art

PINUP PLAYING CARDS — BY MIDWAY, 2 DECKS. ORIGINAL SEALED PACKS. 50's/60's. $35 OBO. 401-596-1314

WHEEL COVERS — 1864 CORVAIR MONZA, $5 EACH OR BO, 860-434-1481

WHEEL COVERS — FROM 1964 CORVAIR MONZA, SPYDER CENTER $10 OR BO, 860-434-1481

WIZARD OF OZ — Framed & matted First Day of Issue stamps & envelope. $35. 860-581-8231

Building Materials

Gen Tran — 30Amp power outlet box. New. $ 40.00ea. 860-884-3014

Generator 30amp — 12ft. power cord with twist lock plugs. New. $ 40.00 ea. 860-884-3014

Business & Office Equipment

COMMERCIAL KITCHEN — PREP TABLE. ALL STAINLESS STEEL. $335 OBO. 401-596-1314

Office Chair — Black, on rollers $25 401-315-2732

Cameras, Film, Photos

Camera Lens — MIRANDA-AUTO, 1:1.4, 50mm, $40 OR BO 860-434-1481

CAMERA LENS — SOLIGAR W/TELE-AUTO, 1:3.5, f=200 mm, W/CASE, $30 or BO, 860-434-1481

INSTANT CAMERA — REAR "KODAK PLEASER", NEVER USED, STILL IN BOX W/INSTRUCTION, $25 OR BO 860-434-1481

Camping Equipment

Tent 2-Room, — from Sears, used 3 times. $45.00, 860-535-1759.

Clothing

Cold Weather Gear — Spyder ski shirt Kids XL $15.00, Columbia Omni Dry Shirt Youth XL. $10.00. 860-434-3181.

LLBean Ski Bibs — Black Size: Kids M 10/12. $15.00

Coal, Wood & Fuels

FIREWOOD — Cut, sp delivered. Seasoned, and Green, $135. Call 514-8608

FIREWOOD — Cut, delivered, seasoned $235/cord depending cation. Call 860-912-

FREE WOODEN PALLETS
Good for firew you pick up at Day receiving 42 Atlantic Av New Londdon.

NICE FIREWOOD — cut & split size for st fireplace. $185.00/cor delivery 860-460-219 857-1941

SEASONED FIREWO quality hardwoods cu and delivered $200. $110.00 1/2 cord ca 439-0393 or 860-823

WOOD STOVE — West #2479 takes 2 - good condition $7 860-739-8179 Mike

WOOD STOVE — Mate - Firebrick lin wood, good co $175.00 860-460-57

Computer

BRAND NEW — IN SON Stylus Photo tra Hi-Def. Photo $125.00/860-389-5

Computer parts - video cards, netwo hard drives. Used/t to $15. Cash and ca 303-6614

Dell Inspirion — 53 All-1 Printer, VGA Webcam, Etherne Clean/Restored. $1 989-6522

Floor Covering/

Oriental Rug — 47"x65" burgundy, moss, w/ gold fr 401-315-2732

Free Ite

Baby Mattress Used about 3 y looks good. FREE! 2935

Pool Table — wit sticks - slightly center but probab

Public Notices

10997

City of New London
Connecticut
LEAD HAZARD REDUCTION PROGRAM
(L-HARP)
111 Union Street
New London, CT 06320
(860) 447-5245

INVITATION FOR BIDS

The City of New London, through the Lead Hazard Reduction Program (L-HARP), will receive bids for residential lead abatement for:

35 Willetts Avenue
New London, CT 06320

There shall be two (2) site inspections held at this property:

Wednesday, January 19, 2011 at 9:30 a.m.
Thursday, January 20, 2011 at 2:30 p.m.

A site inspection is mandatory for all contractors planning to bid. Sealed bids will be accepted at 111 Union Street, New London, Connecticut, until 2:00 p.m. on Friday, January 28, 2011.

At which time all bids will be opened publicly. Only bids by pre-registered contractors will be accepted.

Documents pertaining to the scope of work and specifications will be available at the site inspections. Addenda, if any, will be issued only to contractors who, by our records, have obtained the original specifications.

The City of New London hereby notifies all bidders that it will affirmatively insure that in any contract entered into pursuant to this advertisement, qualified Minority Business Enterprises will be afforded full opportunity to submit bids in response to this invitation and that they will not be discriminated against on the grounds of race, color, national origin, sex, mental retardation or physical disability including but not limited to blindness, in consideration for an award.

The City is an Equal Opportunity Employer and adheres to the practices of Fair Housing and Affirmative Action.

10962

LEGAL NOTICE OF PUBLIC HEARING
ZONING BOARD OF APPEALS
TOWN OF OLD LYME, CT

The Zoning Board of Appeals of the Town of Old Lyme will hold a Regular Meeting at Memorial Town Hall, in the first floor Meeting Room, 52 Lyme Street, Old Lyme, CT, on Tuesday, January 18, 2011 at 7:30 p.m. to conduct Public Hearings for the following:

Case 11-01 - Michael J. and Helen Francis, 81 Connecticut Road, request for variances to allow raising the existing structure to comply with the FEMA requirements

Public Notices

10970

LEGAL NOTICE

Pursuant to Conn. Gen. Stat. § 16-245n(d), the Department of Public Utility Control will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on Wednesday, January 19, 2011, at 10:30 a.m., in Docket No. 10-03-17 - Application of the Connecticut Clean Energy Fund for Approval of 2011-2012 Comprehensive Plan, to review the Connecticut Clean Energy Fund's submitted comprehensive plan for the July 1, 2010, through June 30, 2012 period. The Department may continue the hearing on additional dates, as deemed necessary. The public may call the Department's offices, at (860) 827-1553, option 4 (using a touch tone phone), commencing each day from 7:30 a.m., to be advised as to whether the hearing has been cancelled or postponed due to inclement weather. For information and the Notice of Hearing filed with the Secretary of State's Office, contact: Department of Public Utility Control, kimberley j. santopietro Executive Secretary.

10998

Legal Notice

Lawrence & Memorial Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statutes. The proposal includes the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads located at 196 Parkway South, Waterford, CT 06385. The total capital expenditure for the project is $ 3,250,210.

Automobiles

Dodge Stratus — 2006 white with gray interior. auto trans, cd, power everything, runs great 90k $5500 obo. w/warr. Call Al @ 860-625-5884

Ford Contour — 1999 Sedan.Green. Keyless Entry. Moonroof. 6-cyl. Auto. 101k $2000, 860-389-6329

JAGUAR X TYPE — 2007 Sport, GPS system, loaded, sunroof, leather. $16,999. 860-434-7197, 836-9386

NISSAN: Altima, 2002, 4DR, AT, 102K, CD, NICE! $5600. Call 860-514-0347

Saab 9-5 — 2005 wagon. Gray w/gray interior. AM/FM/CD player. Alarm system. 102000miles Runs great! Heated seats. $9200.00 860-536-4490

VOLVO 960 WAGON - 1995, 4DR, AT, 140K, Excellent! $2300. Call 860-514-0347

VOLVO S60 — 2006, excellent condition, 76K, light green, tan leather, sun roof, all extras, garaged $12,500, 941-893-7326

Four Wheel Drive

Jeep Cherokee — Sport 2001 SUV. 6-cyl. Opt. 4-wheel dr. Black w/black interior. Tinted windows. AM/FM/CD player. Front/rear air cond. Dual airbags. Keyless entry. Sport package. Alloy wheels. Full pwr. 148,000 Excellent condition. $3900 860-235-4567 Rick

Jeep Wrangler — 1995 convertible. 4-cyl. 5-spd. manual. Green w/tan interior. AM/FM/CD player. 160,000

Education

Cable Installation Technicians Needed
Must live within 30 mile radius of office, possess valid driver's license and pass pre-employment testing.
Careers@ftsusa.net

New London Technical School seeking P/T (2 nights 5:45-10:35) evening Electrical Systems Technician Program Instructor to teach in the following areas: mathematics, National Electric Code, conductors and wiring devices, AC/DC, low voltage wiring. Submit your resume to: nldirector@ridley.edu or fax to 860-442-3096

General Help

HEAVY EQUIPMENT OPERATOR
Experience in a scrap yard pref'd, full time w/ benefits. Apply in person ONLY, 20 Town Dump Rd., Essex
www.calamarirecycling.com

RETAIL — Full time Work in an upscale Lingerie Boutique. Apply at Zoe & Co., 69 High St, Westerly, RI.

Hotel / Restaurant / Food

WAIT STAFF & SOUS CHEF
Experience Required
Apply in Person:
Dev's On Bank
345 Bank St., New London

Manufacturing

Maintenance Mechanic — Performs maintenance and repair work to maintain machines, equipment and facilities requiring an advanced knowledge of general trade skills including electrical work. Submit resume & salary to mlaumiere@pccstructurals.com PCC Structurals, Groton.

Real Estate

New Career
Start fresh for 2011
Join one of the countries fastest growing Real Estate Companies. Full "In Field" hands on training. Costs provided. 5 and 10 week classes starting in Jan. Call 860-245-3605 x120, Vincent.
Weichert Realtors

Career & Vocational Training

FREE TRAINING: Based on Income. Office Technology Skills, MS Office, Culinary, CNA. Call OIC, 860-447-1731

financial

Business Opportunities

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WHEEL COVERS — 1864 CORVAIR MONZA, $5 EACH OR BO, 860-434-1481

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WIZARD OF OZ — Framed & matted First Day of Issue stamps & envelope. $35. 860-581-8231

Building Materials

GE 125A — main lug circuit panel. New. 8 full size slots. $ 30.00 860-884-3014

GE circuit — breakers 15A - $ 3.25ea, 20A - 3.50ea, 20A double pole - $ 8.00 ea. 860-884-3014

Gen Tran — 30Amp power outlet box. New. $ 40.00ea. 860-884-3014

Generator 30amp — 12ft. power cord with twist lock plugs. New. $ 40.00 ea. 860-884-3014

Overhead Door — Garage Door w/Opener 16'X9' Insulated w/ windows. Excellent/Like New condition. $500 860-389-0151

Square D — 70amp load center. 2 slots. New, with ground bar kit. Slimline 20A breaker. $ 30.00. 860-884-3014

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Pedestal Table — 4 ft round plus 2 ft leaf, 4 chairs with upholstered seats. Great condition. 4 yrs old. $450. 860-887-1198

PINE HUTCH — VINTAGE 78"H X48"W X18"D. WITH BRASS HINGES. VERY NICE. $265 OBO. 401-596-1314.

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TV: 32", $50. CARPET: 8ft x 10ft, Gray, $40. Call 860-443-0602

Household Goods

Fine Mikasa — China. Minerva Collection. Sets of Eight. Worth $400 buy for half price at $200 best/offer. 860-449-8058

JEWELRY BOX — Reed & Barton mahogany 15"W X 9.5"D X 7.25"H, 2 drawer & lift top $25. 860-581-8231

MANTEL CLOCK — Bulova Quartz, classic mahogany case, white face, black Roman numerals $25. 860-581-8231

Maytag Washer — Front loader, Neptune model 7 yrs. old, $ 75.00 Preston 860-778-5379

Melamine Dishware — incl trays, accent dishes, 50+ white and colors $35 401-

Machinery & Tools

Ridgid 2" — pipe strap wrench. New $20.00ea. 5" pipe strap wrench. New. $60.00. 860-884-3014

Snap-on 3/8" — dial face torque wrench. 600 inch lbs. max. $ 100.00. 860-884-3014.

Snow Pusher — True temper. Wood handle. Excellent condition. $10.00 860-884-3014

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Guitar-Fender Squire — Stratocaster. HOT Guitar!Also includes Silvertone amp. Deserves $100 call 860-908-0121

MUSIC STAND — & METRONOME Music stand $20; Metronome $15. 860-581-8231

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VIOLIN — Suzuki w/bow. Hardcase. Good condition. $120.00 Call 860-389-3745

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China — over 50 asst pcs + lg & med platter turq, rose &gold trim $70 401-315-2732

DVD Set — 3, new in box NBC's "The Greatest Generation". w/ Tom Brokaw-$15

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Public Notices

10897

NOTICE OF PETITION FOR SALE OF MOBILE MANUFACTURED HOME

To any person claiming an interest in a certain Mobile Manufactured Home, further described as a 1991 Spruce Ridge Mobile Home, VIN #50-11-1094 D, color Gray, owned by Brenda Langley, said mobile manufactured home being located at 52 Fair Acres Circle, Mystic, CT 06355, NOTICE IS HEREBY GIVEN that a hearing will be held on 1/27/2011 at 9:30 a.m., at the G.A. 10 courthouse located at 112 Broad St., New London, CT In the matter of Harrison Associates, LLC vs. Brenda Langely, et al, Docket #CV10-24007, wherein the plaintiff petitioner, Harrison Associates, LLC, is requesting the court to order it to conduct a public sale of said mobile manufactured home, and other relief as on file appears. Dated at New London, CT this 15th of December, 2010, BY THE COURT.

10953

PUBLIC HEARING

The Borough of Stonington Zoning Board of Appeals will on Thursday, January 20, 2011 at 7:30 PM hold a public hearing at Borough Hall, 26 Church Street, Stonington, CT, to hear and act on the following matter:

Application # Z 10-01: 4 Cannon Square, Stonington Historical Society, Owner, Mark Kepple, Applicant. Application for variances from Sections 2.4, 2.9.1.2, 2.9.2.1 and 5.3.3 of the Stonington Borough Zoning Regulations for construction of an addition to house an automated teller machine on the existing bank building. The property is located in the RP District.

Interested persons may be heard and written communications relative to the above may be received.

A copy of the application is on file for public inspection at the office of the Borough of Stonington Zoning Officer, Borough Hall, 26 Church Street, Stonington, CT.

The Borough of Stonington
Zoning Board of Appeals

Robert Montgomery
Chairman

10993

TOWN OF WATERFORD
ZONING BOARD OF APPEALS
NOTICE OF ACTION

The Zoning Board of Appeals of the Town of Waterford held a meeting on January 6, 2011. The following are the decisions of the Board:
APPROVED: Application #ZBA2010-018 – Appeal of Larry D. & Colleen M. Bronit, owners and applicants at 69 Miner Avenue, R20 Zone.
Copies of the applications are on file at the office of the Zoning Official, 15 Rope Ferry Road, Waterford, CT 06385.

Denise Ansell, Chairperson

10998

Legal Notice

Lawrence & Memorial Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statutes. The proposal includes the acquisition and operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads located at 196 Parkway South, Waterford, CT 06385. The total capital expenditure for the project is $ 3,250,210.

Automobiles

JAGUAR X TYPE — 2007 Sport, GPS system, loaded, sunroof, leather. $16,999. 860-434-7197, 836-9386

Saab 9-5 — 2005 wagon. Gray w/gray interior. AM/FM/CD player. Alarm system. 102000miles Runs great! Heated seats. $9200.00 860-536-4490

VOLVO S60 — 2006, excellent condition, 76K, light green, tan leather, sun roof, all extras, garaged $12,500, 941-893-7326

Four Wheel Drive

Jeep Cherokee — Sport 2001 SUV. 6-cyl. Opt. 4-wheel dr. Black w/black interior. Tinted windows. AM/FM/CD player. Front/rear air cond. Dual airbags. Keyless entry. Sport package. Alloy wheels. Full pwr. 148,000 Excellent condition. $3900 860-235-4567 Rick

Jeep Wrangler — 1995 convertible. 4-cyl. 5-spd. manual. Green w/tan interior. AM/FM/CD player. 150,000 Dependable. $3200.00 860-961-9941 Awesome in the snow

Trucks

Ford F250 — Super Duty 2009 truck 8-cyl. 5 speed automatic transmission Gray 6500 miles., Snow plow pkg.,trailer towing pkg.,5th wheel tow hitch. 4x4 off road pkg. Great condition. Asking $27,000. 860-376-1043

Toyota Tundra — 2000 Access Cab 4WD, V-8, 4.7 Liter w/Towing Package. 117,000 miles. New Frame! $8,000. Call 860 536-4726

Vans

Chrysler Handicap — Town & Country 2006 Minivan 6-cyl. Auto. 48,000 Excellent condition. Includes power ramp and new power chair. Asking $27,000 860-376-1043

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New London Technical School seeking P/T (2 nights 5:45-10:35) evening Electrical Systems Technician Program Instructor to teach in the following areas: mathematics, National Electric Code, conductors and wiring devices, AC/DC, low voltage wiring. Submit your resume to: nldirector@ridley.edu or fax to 860-442-3096

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Full Time. Fast Paced Newspaper Publishing Group Is Looking For A Data Entry Clerk. Position Including Vendor maintenance, Receiving, Verifying & Entering Invoices. A working knowledge of Windows Based Software & Great Plains a plus. Full benefits.
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860-664-1083

Part Time/Seasonal

Curtin Transportation Currently seeks Drivers For its morning shift. 6am-10am, Mon-Fri & Other drivers for afternoon shift. 1pm-4pm. Seniors & Others urged to apply. Call Kitty or Joe regarding the positions. 860-443-1655

animal/pets

Dogs

ALL BREED PUPPIES
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1-800-245-PETS

ENGLISH SPRINGER SPANIEL PUPS - AKC Females,$650, Males, $550 Ready to Go! 860-889-3130

GERMAN SHEPHERD PUPS — AKC. Black/Tan. 1st shots, wormed, parents on site. $650. 401-624-6803

GOLDEN RETRIEVER PUPS: AKC, OFA hip certified, very calm, family raised, 9f, 3M, 1st shots, $900. Call 860-604-2117 or 860-871-4922. Ready to Go, February 5th.

Yorkshire Terrier Puppies — ADORABLE., Wormed and Shots. $800.00 each. Griswold. Chris (401) 742-4300

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Grady — 21 foot White Cuddy cabin lap streak 1974 Power boat. Excellent stability. Needs TLC. FREE YOU REMOVE CALL 860-443-6808

Supplies - Marine

Garelick Sport/Diver — 3 step ladder. New. 400lb cap, white, mounting hardware. $ 225.00. 860-884-3014

Golight Stryker — series 2-remote spotlight. New. $ 300.00. 860-884-3014

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Antiques/ Collectibles /Art

Adding Machine — Monroe model LA7-160, $10 OR BO, 860-434-1481

GLASS INSULATORS — VINTAGE, VERY DECORATIVE. GREAT GIFT/PAPERWEIGHT. $10EA/10FOR $70, 401-596-1314

LOCOMOTIVE TYCO — GOLDEN EAGLE DOUBLE ENDER HO LOCOMOTIVE. $75 OBO. 401-596-1314

PINUP PLAYING CARDS — BY MIDWAY, 2 DECKS. ORIGINAL SEALED PACKS. 50's/60's. $35 OBO. 401-596-1314

WHEEL COVERS. — 1864 CORVAIR MONZA, $5 EACH OR BO, 860-434-1481

WHEEL COVERS — FROM 1964 CORVAIR MONZA, SPYDER CENTER $10 OR BO, 860-434-1481

WIZARD OF OZ — Framed & matted First Day of Issue stamps & envelope. $35. 860-581-8231

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Preview at 4:00PM
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Building Materials

Bostitch — galv. clipped head wire collated stick nails. 16D,12D,10D, staples, finish nails. $ 80.00. 860-884-3014

GE 125A — main lug circuit panel. New. 8 full size slots. $ 30.00 860-884-3014

GE circuit — breakers 15A - $ 3.25ea, 20A - 3.50ea, 20A double pole - $ 8.00 ea. 860-884-3014

Gen Tran — 30Amp power outlet box. New. $ 40.00ea. 860-884-3014

Generator 30amp — 12ft. power cord with twist lock plugs. New. $ 40.00 ea. 860-884-3014

Overhead Door — Garage Door w/Opener 16'X9' Insulated w/ windows. Excellent/Like New condition. $500 860-389-0151

Square D — 70amp load center. 2 slots. New, with ground bar kit. Slimline 20A breaker. $ 30.00. 860-884-3014

Business & Office Equipment

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Camera Lens — MIRANDA-AUTO, 1:1.4, 50mm, $40 OR BO 860-434-1481

CAMERA LENS — SOLIGAR W/TELE-AUTO, 1:3.5, F=200 mm, W/CASE, $30 or BO, 860-434-1481

INSTANT CAMERA — REAR "KODAK PLEASER", NEVER USED, STILL IN BOX W/INSTRUCTION, $25 OR BO 860-434-1481

Clothing

Cold Weather Gear — Spyder ski shirt Kids XL $15.00, Columbia Omni Dry Shirt Youth XL. $10.00. 860-434-3181.

LLBean Ski Bibs — Black Size: Kids M 10/12. $15.00 860-434-3181.

Men's Suits — most sz 42, asst colors $30 each 401-315-2732

AFFIDAVIT

Applicant: **Lawrence & Memorial Hospital**

Project Title: **Acquisition and Operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT**

I, Bruce Cummings, President and Chief Executive Officer of Lawrence & Memorial Hospital being duly sworn, depose and state that Lawrence & Memorial's information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature

1/12/11
Date

Subscribed and sworn to before me on 1/12/11

Jacqueline E Cooper
Notary Public/~~Commissioner of Superior Court~~

JACQUELINE E. COOPER
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2013

My commission expires: 6/30/13

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

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:	
Applicant:	Lawrence & Memorial Hospital
Contact Person: **Contact Title:**	Ms. Shraddha Patel Director of Business Development & Planning
Contact Person's Address:	365 Montauk Avenue New London, CT 06320
Contact Person's Phone Number:	(860) 442-0711 ext. 5185
Contact Person's Fax Number:	(860) 444-3716
Contact Person's Email Address:	spatel@lmhosp.org
Project Town:	Waterford
Project Name:	Acquisition and Operation of a 3.0 Tesla Magnetic Resonance Imaging Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT
Statute Reference:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$3,250,210

Project Description: Acquisition of Equipment

a. Please provide a narrative detailing the proposal.

Response:
Lawrence & Memorial Hospital (L&M Hospital) is a 308-bed acute care hospital located in New London, CT. L&M Hospital proposes to acquire and operate a fixed 3.0 Tesla (3T) Magnetic Resonance Imaging Scanner (MRI) at L&M Diagnostic Imaging at Crossroads in Waterford, CT, which is located within the Hospital's primary service area (PSA). The following imaging modalities are currently offered at L&M Diagnostic Imaging at Crossroads: CT scan, ultrasound, general radiology, digital mammography, and bone densitometry.

A CON was initially granted by OHCA on September 22, 2006 under Docket Number 05-30661 to L&M Systems (LMS), a for-profit and wholly owned subsidiary of Lawrence & Memorial Corporation (the parent corporation of L&M Hospital), and Ocean Radiology Associates, P.C. (ORA) to operate a freestanding imaging center in Waterford, CT. The imaging center was known as Southeastern Connecticut Imaging Center (SCIC) and provided CT scan, ultrasound, general radiology, mammography, and bone densitometry services. On February 1, 2010, LMS, L&M Hospital, and ORA received approval from OHCA to (1) transfer ownership of SCIC to LMS, (2) dissolve SCIC, and (3) transfer the business and operating assets of the former SCIC from LMS to L&M Hospital (Docket Number 09-31413-CON). Ownership transfer was effective March 1, 2010 and the name of the imaging center was changed to L&M Diagnostic Imaging at Crossroads.

L&M Hospital currently operates two fixed 1.5 Tesla (1.5T) MRIs. The units are located at L&M Hospital's main campus in New London, CT and at Pequot Health Center in Groton, CT. Both locations serve outpatients (scheduled and add-ons) and MRI scans generated through the emergency department. In addition, the main campus MRI provides imaging scans to inpatients.

Both units are currently operating extended business hours, yet are above or near capacity and are constrained in their ability to accommodate additional volume. Backlogs for scheduled outpatient appointments are becoming more severe due to increases in demand for outpatient MRI services, coupled with increased use of MRI by inpatients and emergency department patients. Outpatients appointments are frequently rescheduled leading to decreased timeliness in patient diagnosis and treatment. In addition, inpatients and emergency department patients experience delays in scanning which similarly impact diagnosis and treatment, as well as length of stay. To mitigate access issues, L&M Hospital offers MRI services seven days a week with daily hours that can extend to 11pm on an as needed basis. Further extension of operating hours to add capacity is no longer possible. Testing past 8 or 9pm on any day of the week for outpatients is challenging as patients do not prefer testing so late. In addition, testing past 9pm is also a dissatifier for inpatients for the same reason; however, it sometimes is the only time these patients can be fit in.

L&M Hospital has experienced steady growth of MRI volume since FY 2006. Demographic trends, use rate increases, as well as L&M Hospital's strategic priorities are expected to drive continued growth in demand and utilization of MRI services in the region and at L&M Hospital. The issues with access that L&M Hospital is experiencing are expected to worsen unless a third MRI is added to the system. Adding a third MRI will allow L&M Hospital to shift outpatient volumes from existing sites, freeing up capacity for inpatients and emergency department patients and allowing outpatient appointments to be scheduled at reasonable times of day. The addition of a third MRI will also allow L&M Hospital to accommodate expected growth that will result from increased demand. The proposed location in Waterford is ideal for outpatients due to its proximity to major highways and roadways. In addition, the MRI unit would be a complementary service to the existing imaging services offered at the center and would also complement physician practices located within the building (e.g., the orthopedic, oncology, surgery). The proposed scanner is expected to be in operation initially Monday through Thursday (7:30am-6pm), Friday (7:30am-4:30pm), and Saturday (7:30am-2:30pm).

L&M Hospital proposes to add a 3T MRI as its third unit. The 3T model of MRI will be the first of its kind in the region and New London County. 3T MRI technology has been recognized to boost imaging quality and consistency over 1.5T and lower Tesla machines. Scans on a 3T MRI are faster which reduces the likelihood of image degradation as a result of patient motion, while increasing patient throughput. Also the resolution of the 3T system is higher, resulting in improved image clarity and detection of disease at an earlier stage.

MRI services at L&M Hospital are accredited by the American College of Radiology (ACR). L&M Hospital plans on applying for accreditation for the proposed third MRI as soon as possible. L&M Hospital is also accredited by the Joint Commission. All quality requirements of these organizations have been met.

Within the Hospital's PSA which is the same region as the proposal's proposed service area, there is only one other provider of MRI services. Groton Open MRI, which operates a low field MRI, is located in Groton, CT. In towns nearby to the proposed service area, there are other providers of MRI services; however, Tesla strength of these machines does not exceed 1.5T. The closest known Connecticut providers of 3T MRI technology are located in New Haven, CT and Hartford, CT.

In summary, through this project, L&M Hospital would like to alleviate access issues on its existing MRIs and prepare for expected increases in market demand for MRI services through the addition of a third MRI. By adding 3T technology, L&M Hospital will offer a service new to the region that is expected to improve quality of care through enhanced imaging capabilities.

b. Provide letters that have been received in support of the proposal.

Response:
Refer to Attachment A for letters received in support of the proposal. Select issues identified with current MRI services at L&M Hospital include:

- Increased difficulty accessing MRI services for inpatients and emergency department patients due to congestion on scanners from outpatients
- Increased wait times for outpatient appointments
- Patient inconvenience for rescheduled or untimely testing
- Delayed diagnosis and treatment

c. Provide the Manufacturer, Model, Number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

Manufacturer	Model	Tesla Strength
Siemens	Magnetom Verio	3.0 Tesla

d. List each of the Applicant's sites and the imaging modalities and other services currently offered by location.

Response:

L&M Imaging Modalities and Other Services by Location					
Facility:	**L&M Hospital**	**Pequot Health Center**	**L&M Medical Office Building in Old Saybrook**	**L&M Diagnostic Imaging at Crossroads**	**Stonington Walk-in Clinic**
Town:	**New London, CT**	**Groton, CT**	**Old Saybrook, CT**	**Waterford, CT**	**Stonington, CT**
Diagnostic Radiology	*	*	*	*	*
CT Scan	*	*	Not Available	*	Not Available
MRI	*	*	Not Available	Proposed	Not Available
Ultrasound	*	*	*	*	*
Cardiovascular Ultrasound	*	*	Not Available	*	*
Mammography	*	*	*	*	*
Bone Density	Not Available	*	Not Available	*	*
Nuclear Medicine	*	Not Available	Not Available	Not Available	Not Available
PET (mobile)	*	*	Not Available	Not Available	Not Available
Laboratory	*	*	Not Available	Not Available	*
Inpatient Services	*	Not Available	Not Available	Not Available	Not Available
Emergency Department Services	*	*	Not Available	Not Available	Not Available

Note: * denotes modality or service offered at location.

2. Clear Public Need

a. Explain why there is a clear public need for the proposed equipment. Provide evidence that demonstrates this need.

Response:
The addition of a third MRI to L&M with 3T technology represents a system-wide strategy to increase access to state-of-the-art imaging services for residents of the proposed service area.

The need for a third MRI within L&M system is based on the following factors:

1. Increasingly constrained ability to respond to current and future needs due to the following:
    a. Scheduling backlogs for outpatients
    b. Testing delays for inpatients, emergency department patients, and outpatients
    c. Inability to expand beyond already extended scheduled hours of operation
    d. Existing equipment operating above or near optimal capacity
2. Increasing demand for MRI services due to the following:
    a. Increasing use rates due to aging of population and new clinical applications
    b. Population growth within L&M's service area
3. Demand for MRI services in the proposed service area exceeds available capacity
4. Consistent year-over-year increases in MRI volume at L&M Hospital historically
5. L&M Hospital strategic initiatives that will result in additional MRI volume

The need for 3T technology within L&M system is based on the following factors:

1. Enhanced capabilities with 3T compared to 1.5 Tesla or lower field MRIs
2. Lack of 3T technology in the proposed service area or in nearby towns
3. Physician and patient preference for advanced imaging

Additional detail regarding the factors impacting the need for a third MRI and 3T technology is provided below.

Rationale for the Third MRI No. 1

Scheduling Backlogs

A review of scheduling backlogs identified significant wait times for outpatient appointments for MRI scans at L&M's existing facilities. The data in the Table A was compiled using an analysis of 24 weeks of scheduling backlogs by facility and scan type during the time period of July 5, 2010 through December 27, 2010 (refer to Attachment B for detailed statistics by week). The average wait time for an appointment is presented in days.

Table A

Average Scheduling Backlog in Days for MRI Comparison of Data for July 2010 vs. December 2010					
		Month of July 2010		Month of December 2010	
Scan Type		Main Campus	Pequot Health Center	Main Campus	Pequot Health Center
MRI Brain (Adult)		0	0	4	3
MRI Knee		0	0	4	3
MRI Lumbar Spine		0	0	4	3
MRI Shoulder		0	0	4	3
MRI Breast		1	0	5	4

Source: L&M Hospital Data: MRI Wait Times.

According to Table A, there have been significant backlogs or wait times for appointments for MRI services at both sites and for all scan types. The scheduling backlogs exist at L&M despite extended hours for MRI services at both sites (refer to "Scheduled Hours of Operation" section for additional detail). Appointment availability is a significant factor in patient satisfaction as noted by The Advisory Board Company in its recent publication, "Outlook for Outpatient Imaging Growth, Executive Briefing for Hospital Executives and Radiology Leaders."[1] In addition to being a patient dissatisfier, increasing wait times for appointments can delay diagnosis and treatment, which may impact health status and quality of care.

Following the addition of the proposed third MRI in Waterford, outpatient volume from the main campus and Pequot Health Center will be shifted to the new 3T MRI unit (using the central scheduling system) to eliminate MRI backlogs for outpatients, and improve timely access to MRI services for inpatients and/or emergency department patients at the existing sites.

Testing Delays

Timely access for inpatients and/or emergency department patients has been an issue as noted in the letters of support from L&M medical staff physicians (refer to Attachment A for letters of support). According to the letters of support for the proposal, the significant MRI outpatient volume has impacted the ability of L&M to scan inpatients and emergency department patients in a timely manner. This often delays diagnosis and care delivery, and can prolong a patient's length of stay. The increased need for MRI services in the emergency department diagnosis process is likely to add more strain to the available capacity and further exacerbate delays. In the letters of support, physician note that by adding an addition MRI in an outpatient location, this will allow more capacity at

[1] The Advisory Board Company. Outlook for Outpatient Imaging Growth, Executive Briefing for Hospital Executives and Radiology Leaders, October 2010. Page 9.

the main campus for inpatients and more capacity at both existing sites for emergency department patients.

In addition, to accommodate emergent testing, scheduled outpatients or add-ons are frequently delayed or rescheduled to another date. This can be a patient dissatisfier as patients often have made accommodations to their personal or work schedules to complete testing. Also, similar to delays for inpatients and emergency department patients, delays in testing for outpatients can impact timely diagnosis and treatment and potentially health status.

Scheduled Hours of Operation

An expansion of hours of operation in response to the existing scheduling backlog is not feasible. Both the main campus and Pequot Health Center sites offer MRI services seven days a week with scheduled appointments on most days until 9pm and with extended hours on an as needed basis until 11pm.

Currently, the main campus MRI operates 104.5 hours per week and beyond that timeframe on an as needed basis. On the main campus, at times the MRI operates until 11pm for inpatients and emergency department patients who cannot access the MRI during the earlier hours. This is a patient dissatisfier as inpatients prefer not to have tests completed so late in the day. Delay in testing, as noted previously, can delay diagnosis and treatment and can add to length of stay, impacting both quality of care and timely discharges.

Pequot Health Center's MRI operates 93.5 hours per week and beyond that timeframe on an as needed basis. It is difficult to expand outpatient hours of operation past 9pm as patients rarely prefer to complete testing so late in the day. There are also greater issues with access to transportation for patients without an automobile or a driver's license due to limitations on public transportation during these hours in the town of Groton.

Even with extended hours, L&M Hospital has reached and exceeded its optimal utilization for its MRI units as demonstrated in the next section.

Existing MRI Units Operating Above or Near Capacity

L&M Hospital operates two MRI scanners currently, one at the main campus and the other at Pequot Health Center. Both scanners operate seven days a week and are available for procedures up to 15.5 hours per day. Table B includes the current utilization percentage of each MRI unit within L&M Hospital and for both units combined. Based on average hours per week (refer to Table 1 for hours of operation per day), time per patient visit, weeks in operation per year, and scans per patient, the main campus's maximum capacity is 7,250 scans and Pequot Health Center's maximum capacity is 6,480 scans. In FY 2010, the main campus operated at 87% utilization, while Pequot Health Center operated at 74% utilization. Combined, L&M Hospital's MRIs operated at 81% utilization in FY 2010.

Table B

MRI Scan Volume Compared to Equipment Capacity, FY 2010			
	Main Campus	**Pequot Health Center**	**L&M Hospital – Both Units**
Number of MRI Units	1	1	2
Average Hours per Week	104.5	93.5	99.0
Time per Patient Visit (minutes)	45.0	45.0	45.0
Weeks per Year	52	52	52
Scans per Patient	1	1	1
Maximum Scans	7,245	6,483	13,728
Current Scan Volume (FY 2010)	6,285	4,816	11,101
Current Utilization (FY 2010)	87%	74%	81%

Optimal or targeted utilization for MRI units is 80% based on industry standards. In 2008, an established health care consulting firm with national experience, Health Strategies & Solutions, Inc, 1628 JFK Boulevard, Suite 500, Philadelphia, PA 19103, was engaged by L&M Hospital to complete a market-based demand analysis and capacity analysis for select imaging modalities, including MRI. In their analysis, Health Strategies & Solutions employs 80% utilization as the targeted planning operating assumption (refer to Attachment C for excerpt of their study showing this key assumption). A targeted utilization rate of 80% is appropriate to recognize variability from inpatient and emergency department use, urgent same day requests, routine maintenance, staff training, and equipment repair.

L&M Hospital is operating above the optimal utilization level. This severely limits L&M Hospital's ability to respond to the anticipated increase in demand for MRI scans in the proposed service area. The third MRI is expected to be operational in FY 2012. Without the new MRI, the two existing MRIs would need to operate at over 85% utilization to accommodate expected volume increases from market growth, market share increases, and increases in inpatient and emergency department-related MRI volumes. This scenario is depicted in Table C. Approaching 90% utilization would exacerbate scheduling backlogs and further delay care for all patient types (inpatient, emergency department, and outpatient (scheduled and add-ons)). Table C also indicates the utilization percentage at targeted FY 2015 volumes. L&M would not be able to achieve targeted FY 2015 volume projections with two MRI units without significant wait times, delays, and impacts on timely testing, diagnosis, and treatment.

Table C

MRI Scan Volume Compared to Equipment Capacity for L&M Hospital - Both Sites, Projected FY 2012 and FY 2015			
	L&M Hospital - Both Sites		
	FY 2012	FY 2015	
Number of MRI Units	2	2	
Average Hours per Week	99.0	99.0	
Time per Patient Visit (minutes)	45.0	45.0	
Weeks per Year	52	52	
Scans per Patient	1	1	
Maximum Scans	13,728	13,728	
Projected Scan Volume	11,795	13,491	
Projected Utilization	86%	98%	

Rationale for the Third MRI No. 2

Increased Use Rates and Market Demand for MRI Services

Studies have suggested that the demand for MRI services will increase due to population growth and utilization or use rate (scans per 1,000 population) increases. One study completed by Siemens Healthcare (refer to Appendix D) shows use rates in Connecticut increasing at 4% annually from 113.0 scans per 1,000 population in 2009 to 138.0 scans per 1,000 population in 2014. Several factors impact use rate growth including aging of the population, advancements in imaging capabilities (e.g., 3T), and new clinical applications for testing (e.g., breast MRI). In addition, a concern for radiation exposure with CT scanning is also likely to increase MRI utilization.

In the proposed service area, the portion of residents over age 65 is expected to increase from 13.9% to 15.2% between 2009 and 2004 (refer to Table D).

Table D

Population Age 65 and Above and Portion of Total Population Age 65 and Above		
	2009	2014
Proposed Service Area	24,331 (13.9%)	26,995 (15.2%)
Connecticut	487,531 (13.9%)	550.098 (15.4%)

Source: Claritas.

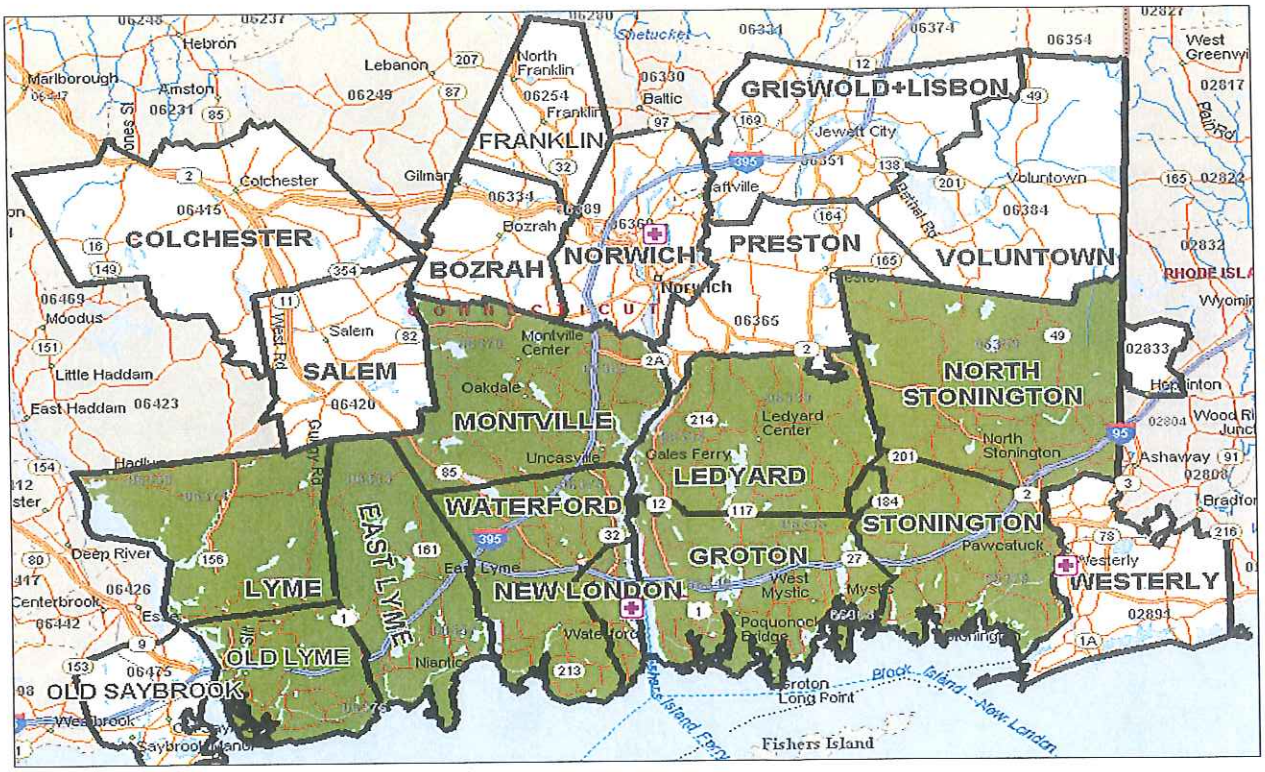
The aging of the population contributes to health care services demand increases, and in this case, contributes to MRI use rate increases experienced in Connecticut and the proposed service area.

Based on population estimates from Claritas (noted in Table E to follow), those use rates equate to total market scans of 19,710 in the proposed services area in 2009 which increases to 24,520 by 2014. Therefore, the market demand for MRI services in the

proposed service area is expected to increase by 4% annually. As demonstrated in "Rationale for the Third MRI No. 3" in section 2a, demand for MRI services exceeds MRI capacity.

Population Growth

The proposed MRI is expected to serve L&M's PSA (refer to map below) which includes the following towns: New London, Groton, Ledyard, Stonington, North Stonington, Montville, East Lyme, Waterford, Lyme, and Old Lyme.



The population within the ten PSA towns is projected to increase by 1.9% between 2009 and 2014 (refer to Table E). Population growth coupled with expected use rate increases will increase the market demand for MRI services in the proposed service area or PSA. Without adequate MRI capacity, there will be significant unmet need for MRI services in the proposed service area.

Table E

	Population			Percent Increase	
	2000	2009	2014	2000-2009	2009-2014
PSA Towns					
East Lyme	18,107	19,164	19,761	5.8%	3.1%
Groton	43,741	47,204	48,850	7.9%	3.5%
Ledyard	14,643	14,885	15,029	1.7%	1.0%
Lyme/Old Lyme	9,422	9,305	9,258	-1.2%	-0.5%
Montville	18,314	19,655	20,324	7.3%	3.4%
New London	25,687	25,665	25,667	-0.1%	0.0%
North Stonington	4,993	5,172	5,271	3.6%	1.9%
Stonington	14,118	14,174	14,218	0.4%	0.3%
Waterford	19,137	19,203	19,304	0.3%	0.5%
Total PSA	**168,162**	**174,427**	**177,682**	3.7%	1.9%

Source: Claritas.

Rationale for the Third MRI No. 3

Market Demand for MRI Services in the Proposed Service Area Exceeds Available Capacity

As noted in "Rationale for the Third MRI No. 2" above, total market scans are expected to be 19,710 in 2009 and 24,520 by 2014. There are currently only three MRI scanners in the proposed service area (refer to section 2c and 2d iv). Based on the scheduling backlog at L&M Hospital, there seem to be a significant unmet demand for MRI services in the proposed service area.

Although utilization at Groton Open MRI (a non-L&M Hospital MRI provider in the proposed service area) is not known, it is estimated that the optimal maximum volume of that facility, based on current hours of operation (refer to section 2b), equates to 2,614, assuming 80% utilization of the unit (refer to Table F). Utilizing a similar methodology for L&M Hospital's MRIs, the optimal maximum volume is 5,796 for the main campus MRI and 5,186 for the Pequot Health Center MRI. Table F displays the current optimal maximum supply of scans assuming current hours of operation for each facility and 80% targeted utilization rates. Based on the market demand, there is a significant discrepancy between the available capacity of the three MRIs in the proposed service area and the demand for MRI services from the residents located within the proposed service area.

Table F

	Number of Units	Time per Patient Visit (min.)	Avg. Hours per Week	Ave. Weeks per Year	Scans per Patient	Max. Scans	Scans at 80% Util-ization
L&M Hospital MRI	1	45.0	104.5	52	1.00	7,245	5,796
Pequot Health Center	1	45.0	93.5	52	1.00	6,483	5,186
Groton Open MRI	1	45.0	49	50	1.00	3,267	2,614
TOTAL	3	45.0				16,995	13,596

Based on Table F, the three existing MRI scanners' available capacity cannot meet the current or future demand for MRI services. Due to the constraints on available resources in the proposed service area, residents are likely seeking services outside of the proposed service area, are waiting for available appointments, or are choosing to forgo testing altogether. Even assuming a 10% outmigration rate of proposed service area residents to sites outside the proposed service area, the market demand of 17,740 scans in 2009 still exceeds available supply (17,740 calculated as follows: 19,710 – ((1-0.90)*19,710) = 17,740).

Projecting forward to FY 2012 (the year the proposed unit will begin operations), with a population of 176,368 and use rate of 127.4 (refer to Table L for population and use rate statistics), the market demand for MRI will be 22,470 scans. Demand exceeds available capacity during the first year of the third unit's operation. Another MRI within the proposed service area will be vital to meet the needs of the growing, aging, and more health care services demanding community.

Rationale for the Third MRI No. 4

Increased Patient Volume

As shown in Table G, MRI volume at L&M Hospital's existing sites has increased from 8,864 scans to 11,101 scans, a 25% growth rate, between FY 2006 and FY 2010. Year-over-year volumes demonstrate consistent growth at L&M.

Table G

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	Change (2006 to 2010)	
						#	%
MRI Scans (both locations)	8,864	9,986	10,279	10,863	11,101	2,237	25%

A comparison of FY 2010 first quarter MRI scan volume versus FY 2011 first quarter MRI scan volume indicates continued growth at L&M Hospital (refer to Table H).

Table H

	FY 2010 - First Quarter	FY 2011 - First Quarter	Change	
			#	%
MRI Scans (both locations)	2,683	2,923	240	9%

Note: First quarter is three months, October through December.

Since FY 2006, L&M has expanded hours and days of operation of its two units to accommodate volume growth; however, even with extended hours, L&M Hospital has reached and exceeded its targeted 80% utilization at FY 2010 total volumes as demonstrated earlier. Further growth in MRI volumes is anticipated; therefore, adding a third MRI in FY 2012 is necessary to accommodate growth and alleviate the access issues L&M Hospital's patients are already experiencing. To achieve the volumes in Table H, L&M Hospital has, more frequently, extended hours beyond its already expanded hours which has caused patient satisfaction issues due to patients' preference for testing at reasonable times of the day (e.g., testing before 8pm or 9pm).

Rationale for the Third MRI No. 5

L&M Strategic Initiatives

Several of L&M Hospital's strategic initiatives will drive increases in MRI utilization. Planning is underway to develop more robust programs in spine, cancer, and orthopedics at L&M Hospital. Through program development, L&M Hospital is projecting to increase inpatient market share and outpatient market share in services related to these programs. Since MRI is an effective modality for the diagnosis and management of breast, spine, and orthopedic issues, MRI market share and volume is expected to increase making adequate MRI capacity vital to developing comprehensive programs that meet the needs of patients. Since L&M Hospital is already operating above optimal capacity, a third MRI will be instrumental to ensuring patients within these programs receive the diagnostics necessary for proper treatment.

MRI is also effective for the diagnosis and management of acute stroke and neurofunctional assessment. L&M Hospital is designated by both the Joint Commission and Connecticut Department of Public Health as a Primary Stroke Center. As a designated stroke center, L&M Hospital is a regional referral source for residents who have suffered from a stroke. Since MRI is an important diagnostic tool for patients with stroke, adequate MRI capacity is necessary to continue to provide the level of care to quickly diagnosis and treat stroke patients when timing is critical to survival and long-term health status.

Rationale for Adding 3T Technology No. 1

Enhanced Capabilities

L&M is proposing to add 3T technology with the proposed third MRI. This state-of-the-art technology has been shown to improve diagnoses, particularly for anatomic head/brain, advance neuro-imaging, and orthopedic or musculoskeletal imaging. Compared to 1.5T units, 3T technology allows for faster image acquisition times and higher resolution. Refer to Attachment E for documentation of the benefits of 3T technology.

In summary, 3T MRI technology has the following advantages:

- Increased signal-to-noise ratio (SNR) (allows for certain types of scans to be acquired that are not feasible on a 1.5T, for example high in-plane spatial resolution diffusion weighted imaging)
- Enhanced imaging quality particularly for head/brain and neuro-imaging; applications also include orthopedic and cartilage assessment, and breast, vascular, and cardiac imaging
- Smooth depiction of gray white matter for neuro-imaging
- High resolution scans resulting improved diagnosis of a broad range of disease and detection of disease at an earlier stage
- Faster scan times (reduces motion artifacts and repositioning; increases quality of scans for patients who many have trouble holding still and improves experience for patients who are claustrophobic or have anxiety)
- Less trade-offs between speed and quality (decreased slice thickness and increased in-plane resolution)
- Better visualization of anatomy and enhanced lesion detectability
- Larger bore (70 cm) and stronger magnet make the 3T well suited to meet needs of patients with special needs such as obesity, claustrophobia, and anxiety
- Shorter scanner length appeals to patients with claustrophobia and anxiety
- Patients are more comfortable with the larger bore and tend to lie still longer, which improves images
- System can accommodate patients up to 550 lbs.

According to the letter of support (refer to Attachment A) filed by Todd Blue, MD, Chair, Department of Radiology, "while [L&M's] 1.5 units continue to perform at a high level, the 3.0 Tesla field scanning strength has clearly progressed and will allow [L&M] to scan patients faster and allow for increased resolution and earlier disease detection." In addition, Arun Basu, MD, Vice-Chair, Department of Radiology, in his letter of support, highlights the ability of the 3T to "visualize smaller structures" and its "greater sensitivity." Also, Dr. Basu notes the "better resolution" for musculoskeletal imaging resulting in "improved detection and quantification of tendon/ligamentous tears/inflammation." Clearly Department of Radiology clinical leaders at L&M Hospital fully realize the clinical benefits of 3T technology and welcome it as a complementary services to L&M Hospital's existing 1.5T MRIs.

Rationale for Adding 3T Technology No. 2

Lack of 3T Technology in Region

There are no other providers of 3T MRI services in the proposed service area or in nearby towns. L&M would be the first in the region to offer this technology.

To access 3T technology, the proposed service area residents were required to migrate well outside of the PSA and region. The closest known Connecticut providers of 3T MRI technology are located in New Haven, CT and Hartford, CT. Locating the 3T MRI in an easily accessible building in Waterford greatly enhances access for residents of the proposed service area and all of southeastern Connecticut.

Rationale for Adding 3T Technology No. 3

Physician and Patient Preference

As noted in the "Rationale for Adding 3T Technology No. 1," the preference of Department of Radiology clinical leaders is to add 3T technology for the third MRI. The physicians note the clinical advantages of 3T technology and recommend the 3T to improve the quality of health care delivery. In the letters of support from these physician leaders, the location of the proposed third MRI is also noted as ideal as the site allows for more comfortable access to patients and is patient-friendly.

Patients are becoming more attuned to advances in medical technology and are increasingly savvy with their health care choices. More patients are seeking the best diagnosis and treatment options available and are traveling for care. As documentation of the clinical advantages of 3T technology becomes more widespread, patients in the proposed service area will migrate outside of the local region to seek these services to a larger degree. By offering advanced MRI technology in the proposed service area, L&M Hospital will be positioned to capture volume from patients who just now are beginning to understand 3T's benefits. Patients will no longer need to travel far for care, which can be patient dissatisfier. Patients will be able to receive state-of-the-art imaging services close to their town of residence in a highly accessible, convenient location.

b. Provide the utilization of existing health care facilities and health care services in the Applicant's service area.

Response:
There is one other provider of MRI services in the proposed service area. Information regarding this provider is provided below. Utilization statistics for L&M's facilities is provided in Table 1 of question 2C in this section.

Provider Name Street Address Town, Zip Code	Description of Service	Hours/Days of Operation	Utilization
Groton Open MRI 565 Long Hill Rd, Groton, CT 06340	Low Field MRI (Open)	Mon, Wed, Fri, 8:00am-5:00pm Tues, Thurs, 8:00am-7:00pm	Unknown

c. Complete **Table 1** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

Table 1: Existing Equipment Operated by the Applicant

Provider Name Street Address Town, Zip Code	Description of Service *	Hours/Days of Operation **	Utilization ***
L&M Hospital 365 Montauk Avenue New London, CT 06320	Siemens 1.5 Tesla Avanto MRI (Closed)	Mon-Fri, 5:30am-9:00pm Sat-Sun, 5:30am-7:00pm	6,285 scans in FY 2010
Pequot Health Center 52 Hazelnut Hill Road Groton, CT 06380	GE 1.5 Tesla Twinspeed MRI (Closed)	Mon-Fri, 6:30am-9:00pm Sat-Sun, 6:30am-5:00pm	4,816 scans in FY 2010

* Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)
** Days of the week unit is operational, and start and end time for each day; and
*** Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

NOTE: L&M Fiscal Year is October 1 to September 30.

d. Provide the following regarding the proposal's location:

i. The rationale for locating the proposed equipment at the proposed site;

Response:
The proposed MRI will be located at L&M Diagnostic Imaging at Crossroads in Waterford, CT. Several diagnostic imaging services are already provided at this location including CT scan, ultrasound, general radiology, digital mammography, and bone densitometry. The facility was designed with shell space sufficient to house a MRI unit.

L&M Diagnostic Imaging at Crossroads is located on the first floor of a medical office building that contains a large orthopedic physician practice, as well as cardiology, oncology, and surgery physicians.

In reviewing its options to expand MRI capacity, L&M decided that the optimal location for a third scanner was at the L&M Diagnostic Imaging at Crossroads for the following reasons:

- 85% of MRI exams are for outpatients (based on FY2010 data; refer to Table 2a in this CON application); therefore, an off-campus, outpatient location is ideal
- The proposed site is easily accessible for a large percentage of service area residents due to its proximity to I95, I395, and US1
- MRI services are compatible with the existing imaging services provided by L&M Hospital at this site
- The addition of MRI services to this site will allow cross-coverage of staff, improving efficiency and reducing costs associated with per diem staffing
- MRI services complement physician practices located within the Crossroads medical office building (e.g., orthopedics for tissue/joint MRI, oncology for breast MRI)
- The facility is attractive, patient-friendly, and can provide one-stop access to a range of health care services for patients

The main campus and Pequot Health Center were not considered viable options for the third MRI due to space constraints at each of these locations. In addition, L&M Hospital's main campus can be difficult to access for patients living outside the town of New London due to its location in relation to major roadways (local roads, frequent starts and stops, and multiple turns that are required). Parking can also be an issue once the patient reaches the main campus.

Locating the proposed third MRI in Waterford also supports L&M Hospital's strategy to offer outpatient services out in the community. In the past year, L&M Hospital developed a physician walk-in practice with radiology and laboratory services in Stonington, opened an outpatient rehabilitation facility in Waterford, moved its sleep services from the main campus to an off-site facility in Groton, and is planning to develop a wound care center in Waterford. Adding the MRI unit at the Crossroads building fits with L&M Hospital's strategic drive to bring services out to the communities it serves.

ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

Response:
The proposed MRI is expected to serve L&M's PSA which include the following towns: New London, Groton, Ledyard, Stonington, North Stonington, Montville, East Lyme, Waterford, Lyme, and Old Lyme.

The population of the PSA was 174,427 in 2009 and is expected to increase by 1.9% to 177,682 by 2014. A Siemens Healthcare study shows use rates in Connecticut increasing at 4% annually from 113.0 scans per 1,000 population in 2009 to 138.0 scans per 1,000 population in 2014. Based on service area population estimates, that equates to total market scans of 19,710 in the proposed service area in 2009 which increases to 24,520 by 2014. As noted in section 2a, based on presence of only three MRI scanners in the proposed service area, there seems to be unmet demand for MRI services in the market.

iii. How and where the proposed patient population is currently being served;

Response:
The proposed patient population is currently being served by L&M Hospital's two existing MRIs located in New London and Groton and by Groton Open MRI located in Groton. In addition, patients are likely leaving their town of residence and seeking MRI services at nearby towns outside of the PSA. To utilize 3T technology, the proposed patient population is required to migrate well outside of the proposed service area and region as this service is not provided in southeastern Connecticut. The closest known Connecticut providers of 3T MRI technology are located in New Haven, CT and Hartford, CT. Locating the 3T MRI in an easily accessible facility in Waterford would greatly enhance access to MRI services and 3T technology for residents of the proposed service area and for all of southeastern Connecticut.

iv. All existing providers (name, address) of the proposed service in the towns listed above and in nearby towns;

Response:
Refer to Table I below for all providers of MRI services in the proposed service area and in nearby towns.

Table I

Other MRI Providers in Proposed Service Area (i.e., L&M's PSA)		
Groton Open MRI	565 Long Hill Road Groton, CT 06340	Low Field Open MRI (fixed)
Other MRI Providers in Nearby Towns		
Neurology Associates, LLC	One Towne Park Plaza Norwich, CT 06134	1.5 Tesla Closed MRI (fixed)
The William Backus Hospital	326 Washington Street Norwich, CT 06360	1.5 Tesla Closed MRI (fixed)
The William Backus Hospital & Backus Health Center	326 Washington Street Norwich, CT 06360 & 163 Broadway Colchester, CT 06415	1.5 Tesla Closed MRI (mobile)
Backus Outpatient Care Center	113 Salem Turnpike Norwich, CT 06360	1.2 Tesla Open MRI (fixed)

v. The effect of the proposal on existing providers; and

Response:
The proposal is expected to impact mainly L&M Hospital's sites and volume. Through L&M Hospital's central scheduling system, outpatient volume from the main campus and Pequot Health Center is expected to shift to the new site which will increase capacity at these locations for inpatients and/or emergency department patients. As noted by Peter Later, DO, Chair, L&M Emergency Department, in his letter of support (refer to Attachment A), "currently [L&M is] having difficulty getting our patients scanned due to the high amount of congestion on our scanners from outpatient volume." The addition of a third scanner utilized exclusively for scheduled and urgent add-on outpatients will alleviate the congestion issues at the main campus and Pequot Health Center.

The addition of 3T technology and L&M Hospital's programmatic initiatives (e.g. orthopedics) may result in some market share growth for L&M system; however, only minor market share increases were built into the volume projections (refer to section 3e for projection assumptions). Most volume growth projected for L&M Hospital is attributed to rising market demand resulting from use rate and population increases. Based on the increasing total market demand for MRI services, there are minimal impacts expected to the volumes of non-L&M Hospital providers even with minor market share growth at L&M Hospital.

vi. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

Response:
The proposed MRI is expected to serve L&M Hospital's PSA which includes the following towns: New London, Groton, Ledyard, Stonington, North Stonington, Montville, East Lyme, Waterford, Lyme, and Old Lyme. The majority of L&M Hospital's patients (inpatient, emergency department, and outpatient) originate from these towns. For MRI services, 86% of L&M Hospital patients originate from the PSA as shown in Table J in Section 3b. It is expected that for MRI services at Crossroads in Waterford, a similar draw will result, particularly because of the attractiveness of advanced 3T technology and the site's proximity to major highways and roadways.

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

Response:
The proposed MRI will not result in unnecessary duplication of existing or approved health care services because 3T technology will be a new service to the region. No other provider in the proposed service area offers 3T MRI services currently. In addition, as depicted earlier, L&M Hospital's volumes continue to rise and to accommodate further growth, an additional unit is necessary. Demand for MRI services is escalating nationally and within Connecticut. A third MRI will position L&M Hospital to be able to serve

existing patients better (e.g., reduce scheduling backlogs, reduce delays) and meet the growing needs for MRI services in the community.

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 2a, report the units of service by piece of equipment, and in Table 2b, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

Table 2a: Historical, Current, and Projected Volume, by Equipment Unit

		Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**			
	Patient Type	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
L&M Hospital MRI	Inpatient	1,478	1,408	1,454	419	1,544	1,589	1,634	1,679
	Outpatient	4,100	4,370	4,677	1,172	4,588	4,275	3,926	3,537
	ED	124	149	154	27	160	163	165	179
	Total	5,702	5,927	6,285	1,618	6,292	6,027	5,725	5,395
Pequot Health Center MRI	Outpatient	4,554	4,912	4,786	1,303	4,802	4,871	4,937	4,999
	ED	23	24	30	2	32	33	39	45
	Total	4,577	4,936	4,816	1,305	4,834	4,904	4,976	5,044
L&M Diagnostics at Crossroads MRI	Outpatient	-	-	-	-	669	1,399	2,191	3,052
Total		**10,279**	**10,863**	**11,101**	**2,923**	**11,795**	**12,330**	**12,892**	**13,491**

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

CFY 2011 volume includes first quarter statistics (October 2010 through December 2010).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

The proposed MRI is expected to be operational November 2011; therefore FY 2012 is a partial year of operation for the unit. FY 2013 through FY 2015 will be full years of operation for the unit.

*** Identify each scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

NOTE: L&M Fiscal Year is October 1 to September 30.

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

Service Type***	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**			
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
MRI Brain	2,519	2,505	2,399	590	2,549	2,665	2,786	2,915
MRI Knee	1,520	1,753	1,604	449	1,704	1,782	1,863	1,949
MRI Spine	3,243	3,491	3,619	990	3,846	4,020	4,203	4,398
MRI Shoulder	789	879	949	255	1,008	1,054	1,102	1,153
MRI Breast	413	368	315	74	335	350	366	383
MRI Other	1,795	1,867	2,215	565	2,353	2,459	2,572	2,693
Total	**10,279**	**10,863**	**11,101**	**2,923**	**11,795**	**12,330**	**12,892**	**13,491**

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

CFY 2011 volume includes first quarter statistics (October 2010 through December 2010).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

The proposed MRI is expected to be operational November 2011; therefore FY 2012 is a partial year of operation for the unit. FY 2013 through FY 2015 will be full years of operation for the unit.

*** Identify each type of scan/exam (e.g. orthopedic, neurosurgery or if there are scans/exams that can be performed on the proposed piece of equipment that the Applicant is unable to perform on its existing equipment) and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

NOTE: L&M Fiscal Year is October 1 to September 30.

b. Provide a breakdown, by town, of the volumes provided in Table 2a for the most recently completed full FY.

Response:
Refer to Table J for FY 2010 volumes by service area town for MRI services at L&M.

Table J

Primary Service Area	Volume	% of Total
East Lyme	1,103	10%
Groton	2,718	24%
Ledyard	795	7%
Lyme/Old Lyme	265	2%
Montville	694	6%
New London	1,856	17%
North Stonington	164	1%
Stonington	443	4%
Waterford	1,523	14%
Primary Total	9,561	86%
Secondary Service Area (1)		
Bozrah	20	0%
Colchester	54	0%
Franklin	8	0%
Griswold+Lisbon	123	1%
Norwich	327	3%
Old Saybrook	57	1%
Preston	-	0%
Salem	131	1%
Voluntown	20	0%
Secondary Total	739	7%
Other	801	7%
Total	11,101	100%

(1) In this analysis, Westerly, RI is included in "Other" category. Westerly, RI traditionally included in SSA of L&M.

c. Describe existing referral patterns in the area to be served by the proposal.

Response:
There are three providers of MRI services within the proposed service area (L&M Hospitals' PSA). Two units are operated by L&M Hospital and are located in New London and Groton. The third provider of MRI services is located in Groton and

operates a Hitachi low field open MRI. This provider's hours of operation are Monday, Wednesday, and Friday from 8am to 5pm and Tuesday and Thursday from 8am to 7pm.

Residents in the proposed service area are referred and can receive a MRI scan at any of these three locations. Alternatively, patients can migrate outside of the proposed service area to nearby towns for MRI services. Additional MRI services are located just outside the proposed service area in Norwich, CT and Westerly, RI (refer to Table I).

At L&M Hospital, outpatients are scheduled using a central scheduling system at either the main campus or Pequot Health Center depending on patient preference, patient home or work location, and availability of appointments. Since both of L&M Hospital's units are similar Tesla strength, it is rare one machine is preferred over another based on type of equipment.

d. Explain how the existing referral patterns will be affected by the proposal.

Response:
The addition of a third MRI within L&M Hospital will alleviate the scheduling backlogs currently experienced at both existing sites. Utilizing central scheduling, outpatient volume will shift to the new unit, freeing up capacity at each of the other locations for inpatients and/or emergency department patients. Currently, one-third of L&M's outpatient MRI volume (3,086 scans in FY 2010) is generated by patients residing in the western region of the proposed service area (Lyme, Old Lyme, East Lyme, Montville, and Waterford). Through the central scheduling system, these outpatients will be able to receive their outpatient MRI at the highly accessible site in Waterford, rather than travel to the main campus or across the Thames River to Pequot Health Center.

Referral patterns within L&M Hospital may shift due to the presence of 3T technology with the proposed third unit. The benefits of 3T described earlier make it an attractive diagnostic tool for select patients. Patients and/or their physicians may opt to choose the 3T scanner for their imaging study if it offers the best scanning capability for their particular clinical issue.

As noted previously, the addition of 3T technology is expected to increase L&M Hospital's market share slightly as this service may attract new referrals. In addition, program development at L&M Hospital also will contribute to share increases in MRI and volume growth. The impact to non-L&M Hospital provider volumes is expected to be minimal due to the increasing market demand for MRI services.

e. Explain any increases and/or decreases in volume seen in the tables above.

Response:
MRI volume projections in Table 2a were developed for inpatient (IP), emergency department (ED), and outpatient scans.

Inpatient and emergency department MRI projections for the main campus and/or Pequot Health Center reflect (as applicable):

- Growth in medical-surgical admissions
- Tests generated by the ED projected to increase commensurate with overall increases in ED volume at each site
- Annual increases in testing incidence as projected based on input from L&M Radiology Department clinical staff

Table K below includes actual medical-surgical admissions and emergency department visit trends by L&M facility from FY 2008 to FY 2010. Using data for actual number of MRI inpatient scans and MRI ED scans, testing incidence was calculated (e.g., IP MRI scans per 100 medical-surgical admissions and ED MRI scans per ED visits(%)). Testing incidence was projected forward assuming a compound annual growth rate (CAGR) based on input from clinical staff within the Radiology Department at L&M. Once testing incidence was calculated for FY 2012 through FY 2015, MRI inpatient and emergency department scans were calculated by applying the incidence to projections for medical-surgical admissions and ED visits forecasted by L&M. These forecasts are consistent with L&M long-term strategy.

Table K

	Actual			CAGR in Testing Incidence	Projected			
	FY 2008	FY 2009	FY 2010		FY 2012	FY 2013	FY 2014	FY 2015
Main Campus								
Med-Surg Admissions	10,605	10,673	11,334		11,800	12,020	12,240	12,450
ED Visits	43,323	46,316	48,258		49,570	50,210	50,830	54,800
MRI IP Scans	1,478	1,408	1,454		1,544	1,589	1,634	1,679
MRI ED Scans	124	149	154		160	163	165	179
IP Scans/100 Med-Surg Admissions	14	13	13	1.0%	13.1	13.2	13.4	13.5
% ED Scans/ED Visits	0.3%	0.3%	0.3%	0.5%	0.3%	0.3%	0.3%	0.3%
Pequot Health Center								
ED Visits	39,865	36,409	35,807		37,410	39,020	45,190	52,330
MRI ED Scans	23	23	30		32	33	39	45
% ED Scans/ED Visits	0.1%	0.1%	0.1%	0.5%	0.1%	0.1%	0.1%	0.1%

Note: FY 2011 excluded since partial year of data available and because new MRI unit will not be operational until FY 2012.

Projected outpatient scan volumes at the main campus, Pequot Health Center, and the proposed location in Waterford take into consideration:

- Population growth in the proposed service area
- 4% annual increases in MRI use rates through FY 2015 based on industry data
- Estimated market share by site between FY 2011 and FY 2015

Outpatient volume growth will be driven primarily by market demand increases due to use rate changes and growth of the population, as well as projected market share increases due to the addition of 3T technology and L&M programmatic development which attract new referrals. As demonstrated in Table L, the market demand for outpatient MRI services is expected to increase. Here, the use rates from the Siemens study was used to estimate the outpatient market since the vast majority of MRI scans are completed on outpatients. Contributing factors to this increase is population growth in the proposed service area or PSA and MRI outpatient use rate (exams per 1,000 population) increases. Use rates were provided by Siemens Healthcare and per Siemens, use rate are projected to increase 4% annually (refer to Attachment D). Despite FY 2011 first quarter MRI volume exceeding FY 2010 first quarter MRI volume (refer to Table H), a market share reduction is anticipated in full year FY 2011 due to capacity constraints that will limit L&M Hospital's growth compared to market growth.

Table L

FY	PSA Population	MRI Outpatient Exams per 1,000 Pop	MRI PSA Outpatient Market Demand	L&M Outpatient Market Share – Main Campus and Pequot	L&M Outpatient Market Share – New Unit in Waterford	L&M Outpatient Market Share – ALL Sites
2008 Actual	173,620	108.6	18,850	39.1%	0.0%	39.1%
2009 Actual	174,427	113.0	19,710	40.0%	0.0%	40.0%
2010 Actual	175,070	117.6	20,590	39.4%	0.0%	39.4%
2011 Projected	175,717	122.4	21,509	38.5%	0.0%	38.5%
2012 Projected	176,368	127.4	22,469	36.0%	2.6%	38.6%
2013 Projected	177,023	132.6	23,472	33.5%	5.2%	38.7%
2014 Projected	177,682	138.0	24,520	31.0%	7.8%	38.8%
2015 Projected	178,345	143.6	25,615	28.5%	10.4%	38.9%

Note: Population statistics provided by Claritas. MRI use rates (exams per 1,000 population) provided by Siemens Healthcare.

Shifts in outpatient volume from the main campus and Pequot Health Center will result in market share declines at these facilities between FY 2012 and FY 2015.[2] The new MRI unit in Waterford is projected to capture the shifted volume. In addition, 3T technology and L&M Hospital's programmatic development will increase market share through new referrals. Total volumes from Table 2a were calculated using the above market demand and share projections, plus estimates of out-of-area draw[3] which were assumed to be consistent with historical statistics for the main campus and Pequot Health Center (13 to 17%). Out-of-area draw for the Waterford site was assumed to be at the lower end of this range (13%) because this site lacks emergency department and other services that would

[2] Despite share decreases at Pequot Health Center, outpatient volume expected to increase due to increasing market demand.

[3] Out of area draw equals percent of volume generates by patients who live outside the proposed service area.

draw patients from beyond the proposed service area. 3T technology, however, will keep out of area draw close to the existing facilities' ranges as it will be a new service to the region.

L&M Hospital MRI volume increased from 8,864 scans to 11,101 scans between FY 2006 and FY 2010 as noted earlier. That growth equates to a 5.8% average annual growth over that time horizon. The annual growth rate between FY 2010 and FY 2015 in Table 2a projects a 4% annual increase in MRI volume. Even with more moderate growth projected, future volumes justify adding a third unit to L&M Hospital.

MRI volume projections in Table 2b were based on the distribution of MRI volume by service or scan type experienced in FY 2010. After total volumes were calculated for Table 2a, the distribution experienced in FY 2010 was applied to the totals to determine volume by service/scan type in FY 2012 through FY 2015. This methodology was utilized because there are minimal changes in disease incidence and prevalence expected in the proposed service area between FY 2010 and FY 2015.

f. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:
Key assumptions for the calculation of projected volume are described in section 3e. Inpatient and emergency department MRI projections were based on testing incidence and projections of medical-surgical admissions and ED visits. Medical-surgical admissions and ED visits projections are consistent with L&M Hospital's long-term strategy and planning. Outpatient volumes were based on market demand (from use rates provided by Siemens Healthcare) and assumptions for market share. Market share was assumed to increase slightly at L&M Hospital between FY 2011 and FY 2015 due to the addition of 3T technology and downstream impact from L&M Hospital's programmatic initiatives. Population statistics were provided by Claritas.

Projected volume by scan service/scan type assumes the same distribution of MRI volume by service or scan experienced in FY 2010. Minimal changes in disease incidence and prevalence are expected in the proposed service areas between FY 2010 and FY 2015.

g. Provide a copy of any articles, studies, or reports that support the need to acquire the proposed scanner, along with a brief explanation regarding the relevance of the selected articles.

Response:
Several reports have documented the benefits of 3T MRI technology in clinical practice as compared to 1.5T or low field MRI services. Refer to Attachment E for key reports outlining the benefits and supporting the notion that the addition of a 3T MRI unit to the proposed service area will enhance the quality of MRI service delivery to area residents.

The use rate for outpatient MRI services is expected to increase in the proposed service area. Attachment D includes an excerpt from a key study utilized to determine the market size for MRI services that was the basis for determining expected market share and volume projections. This market analysis helped support the need for the proposed scanner.

The demand for MRI services is expected to increase nationally according to statistics published by health care research firms The Healthcare Advisory Board and Sg2 (refer to Attachment F for excerpts from key reports). These national forecasts support the assumption that MRI volumes will continue to grow.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

Response:
Key personnel related to the proposal are listed below. Refer to Attachment G for each individual's Curriculum Vitae.

- Bruce D. Cummings, President and Chief Executive Officer
- Daniel Rissi, MD, Vice President and Chief Medical & Clinical Operations Officer
- Lugene Inzana, Vice President and Chief Financial Officer
- Todd M. Blue, MD, Chair, Department of Radiology
- Arun Basu, MD, Vice-Chair, Department of Radiology
- Louis Mazzarelli, MD, Department of Radiology
- Faruk Soydan, MD, Department of Radiology
- Donna Blakely, MS, R.T.(R)(M), (CRA), Director of Diagnostic Imaging
- Mary Wadsworth, RT(R), CT, Imaging Manager, Satellite Facilities
- Marci Gwiazdowski, RT (R)(CT)(MR), CT/MRI Manager

b. Explain how the proposal contributes to the quality of health care delivery in the region.

Response:
The addition of a third MRI within L&M system will eliminate the scheduling backlogs that have increased recently. In addition, outpatient volume can shift to the third MRI freeing up capacity for inpatients and/or emergency department patients at the other locations. As noted in the letters of support, outpatient volume has been causing congestion at both sites, delaying testing for all patient types. Testing delays result in diagnosis and treatment delays which can significantly impact health status. The third MRI will improve quality of health care delivery by ensuring patients receive MRI services in a timely manner.

Also, the addition of 3T technology will enhance the quality of images for improved diagnostics for patients with certain conditions (neurological, orthopedic). In addition,

because the 3T unit requires less time per patient visit, patients who are claustrophobic may find the 3T a more appealing option than 1.5T units or open MRIs which can result in less quality scans. The 3T scanner also has a larger bore (70 cm versus 60 cm in a traditional MRI) and is shorter in length than L&M Hospital's current scanners, which also appeals to patients who may be claustrophobic.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Response:
Corporation.

b. Does the Applicant have non-profit status?
☒ Yes (Provide documentation) ☐ No

Response:
Refer to Attachment H for documentation of non-profit status.

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

Response:
A copy of the State of Connecticut, Department of Public Health license is included as Attachment I. No additional licensure categories are being sought in relation to the proposal. The existing site is a satellite location of the Hospital and operates under the Hospital's license.

d. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

Response:
Refer to Attachment J for a copy of the hospital's audited financial statements.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$25,000
Imaging Equipment Purchase	$2,525,210
Non-Medical Equipment Purchase	$100,000
Land/Building Purchase *	
Construction/Renovation **	$600,000
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	$3,250,210
Medical Equipment Lease (Fair Market Value) ***	
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	
Total Project Cost (TCE + TCC)	$3,250,210
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$3,250,210

Note: Medical equipment includes stretcher, injection chair, and miscellaneous treatment room equipment. Non-medical equipment includes furniture and furnishings, telephone equipment, data systems equipment, and PACS workstation.

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

Not Applicable

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

Refer to Attachment K for description of proposed building work, including floor plans.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

Refer to Attachment L for equipment vendor quote. Refer to Attachment N for schedule of depreciation.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Response:
The proposal ($3,250,210) will be funded through the Hospital's equity.

g. Demonstrate how this proposal will affect the financial strength of the state's health care system.

Response:
L&M Hospital has been experiencing significant scheduling backlogs as well as delays in scanning for inpatients and emergency department patients as a result of congestion on its MRI units. Scanning delays can hinder diagnosis and, in turn, timely treatment which can negatively impact health status. By adding a third MRI and additional capacity to serve the growing demand, L&M Hospital expects to reduce delays in diagnosis and treatment.

Scanning delays that lead worsening health status can increase the presence of chronic issues, which can increase demand for other health services. Additional utilization of services from delays adds unnecessary costs to the health care system which negatively impacts the system's financial strength. Delays can also impact residents' ability to return to work and regular life activities which can affect not just the strength of the health care system, but the financial status of the state in general due to a less productive population.

In addition to reduction in delays, the use of the 3T model of MRI proposed will appeal to patients who may have forgone testing due to claustrophobia or anxiety with typical MRI units. As noted previously, the 3T unit proposed has a larger bore, shorter length, and decreased scan time, all features that would appeal to these patients. Patients with claustrophobia or anxiety strong enough to forgo testing often have deteriorating health as it is difficult to diagnosis and then treat their condition. Again, these patients may end up utilizing more services long-term due to the delay in diagnosis.

Scanning delays can also result in unnecessary length of stay for inpatients and emergency department patients. Extended lengths of stay not only decrease patient satisfaction, but also increase costs of health care delivery further negatively affecting the financial strength of the state's health care system.

By adding a third MRI and additional capacity to serve the growing demand, L&M Hospital is improving the financial strength of the state's health care system by providing timely access to services for residents of the proposed service area.

6. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 4: Patient Population Mix

	Current** FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Medicare*	25.6	25.6	25.6	25.6	25.6	25.6
Medicaid*	12.7	12.7	12.7	12.7	12.7	12.7
CHAMPUS & TriCare	9.6	9.6	9.6	9.6	9.6	9.6
Total Government	47.9	47.9	47.9	47.9	47.9	47.9
Commercial Insurers*	49.2	49.2	49.2	49.2	49.2	49.2
Uninsured	.7	.7	.7	.7	.7	.7
Workers Compensation	2.2	2.2	2.2	2.2	2.2	2.2
Total Non-Government	52.1	52.1	52.1	52.1	52.1	52.1
Total Payer Mix	100.0	100.0	100.0	100.0	100.0	100.0

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

Response:
Patient mix is projected to be consistent with FY 2010. Despite aging population, age distribution of patients expected to remain unchanged due to L&M Hospital's programmatic development which will attract patients under 65 (e.g., spine program, breast cancer services).

7. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

Response:
Financial Attachment I is enclosed in Attachment M.

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

Response:
Financial Attachment II is enclosed in Attachment M.

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Response:
Refer to Attachment N for details. Project commencement of operation date is November 7, 2011.

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

Response:
Rate schedule is enclosed as Attachment O.

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

Response:
Not Applicable

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

Response:
Not Applicable

g. Describe how this proposal is cost effective.

Response:
This proposal is cost effective because the new MRI unit will be collocated with other imaging modalities allowing for sharing of staff, as appropriate, on an as needed basis. This reduces the costs associated with per diem staff for coverage. If the new MRI were located in a single modality location, these cost saving would not be possible.

In addition, as noted previously, the delays in scanning can extend length of stay for inpatients. It will be cost effective for L&M Hospital to have three units in operation so there is adequate capacity on the main campus for inpatients to receive MRI scans in an appropriate timeframe. This will ensure that diagnosis, treatment, and discharge are timely. Extended lengths of stay that are unnecessary are costly for the hospital as services are utilized to a greater extent than needed.

Attachment A

Letters of Support

Ocean Radiology Associates, P.C.

Lawrence & Memorial Hospital
365 Montauk Avenue
New London, Connecticut 06320
Phone: (860) 444-5151
Fax: (860) 444-6851

Dan Rissi, MD
Chief Operating Officer and Vice President of Medical Affairs
Lawrence and Memorial Hospital
365 Montauk Avenue
New London, CT
06320

Dr. Rissi:

This letter is written addressing the magnetic resonance imaging 3.0 Tesla technology as it relates to patient care. The need for medical imaging has, in recent years, been recognized as an integral element in executing superior patient care efficiency and accurately. The advent of magnetic resonance imaging (MRI) has proven to be one of the most important advances in modern medicine as widely recognized by all healthcare providers and even by the Nobel Prize Committee. The ability to non-invasively image organs, vessels and musculoskeletal structures without ionizing radiation in great detail has significantly improved healthcare in the modern age and, I believe this to be a widely accepted tenet.

As with all technology, there are advancements. The same is true for MRI. Over the years there have been small incremental steps to improving this technology but, arguable on of the greatest step is progress in 3.0 Tesla technology which, in essence doubles the field strength of the conventional 1.5 Tesla magnets. The advantages of this upgrade, in short, allow for increased resolution, faster scan times, ability to visualize smaller structures and greater sensitivity.

These improvements allow for detection of disease at an early state, increase detection for small tumors/lesions within multiple organ systems. With regard to musculoskeletal MRI, better resolution should result in improved detection and quantification of tendon/ligamentous tears/inflammation. All of these advancements should also result in a better understanding in the pathophysiology of certain disease entities.

If I can be of further assistance please do not hesitate to contact me anytime.

Sincerely,

Arun Basu, MD
Vice-Chair, Department of Radiology

Ocean Radiology Associates, P.C.

Lawrence & Memorial Hospital
365 Montauk Avenue
New London, Connecticut 06320
Phone: (860) 444-5151
Fax: (860) 444-6851

December 9, 2010

Daniel Rissi, MD
Lawrence & Memorial Hospital
Vice President/Chief Medical & Clinical Operations Officer
365 Montauk Avenue
New London, CT 06320

Dear Dr. Rissi:

I am writing this letter in support of expanding L&M Hospital's MRI coverage in our community with a 3.0 Tesla Unit in the Crossroad Medical Complex. I believe our patients would benefit from this addition in a number of ways.

In the past few years, there has been increasing utilization of our MRI scanners to the point that wait times are rising. This inconveniences patients and causes potential delay in appropriate treatment. This also can have an affect on attending to L&M inpatients in a timely manner, and has led occasionally to rescheduling less urgent outpatient examinations, which is a further burden. Requests from the Emergency Department have also increased, further straining our current scanners.

In addition to the sheer number of exams performed, adding an additional MRI unit to an outpatient center will allow easier and more comfortable access for the patients in this community. Many patients feel the ease of having a scan at Pequot Health Center is preferable to a visit to the Main Campus for a variety of reasons. Additional access to this imaging technique in another patient-friendly outpatient venue would be welcomed by many in the area.

Last and maybe most important, MRI continues to progress rapidly and the addition of a 3.0 Tesla Unit will allow us to provide state-of-the-art care to our community. While our 1.5 units continue to perform at a high level, the 3.0 Tesla field scanning strength has clearly progressed and will allow us to scan patients faster and allow for increased resolution and earlier disease detection.

For these reasons, I clearly support the addition of a 3.0 Tesla Unit in the L&M community.

Sincerely,

Todd Blue, MD
Chair, Department of Radiology

TD/kfp

Steven V. Curiale MD FACS FCCP
Thoracic/Vascular and EndoVascular Surgery
Lawrence & Memorial Physicians
50 Faire Harbour Place, Suite 2C
New London Ct 06320

December 9, 2010

To Whom It May Concern:

I am writing this letter to offer my full and undivided support of the Radiology Department plan at Lawrence & Memorial Hospital for the purchase of a third MRI imaging device. As a Thoracic, Vascular and Endovascular Surgeon, the diagnostic capabilities of MRI are indispensable. Since my arrival at Lawrence & Memorial Hospital on October 18, 2010 there has been an exponential increase in the number of MRA examinations performed as an essential part of the workup for patients with severe vascular disease. It is my intention to use this modality as the primary, noninvasive technique in the workup of patient's with extra coronary atherosclerotic disease.

Based upon the examinations that have already been performed, is with full confidence, that I am able to offer my complete support and recommendation for this endeavor.

Very sincerely,

Steven V. Curiale M.D. FACS FCCP

12/6/10

From: Kenneth Donovan, MD
Medical Director
IPC Hospitalists of New London
365 Montauk Ave.
New London, CT 06320

To: Daniel Rissi, MD
Vice President
Chief Medical & Clinical Operations Officer
Lawrence & Memorial Hospital
365 Montauk Ave.
New London, CT 06320

Dear Dr. Rissi,

I am writing in support of Lawrence & Memorial's CON application to add another MRI to our campus. Due to increased use of our current MRI by the outpatient community, our ability to provide optimal inpatient care is being adversely affected. We are currently experiencing significant delays in diagnostic imaging for a number of the hospital's inpatients. Addition of another MRI would allow blocks of time to be "protected" for the care of Lawrence & Memorial's hospitalized patients.

Thank you for your consideration.

Sincerely,

Kenneth Donovan, MD

November 22, 2010

Dan Rissi, Vice President, Chief Medical & Clinical Operations Officer
365 Montauk Ave
New London, CT 06320

Dear Mr. Rissi:

Due to the increase in Emergency Department and inpatient orders, I would like to support the hospital's CON application in support of adding another MRI to our system. Currently we are having difficulty getting our patients scanned, due to the high amount of congestion on our scanners from outpatient volume.

There is an increasing need for a MRI in the ED diagnosis process, and for inpatients, for the ability to order them or get them done timely, with our current capacity issues here and at Pequot. Our goal, if we add another MRI at Crossroads, would be to block off some appointments in the main campus to accommodate Emergency Department and inpatients and at Pequot for Emergency Department patients.

If you would like to talk about this in more detail please feel free to contact me.

Sincerely,

Peter Later, DO
Emergency Department Chairman

EMP
Emergency Medicine Physicians
of New London County, LLC

365 Montauk Ave. New London, CT 06320 860-271-4326 *phone* 860-271-4325 *fax*

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SEACOAST ORTHOPEDIC SURGERY & SPORTS MEDICINE

GOLD STAR OFFICE PARK
495 ROUTE 184, SUITE 305
GROTON, CONNECTICUT 06340
TELEPHONE (860) 449-1413
FAX (860) 449-0390

January 13, 2011

Daniel Rissi, MD
Chief Medical and Operating Officer
Lawrence and Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Re: Request for 3T MRI at Crossroads

Dear Dr. Rissi,

The demands for MRI testing are continuing to grow due to the rapidly expanding clinical indications, the aging population, and regional growth. I support the addition of a new 3T MRI at the Crossroads Medical Office Building for the following reasons:

The Technology advances of 3T in image quality greatly improve the diagnostic viewing capability compared to older technology and lower field strengths. The 70 cm wide bore will more easily accommodate large or claustrophobic patients or shoulder exams.

Having further MRI capability will decrease wait times for those in urgent need of MRI. This will decrease the usage of non-emergent cases at the main campus which will lead to improved emergent patient care at the main campus.

The parking and location greatly increase usage do to its proximity to interstate 95 and the building's vast parking lot.

Sincerely,

Attachment B

MRI Scheduling Backlog Data

MRI Wa[illegible]Times
July 2010 - Present

WEEK OF:	7/5/2010		7/12/2010		7/19/2010		7/26/2010		AVE PER MONTH	
	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot	MAIN	PEQUOT
MRIB	0	0	0	0	0	0	0	0	0	0
MRIK	0	0	0	0	0	0	0	0	0	0
MRILS	0	0	0	0	0	0	0	0	0	0
MRIUE	0	0	0	0	0	0	0	0	0	0
MRIBR	0	0	0	0	4	0	0	0	1	0

	8/2/2010		8/9/2010		8/16/2010		8/23/2010		8/30/2010		MAIN	PEQUOT
	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot		
MRIB	0	2	0	2	0	2	0	3			0	2
MRIK	0	2	0	2	0	2	0	3	NO INFORMATION AVAILABLE		0	2
MRILS	0	2	0	2	0	2	0	3			0	2
MRIUE	0	2	0	2	0	2	0	3			0	2
MRIBR	4	3	0	2	0	2	0	3			1	3

	9/6/2010		9/13/2010		9/20/2010		9/27/2010		AVE PER MONTH	
	9/6/2010	Pequot	Main	Pequot	Main	Pequot	Main	Pequot	MAIN	PEQUOT
MRIB	0	0	0	0	0	3	6	6	2	2
MRIK	0	0	0	0	0	3	6	6	2	2
MRILS	0	0	0	0	0	3	6	6	2	2
MRIUE	0	0	0	0	0	3	6	6	2	2
MRIBR	0	0	0	2	0	3	7	7	2	3

MRI Wa. imes
July 2010 - Present

	10/4/2010		10/11/2010		10/18/2010		10/25/2010		MAIN	PEQUOT
	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot		
MRIB	4	5			0	0	3	3	2	3
MRIK	4	5	NO INFORMATION AVAILABLE		0	0	3	3	2	3
MRILS	4	5			0	0	3	3	2	3
MRIUE	4	5			0	0	3	3	2	3
MRIBR	8	4			0	0	5	3	4	2

	11/1/2010		11/8/2010		11/15/2010		11/22/2010		11/29/2010		MAIN	PEQUOT
	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot		
MRIB	6	4	5	5	5	4	5	4	4	2	6	5
MRIK	6	4	5	5	5	4	5	4	4	2	6	5
MRILS	6	4	5	5	5	4	5	4	4	2	6	5
MRIUE	6	4	5	5	5	4	5	4	4	2	6	5
MRIBR	5	5	8	8	7	7	7	7	8	4	9	8

	12/6/2010		12/13/2010		12/20/2010		12/27/2010		AVE PER MONTH	
	Main	Pequot	Main	Pequot	Main	Pequot	Main	Pequot	MAIN	PEQUOT
MRIB	4	2	6	4	7	5	0	0	4	3
MRIK	4	2	6	4	7	5	0	0	4	3
MRILS	4	2	6	4	7	5	0	0	4	3
MRIUE	4	2	6	4	7	5	0	0	4	3
MRIBR	4	4	6	4	9	6	0	0	5	4

Attachment C

Health Strategies & Solutions Study Exert

LAWRENCE & MEMORIAL

New London, Connecticut

High End Imaging Study

May 2008

Key Assumptions (continued)

- Emergency department use rates (imaging exams per ED visit) at L&M will increase between 5% and 10% per year for CT, and 5% per year for MRI
- Emergency department uses rate at Pequot will increase 10% per year for CT and 5% per year for MRI
- Primary and secondary service area market share targets and out of area draw will remain at current levels
- Average procedure times(1) and hours of operation(2) will remain at current levels for each modality at each site
- Future capacity requirements assume 80% room utilization during regularly scheduled hours

(1) Average procedure time per patient equal to 20 minutes for CT, 30 minutes for MRI, and 30 minutes for PET/CT at both the hospital and Pequot.
(2) Hours of operation assumes current hours per week scheduled OP tests are available. At the hospital, hours per week for CT, MRI, and PET/CT equal to 85, 92, and 16, respectively. At Pequot, hours per week for CT, MRI, and PET/CT equal to 94, 90, 8, respectively.

Attachment D

Siemens Healthcare Data

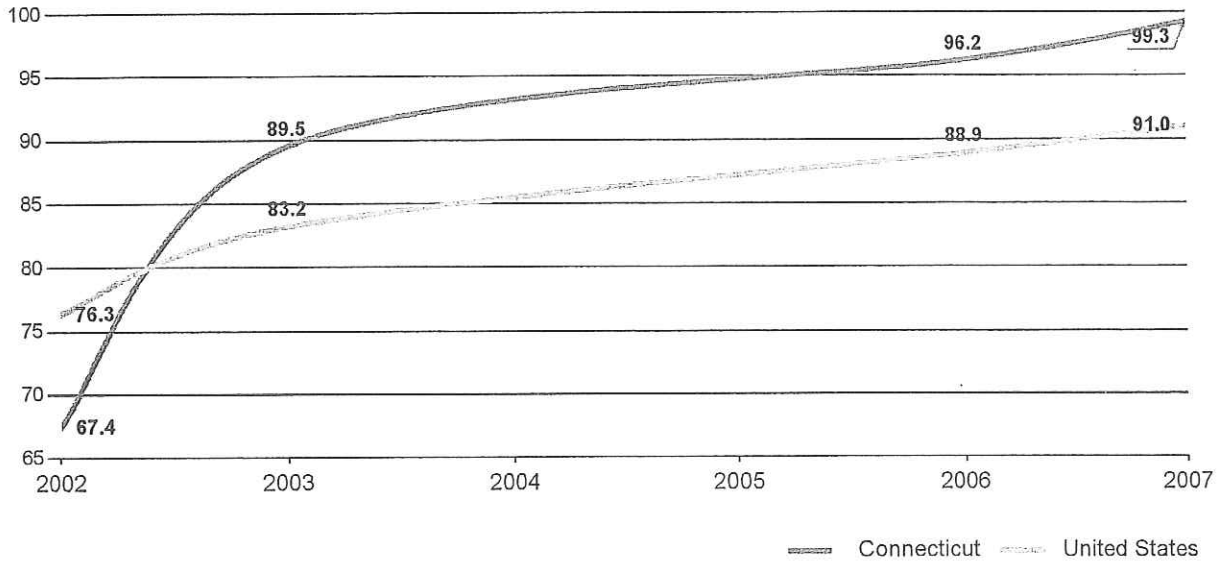
Prepared by:
Claudia Safran
Healthcare Analytics

Siemens Healthcare
Malvern, PA

Lawrence & Memorial Hospital

A Demographic and Economic Profile of the Area Surrounding New London, CT
July, 2010

Magnetic Resonance: Procedures per 1,000 (Total Population)



Note:

The service area estimates below are based on the rates listed to the right. The rates for 2009 and 2014 were calculated based on historic Magnetic Resonance rates (Procedures per 1,000) using an assumption of linear growth. The most recent historic rate (*) was used to calculate the flat growth service area estimate.

	2007*	2009	2014
Connecticut	99.3(16)	113.0	138.0

The number in parentheses indicates where the state ranks versus all states

Lawrence & Memorial Hospital: Service Area Estimates

	2009 Procedures		2014 Procedures	
Zip Code List	**Flat Growth**	**Linear Growth**	**Flat Growth**	**Linear Growth**
Primary	17,289	19,682	17,332	24,085
Secondary	9,565	10,888	9,644	13,401
Totals	26,854	30,570	26,976	37,486

Attachment E

3.0 Tesla Magnetic Resonance Imaging Scanner Benefits Study

Clinical Advantages of 3T

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Val M. Runge, MD, Editor-in-Chief, *Investigative Radiology*
Robert and Alma Moreton Centennial Chair in Radiology,
Scott and White Clinic and Hospital, Texas A&M University
Health Science Center, Temple, Texas, USA

When considering the field of 3T MR, one has to ask: "What can I gain at 3T?" Certainly increased signal-to-noise ratio (SNR) is the major benefit. Some debate whether a factor of two increase is actually achieved (or whether the gain is slightly less). In this consideration, it is important to emphasize that a factor of two gain in SNR would require a scan at 1.5T that is four times as long. Thus even if the improvement is slightly less than two-fold at 3T, this represents a major advance.

Due to the increase in SNR, certain types of scans can be acquired at 3T that are simply not feasible at 1.5T. High in-plane spatial resolution diffusion weighted imaging is one of many examples. The improvement in SNR affords the ability to substantially decrease scan time and to increase spatial resolution. Tissue properties are altered as well with the increase in main magnetic field. T1 relaxation times lengthen and magnetic susceptibility effects increase. While some may view these changes as challenges, they can be used to advantage when scanning parameters are optimized for 3T. Today, 3T is far more mature in its evolution than compared with the systems available in past years. Suitable coils for imaging of all anatomic regions are readily available. Pulse sequence development has also made formidable strides combating potential problems such as the prolongation of T1 and heat deposition.

The specific absorption rate (SAR) is likely the major challenge that faces 3T. SAR is defined as the energy per unit time deposited into the patient, potentially causing an increase in body temperature. To flip the spin of a proton, or equivalently to raise it to the higher energy level (the fundamental basis for MR imaging), the transmitter coil provides in the form of radio frequency (RF) the energy difference between these two energy levels. The SAR for a patient is proportional to the square of that RF frequency. As compared with a 1.5T system (where the resonance or Larmor frequency is 63 MHz), potential SAR thus increases by a factor of four for a 3T system (where the Larmor frequency is 126 MHz). The safety requirements are however the same whether it is a 1.5T system or a 3T system. Measures thus have to be taken to compensate for the potential increase in SAR due to the higher resonance frequency. For example, the same exact scan often cannot be run at both 1.5 and 3T, simply because of SAR limitations. A scan that has high SAR at 1.5T cannot be employed without changes at 3T, as SAR limits would be exceeded.

SAR issues, and solutions therein, have been the focus of much work over the last several years. Decreasing the refocusing flip angle, which contributes by a power of two to SAR, is a general strategy with several different approaches possible. Low SAR pulses can be used, specifically a long RF pulse with smaller amplitude. Unfortunately this simplistic approach leads to prolonged echo times and echo train length, resulting in reduced signal and higher sensitivity to flow, motion, and susceptibility artifacts. An alternative to reduce SAR is to omit the RF refocusing pulse and use gradient echo (GRE) imaging instead of fast spin echo imaging. This has been effectively employed in brain imaging, where the problem of prolonged T1 with higher field strength together with increased sensitivity to motion artifacts have rendered T1-weighted spin echo images suboptimal. A very effective approach, decreasing SAR while at the same time markedly improving image quality, is the use of a 2D in phase short TE spoiled gradient echo for T1-weighted imaging (in the brain).

A sophisticated and extremely effective technique to reduce SAR, based on the general principle of decreasing flip angle, is variable-rate selective excitation (VERSE). In this approach, a time-varying, slice select gradient waveform is combined with a one-dimensional, spatially selective RF pulse. Typically, the VERSE gradient waveform has a decreased gradient in the center of the pulse and an increased gradient at the beginning and end. This allows the RF amplitude to be decreased in the center of the pulse. Thus VERSE can significantly reduce the heat deposition associated with the RF pulse. The exact reduction depends on the particular pulse and gradient shapes but is typically from 30% to 50%.

Another advanced approach to reducing SAR is to use parallel imaging. In this scenario, parallel imaging is employed with measurement time held constant, resulting in a decrease in SAR. The higher SNR available at 3T permits this approach. Either mSense, an image-based PAT reconstruction technique, or GRAPPA, a k-space-based parallel imaging reconstruction technique, can be employed. Parallel imaging is defined as the use of the spatial distribution of surface coils or imaging matrix elements in the direction of phase encoding to eliminate certain phase encoding steps. The method is called parallel imaging, or PAT, since each coil is measuring the signal from the patient's body simultaneously and in parallel to one another.

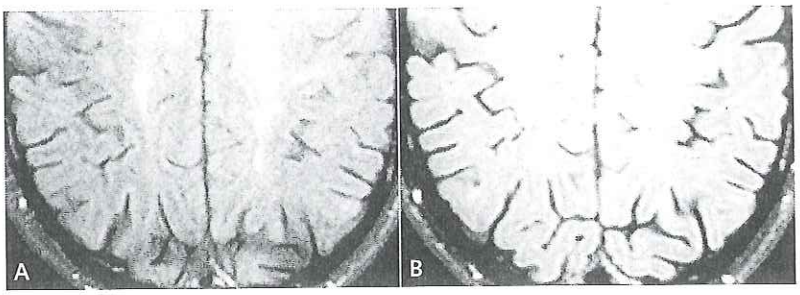

Figure 1: MS Study Comparison. A: 1.5T T1 FLAIR acquired 5mm thick in 3:09. B: 3.0T T1 FLAIR acquired 3mm thick in 1:57

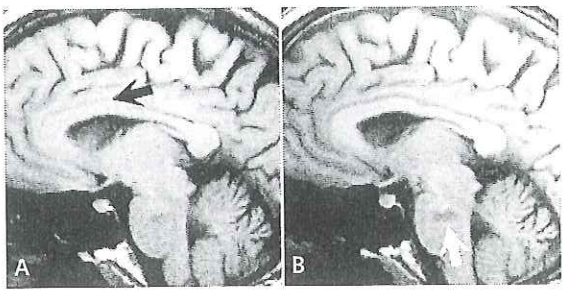

Figure 2: Early Pontine Infarct comparison. A: 1.5T 2D Spin Echo, TR/TE 550/12, 5mm thickness in 2:55. B: 3.0T artifact free 2D Gradient Echo, TR/TE/Flip 449/2.4/90 with GRAPPA factor of 2, 3mm thick in 1:15.

The markedly higher SNR available at 3T translates to improved diagnosis, due largely to the possibility of decreased scan time, thinner slices, and increased in plane resolution. Multiple examples of improved diagnosis, by the use of 3T (as compared with 1.5T) in routine clinical imaging, follow. Figure 1 presents axial FLAIR images obtained at (A) 1.5T and (B) 3T in a 46-year-old woman with a 16-year history of relapsing remitting multiple sclerosis (MS). Slice thickness and scan time were respectively (A) 5 mm, 3:09 min:sec and (B) 2.5 mm, 1:57 min:sec. The lesions are better delineated at 3T, with several small lesions only noted on the 3T exam. Published studies comparing 1.5T and 3T in the evaluation of MS have demonstrated that scans at 3T show a substantial increase in number of enhancing lesions, enhancing lesion volume, and plaque burden (total lesion volume). Experience in cervical spine imaging of MS at 3T has provided similar results, with smaller MS plaques simply not visualized on 1.5T imaging, but easily detected at 3T due to thin section imaging (2 mm) and overall improved image quality.

High-resolution thin section imaging at 3T has improved diagnosis in a broad range of diseases, including specifically congenital abnormalities, ischemia, and neoplastic disease. Small acute infarcts are more easily detected at 3T, due to thinner section imaging combined with overall improved image quality. Important as well is the ability to do high resolution diffusion weighted imaging, providing a major improvement over the limited 128 x 128 matrix typically employed at 1.5T. The potential that 3T offers in metastatic disease of the brain is principally for improved detection of small lesions (< 1 cm diameter). This proves important as well for the follow-up of patients following surgery and/or radiation and chemotherapy for possible recurrent/residual tumor. When 1.5T and 3T are evaluated with matched hardware and software, an improvement of 125% can be demonstrated with regard to detection of contrast enhancement using the gadolinium chelates at 3T. The higher SNR at 3T combined with the increased sensitivity to the gadolinium chelates leads to improved detection of small enhancing lesions, regardless of etiology.

Excellent T1-weighted images of the brain are easily obtained today at 3T, with high SNR, high in-plane spatial resolution, thin sections (3 to 4 mm) and short scan time. This is contrary to a widely held (but false) belief that T1-weighted imaging is difficult at 3T, due to the prolongation of T1 and more prominent artifacts due to the higher SNR. To achieve high quality T1-weighed images, as illustrated in Figure 2, a change in approach (specifically imaging technique) is required. T1-weighted spin echo images at 3T are in general inferior to 2D short TE gradient echo scans, with the latter approach being currently the mainstay for rapid T1-weighted brain imaging at 3T. This evolution in technique shares some features in common with the advance from spin echo to fast spin echo technique some 10 years ago at 1.5T, adopting a new solution that results in faster imaging with less sensitivity to motion artifacts.

The images in Figure 2 are from a 57-year-old diabetic with a 1-day history of unsteadiness. Midline sagittal T1-weighted images depict an early subacute pontine infarct (white arrow) at (A) 1.5T and (B) 3T. 2D spin echo technique was employed at 1.5T with TR/TE 550/12, a slice thickness of 5 mm, and a scan time of 2 min 55 sec. 2D gradient echo technique was employed at 3T with TR/TE/tip angle 440/2.4/90 degrees, a parallel-imaging factor of two, a slice thickness of 3 mm, and a scan time of 1 min 15 sec. Gray-white matter contrast is similar between the two scans. The 1.5T scan demonstrates a prominent ghost (black arrow), with the 3T scan artifact-free. The improved depiction

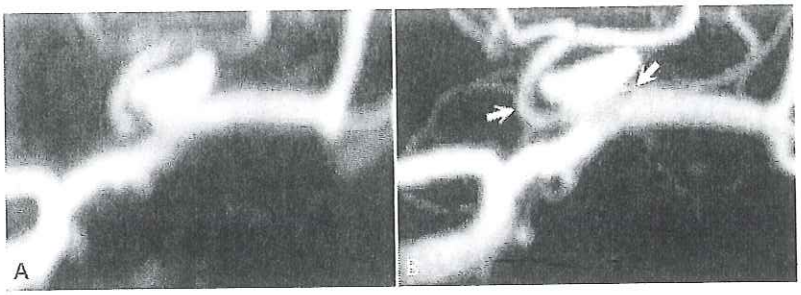

Figure 3: Middle cerebral artery aneurysm comparison. A: 1.5T–voxel dimension of 0.8mm x 0.8mm x 1mm. B: 3T–voxel dimensions of 0.4mm x 0.4mm x 0.4mm

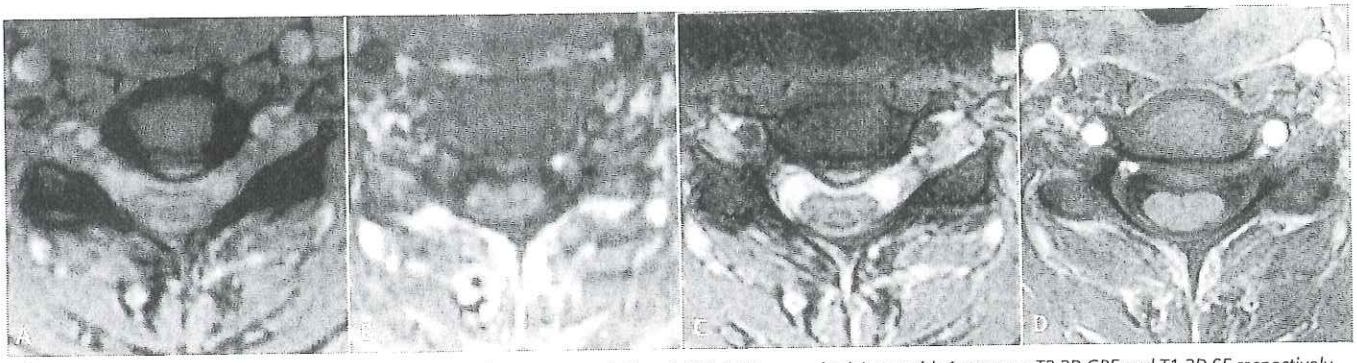

Figure 4: Disk hernation comparison—approximately 3 minutes per acquisition. A & B: 1.5T—acquired 4mm with 1mm gap, T2 2D GRE and T1 2D SE respectively. C & D: 3T—acquired 3mm no gap, T2 2D GRE and T1 3D VIBE respectively.

of the pontine infarct at 3T is largely due to less partial volume imaging (3- versus 5-mm slice thickness).

Figure 3 presents targeted MIP images of a multilobed 8 mm middle cerebral artery aneurysm acquired at (A) 1.5T and (B) 3T. In this case, the higher SNR available at 3T has been used in part to improve spatial resolution. Two small branch vessels (arrows) originate from the aneurysm, a critical imaging finding—seen only at 3T, with the origin of the larger vessel not depicted and the smaller vessel itself not even evident on the 1.5T scan. Voxel dimensions were 0.8 x 0.8 x 1 mm^3 at 1.5T and 0.4 x 0.4 x 0.4 mm^3 at 3T. 3T MR imaging represents a major step forward in image quality for time-of-flight MR angiography (MRA). This is nowhere more evident than in 3D TOF MRA of the circle of Willis. The lengthening of T1 at 3T is in part responsible for this marked improvement.

Illustrated in Figure 4 is a comparison of axial scans in a patient with a cervical disk hernation at (A, B) 1.5 and (C, D) 3T, with the latter images markedly superior for lesion diagnosis. The scan time was approximately three minutes for each sequence, whether for the T2-weighted 2D GRE (A, C), the T1-weighted 2D SE (B), or the T1-weighted 3D VIBE (D) scan, regardless of field strength. The scans at 1.5T have a lower in-plane resolution and are also thicker in section (4 mm with a 1-mm gap as opposed to 3 mm with no gap at 3T in this instance). All scans had slice coverage from C2-3 through C7-T1. Although radiologists have come to accept axial imaging at 1.5T as the gold standard, the axial images at 3T in this instance provide better delineation of the cord (and the mild contouring due to this disk herniation), the relevant cervical nerves (well seen on the axial T1-weighted exam), and the CSF-disk interface.

A major advance in recent years has been the implementation of integrated coils (specifically the Total imaging matrix, or Tim), allowing seamless imaging of adjacent anatomical areas. In the past, some anatomic regions, like the cervicothoracic junction, were poorly imaged simply because the area lay in a transition zone, covered poorly by the coil above (cervical) and that below (thoracic/ lumbar). On modern systems, these regions no longer represent a challenge and are well imaged. Illustrated in Figure 5 is a Pancoast tumor acquired at 3T, sagittal T2-, T1-, and post-contrast fat-suppressed T1-weighted images. Note the excellent depiction of the lesion (at the lung apex) despite the fact that it lies at the cervicothoracic junction. Figure 6 presents MR scans from a 39-year-old man with Von Hippel-Lindau Syndrome who had resection of a pheochromocytoma in the distant past and reports ongoing cervical/upper lumbar back pain, extremity weakness, and paresthesias. Comparison of the lesion in the conus medullaris (a hemangioblastoma) as depicted at 1.5 and 3T is illustrated. Both image sets demonstrate the anatomy of the conus lesion and its associated syrinx cavity. (A, B) are precontrast T2- and postcontrast T1- weighted sections at 1.5T acquired using 4-mm slices and 0.8 mm^2 in-plane resolution, (C, D) are the equivalent images at 3T acquired using 2.4-mm slices—in approximately the same scan time, but with substantially better in-plane spatial resolution (0.3 mm^2). Note the improved detail on the sagittal T2-weighted scan at 3T, enabling demonstrating of prominent arteries and veins supplying the lesion (seen adjacent to the cord just above the conus). With new SAR reduction techniques and thin-section imaging capabilities, 3T can surpass 1.5T in the lumbar spine when applied in a problem solving approach, limiting slice number and evaluating a specific lesion or level.

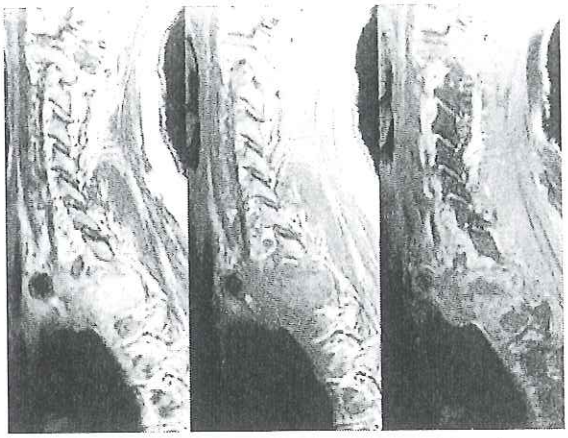

Figure 5: Pancoast tumor at region of cervicothoracic junction imaged with integrated Neck and Spine Matrix coils.

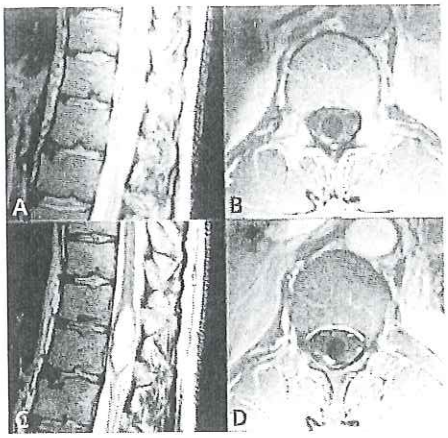

Figure 6: Conus Lesion comparison. A & B: 1.5T Precontrast T2 and T1 acquired at 4mm thickness (0.8mm inplane resolution). C & D: 3T Precontrast T2 and T1 acquired at 2.4mm thickness (0.3mm inplane resolution).

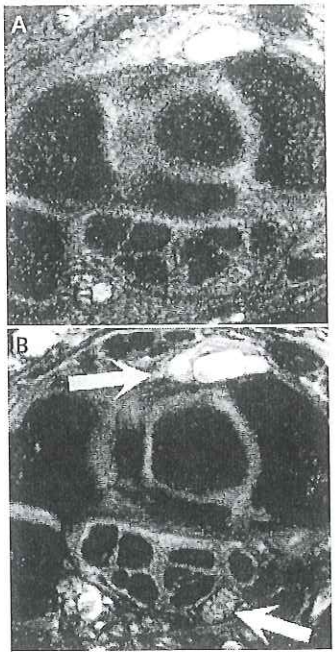

Figure 7: Ganglion cyst comparison. Both acquired with 2mm thickness, matrix 256 x 256, and field of view 50 x 50mm; 1.5T and 3T 5:02 and 4:46 acquisition times respectively.

Along with the advent of 3T, there has been development of multi-coil/ multi-element MR systems that allow for full spine imaging (part of Tim), without manual repositioning or coil reconfiguration between studies, and thus faster overall imaging times. For the exam of the patient illustrated in Figure 6, the lumbar spine study was performed initially, followed by evaluation of the cervical cord. Between the lumbar and cervical scans, the patient table was repositioned from the operator's console, with less than a second needed to transition between the two studies. Axial postcontrast scans were obtained at multiple cervical, thoracic, and lumbar levels, guided by sagittal imaging, all within minutes, depicting cord and nerve root lesions (not illustrated) throughout the full extent of the thecal sac. As a correlate, the ability to do such scans, combined with high resolution thin section imaging at 3T, should dramatically improve detection and depiction of leptomeningeal metastatic disease involving the spine.

Due to the relatively small size of important structures and the intricate anatomy therein, imaging of the musculoskeletal system poses significant challenges for MR. Previously, some of the structures within such joints as the shoulder, wrist, hip, knee, and ankle that are important for patient management have been difficult to evaluate given the lower SNR inherent at 1.5T. With the advent of 3T, the increase in spatial resolution (afforded by improved SNR) has made possible better visualization of anatomy and enhanced lesion detectability. Figure 7 presents paired T2-weighted axial GRE scans demonstrating a ganglion cyst of the radiocarpal joint (black arrow) imaged at 1.5T (A) and 3T (B). The scans demonstrate the cyst arising from the volar aspect of the radiocarpal joint in the wrist of this 26-year-old woman, who presented with gradual onset of discomfort and swelling of the right wrist. Ganglion cysts are one of the most common causes of a mass within the wrist and are thought to be the result of chronic irritation at the point of formation. Both scans were acquired with a 2-mm slice thickness, two acquisitions, a matrix size of 256 x 256, and field of view of 50 x 50. Scan times were 5:02 (min:sec) at 1.5T and 4:46 at 3T. In addition to the improved demonstration of the ganglion cyst, note the exquisite detail of the median nerve (white arrow) and the sharp delineation of the tendon sheaths on the 3T image (due to the markedly higher SNR).

Not illustrated is the dramatic improvement achievable with contrast enhanced MRA at 3T. The improved SNR due to the higher field strength, together with improved sensitivity to the contrast medium (gadolinium chelate), makes possible a substantial boost in spatial resolution, a critical point for many of the disease processes evaluated, for example atherosclerotic stenoses involving the carotid bifurcations and the origins of the renal arteries.

In summary, the introduction of 3T systems into the clinical environment has presented many challenges. However, with the optimization of hardware and imaging protocols available today, spectacular results can be achieved that are simply not possible at lower fields. Heat deposition, changes in T1 relaxation rates, susceptibility differences, and possible increased sensitivity to motion artifacts represented challenges to clinical implementation, which have largely been overcome. The situation appears remarkably similar to that encountered more than 15 years ago as the field of magnetic resonance transitioned from what was then low and mid-field to 1.5T. From the perspective of the imaging now possible in the clinic and hospital environment, it is clear that 3T represents the new mainstream high-end clinical field strength for magnetic resonance.

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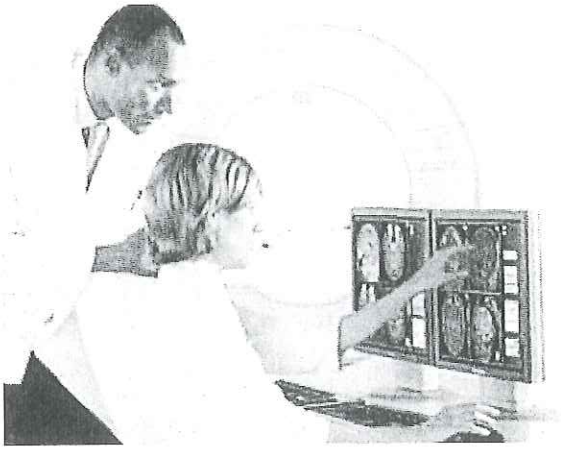
Incorporation of 3T MRI into Clinical Routine

The benefits of 3T MRI and its future level of importance to the MR community have been discussed and debated for many years. By the time the US Food and Drug Administration (FDA) granted clearance for use of clinical MR imaging at main magnetic field strengths of up to 4T in 1998, imaging at field strengths of 3T had been widely implemented in the research community and the development of 3T technology has continued at a dramatic pace ever since. Yet, 1.5T imaging has still remained the standard in many clinical settings. This hesitancy to transition to 3T imaging, despite its benefits, has been due to a variety of factors, including safety concerns, uncertainty about the physical effects of higher magnetic field strengths, cost constraints, and imaging artifacts specific to 3T systems.

However, the current generation of 3T MR systems with redesigned magnet and RF technology are quite different from that of 1998. Some manufacturers of imaging equipment have invested substantial effort in optimizing the hardware, software, and imaging protocols available for 3T imaging, and today, spectacular results can be achieved with the technology. 3T is fast becoming the new mainstream clinical field strength for MR imaging. Many imaging centers and hospitals have installed or are planning to install 3T units for clinical use and, as the technology has become more widely adopted, the cost of the equipment has decreased. Still, factors such as coils, magnet technology, construction costs, and service support, which are often related to the 3T MR "footprint," should be considered when choosing a 3T MR vendor.



Adopting 3T MRI Technology

Memorial Hospital, a 328-bed hospital in Chattanooga, Tenn., is a prime example of how adopting 3T MRI has proven successful despite initial reservations. A full-service, acute-care facility that serves a population of 500,000, Memorial Hospital is part of the Catholic Health Initiatives Network, and is recognized as one of the leading-edge facilities in the Southeastern United States. After much deliberation and research, Memorial replaced one of its two 1.5T MR scanners with a Siemens MAGNETOM® Verio 3T MRI.

"We didn't take the decision to add 3T lightly," said Dr. Don Mills, chief of the Department of Radiology at Memorial Hospital. In fact, Memorial went so far as to hire the consulting company William Faulkner and Associates to help it determine if a 3T system would be appropriate for its clinical setting and, if so, which would be able to serve all of its clinical needs. "We had reservations, but our experience with our new 3T has assured us that we made the right decision. We didn't have to do any major reconstruction for the 3T unit; it fit nicely in the same footprint as our previous 1.5T unit. We were also concerned that with the increased magnet strength, the shielding would go up and be more expensive, but as it turned out, that was not an obstruction at all."

One of the biggest advantages of 3T is the increased signal-to-noise ratio (SNR), which is essentially doubled at 3T. This allows for increased image resolution and/or decreased image acquisition time. An indirect benefit of reduced imaging time is a decrease in associated motion artifacts, since patients do not have to hold still as long. Due to the increase in SNR, certain types of scans can be acquired at 3T that are simply not feasible at 1.5T. The markedly higher SNR available at 3T has the ability to translate to decreased scan time, thinner slices, and increased in-plane resolution as well as better visualization of anatomy and enhanced lesion detectability.

"The increased SNR was definitely a big factor in moving into 3T," said Dr. John Bisese, radiologist at Memorial Hospital. "It's been a welcome addition because of the phenomenal images we're getting with it. And that means a lot of the applications run better, more reliably, more consistently, and with less time and effort."

"When we saw the image quality and speed of the 3T, it became obvious to us that 3T is the wave of the future," said Dr. Don Mills, chief of the Department of Radiology at Memorial Hospital. "I think it will soon be the gold standard for MRI."

Memorial is getting much better results with advanced applications like MRA, especially in the head and neck area, and has been able to expand its offering of spectroscopy and diffusion tensor imaging into neurological applications. This, in turn, has led to increased referrals. "There's been a clear preference for the 3T platform," said Dr. Bisese. "Once doctors see the images and the type of information we're getting from the 3T platform, they begin to ask for it. We've even had some interest from neurosurgeons at another hospital who have been sending some cases here for the 3T."

"Seeing more is seeing more, and seeing it better is seeing it better," said Bill Faulkner, MRI technologist and owner of William Faulkner and Associates, the consulting firm that Memorial Hospital hired to help make the decision to transition to 3T. "That's the main benefit of what 3T offers."

Meeting 3T Challenges

SAR

There have been many obstacles in the road to bringing 3T from the research environment to the clinical environment. One of the main challenges that had always faced 3T was specific absorption rate (SAR), which is a measure of the amount and duration of the energy used to create an MR image. The FDA pre-defines SAR limits to ensure the safety of patients undergoing MR examinations. Unless adjustments are made, an imaging technique at 3T results in a four-fold increase in SAR for the same technique at 1.5T, leading to longer acquisition times and/or reduced imaging capabilities (e.g., fewer slices, lower resolution). However, recent advances in software such as variable flip angle and parallel imaging techniques, as well as hardware advances such as TrueForm, have led to a significant reduction in the overall energy deposition during a 3T MR examination. These improvements have made it possible to achieve the fast imaging times and high spatial resolution that make 3T so desirable.

"With a combination of the inherent technologies in the system, such as alterations in the coil and optimizations for pulse sequences, from a technologist's standpoint, SAR issues can be easily managed with 3T systems," said Faulkner. "Today, SAR is nearly a non-issue with 3T."

Dielectric Effects

Additional imaging challenges in bringing 3T to the clinical arena included T1 relaxation changes, B1 inhomogeneities, also called dielectric effects, and increased chemical shift and susceptibility effects. Again, the latest optimized imaging techniques paired with hardware improvements such as TrueForm Design have virtually eliminated these obstacles. Improvements in hardware and software have allowed for the practical use of a variety of

pulse sequences for T1-weighting, particularly in the spine and brain, which makes T1 lengthening issues no longer an issue in 3T. In fact, 3T technology has been able to use physics issues like susceptibility to its advantage.

"We were concerned about the dielectric effect, particularly in body imaging," said Dr. Bisese. "But with our 3T magnet, we have not had a problem with that kind of artifact at all."

Patient Acceptance

A technological advancement that has led to increased acceptance of 3T in the clinical environment is the introduction of a 3T system with a 70-cm bore. While most whole-body 3T systems have a bore size of 55 to 60 cm, the new 70-cm bore 3T system provides a more comfortable experience for claustrophobic patients and can accommodate patients up to 550 lbs.

In the past, Memorial Hospital would have to send claustrophobic or large patients to a smaller hospital nearby that had a vertical-field MR scanner with a lower field strength. And for critically ill patients, getting an MRI was not an option. "We've definitely had fewer complaints of claustrophobia since we installed the 70-cm bore 3T unit," said Dr. Bisese. "Now, with the larger gantry, we don't need to send large patients elsewhere. And, we are able to scan some critically ill patients, particularly stroke patients and difficult surgical abdominal cases."

"The first time I saw a patient inside the 3T was really surprising to me," said Dr. Mills. "I was amazed by how much room was around the patient, compared to the old days when we had 55-cm bores."

Since patients are more comfortable with the 70-cm bore MR, they tend to lie still longer, which makes for better imaging. 3T technology has gotten to a point where scanners like the one at Memorial can maintain superb image quality, even with a large 70-cm bore.

Safety

A safety concern that had been a challenge for 3T MRI was imaging patients with implanted metallic devices. However, the increased interest in 3T technology has led to a significant increase in the number of implanted metallic devices tested at field strengths of 3 Tesla and higher. Today, many of the commonly implanted devices have been tested.

"We really have encountered no limitations with the 3T at all," said Dr. Mills. "I am extremely impressed with the engineering, forethought, and design that has gone into modern 3T systems. It's just superb."

Education

Lastly, there is the issue of education. Most technologists and radiologists have had their training at field strengths of 1.5T or lower. The challenges and even the benefits of 3T actually generated concern in the early days of clinical 3T imaging. The higher SNR was displaying anatomic structures that were not seen at 1.5T and unrefined protocols required technologists who were highly proficient in their understanding of MR physics. Today, 3T cases are well published and there is an abundance of educational opportunities designed specifically around 3T MR imaging. Additionally, the latest technology paired with optimized imaging protocols makes scanning on some 3Ts no different than scanning on a 1.5T system.

"We were a bit worried about technologist acceptance of the 3T unit, but we found that everyone's experience easily transferred over to the 3T environment," said Dr. Bisese. "The techs picked up the technology very quickly, and our doctors, who were comfortable reading MRIs at 1.5T, have found very little stress going to the new platform. In fact, if anything, they've found it easier to interpret studies."

The Wave of the Future

Many of the challenges that initially faced 3T MR technology are ironically the same changes that once confronted 1.5T technology when it was first used in a clinical setting. And just like the 1.5T issues were resolved over time, tremendous strides have been made in reducing the issues that initially plagued 3T through the efforts of manufacturers to optimize the hardware, software, and imaging protocols available for 3T imaging.

"There will be a more widespread acceptance of 3T in the near future," said Faulkner. "It's really just an educational issue in that there is a lack of understanding about the advantages of 3T. The MR community is just beginning to discover all of those benefits."

According to Bill Faulkner, owner of William Faulkner and Associates consulting firm, there are several issues to consider when deciding on a 3T MRI system:

- **Service** – The service you will be receiving from the vendor should weigh heavily on your purchase decision. You're going to have a relationship with that vendor for a long time; make sure you will be happy with the service they provide.

- **Research investment** – Find out how deeply the vendor is invested in the research of 3T technology. Are they working with institutions that are known for development research to actually develop applications? This is particularly important in terms of coil technology development, which drives applications.

- **Physics issues** – Find out how the vendor is currently addressing physics issues. While physics issues aren't really a problem anymore for 3T, the best manufacturers are constantly working to find new ways to manage these issues.

- **Bore size** – Unfortunately, as a country, we are getting larger, so we need to be able to offer larger patients an environment in which they can be safely imaged.

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Local Contact Information

Siemens Medical Solutions USA, Inc.
51 Valley Stream Parkway
Malvern, PA 19355-1406
USA
Phone: 1-888-826-9702
www.usa.siemens.com/healthcare

Global Business Unit

Siemens AG
Medical Solutions
Magnetic Resonance
Henkestr. 127
DE-91052 Erlangen
Germany
Phone: +49 9131 84-0
www.siemens.com/healthcare

Global Siemens Headquarters

Siemens AG
Wittelsbacherplatz 2
80333 Muenchen
Germany

Global Siemens Healthcare Headquarters

Siemens AG
Healthcare Sector
Henkestrasse 127
91052 Erlangen
Germany
Phone: +49 9131 84-0
www.siemens.com/healthcare

Legal Manufacturer

Siemens AG
Wittelsbacherplatz 2
DE-80333 Muenchen
Germany

www.siemens.com/healthcare

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Clinical Observations from Siemens 3T Customers

Angiography

- Great flexibility- makes images crisper do to higher resolution or super fast studies for BH or ce MRA in 10 seconds

- Thinner slices or scan with higher resolution and get better vessel details- see smaller branch vessels in injected and non injected mra

- Time resolved angiography highest res 4D angio

Clinical Observations from Siemens 3T Customers

Neuro Imaging

- Smooth depiction of gray white matter. Details obscured at 1.5T
Can accelerate scan by using iPAT

- Superficial arteritis- 2mm 1024x1024 fs without biopsy

- Increases susceptibility at 3T-
  - Tuberous sclerosis
  - Cerebral amyloid angiomatosis

Clinical Observations from Siemens 3T Customers

Spine

- 2mm sag cuts through cervical 512x512
- Thoracic and lumbar spine, axial imaging is excellent at 2.5mm cuts
- Pick up small annular tears, bulge and herniations more

interspinous ligament sprains, strains and subtle stress fractures of the pedicales or spondylolysis

Ortho

- 2mm cuts

Tendinitis-higher res, better fat sat and contrast sensitivity

- Increased trabecular detail
- Speed
- Wrist- do one acquisition for 2 min exams 3mm slices

Clinical Observations from Siemens 3T Customers

Body

- Diffusion body for adenopathy,liver tumors and pancreatitis abdomen lymphona, enlarged nodes and soft tissue implants in omentunm and peritoneum
- MRA super fast 10 sec bh
- Decreased fov 3mm cuts
- Pick up smaller pancreatic lesions
- Pelvis- subtle areas of inflammation
- Prostate with body array rivals 1.5t with prostate coil

Breast

- Breast-increased sensitivity to contrast and higher resolution of scans help to increase sensitivity and specificity of breast exams
- Possible improved detection of subtle enhancing nodules of DCIS but more comparative studies need to be performed

Clinical Observations from Siemens 3T Customers

As reported by Siemens MRI Advisory Board:

Breast imaging: while 1.5T had been preferred for breast MRI, progressive programs are starting to move the cases onto 3T, and report better resolution and specificity. We think this could be the next area (after neuro) where 3T takes off.

Orthopedics: small joint imaging and some arthritis imaging improved with 3T

Pediatric imaging: benefits from improved imaging of smaller structures as well as possible shorter scan times.

Body imaging: studies are showing improved results in prostate, liver and other solid organ imaging.

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3T vs 1.5 T

- Increased diagnostic confidence due to increased image quality
  - Brain
  - Spine
  - MSK

- Less trade-offs between speed and quality
  - Faster acquisition times
  - Decreased slice thickness
  - Increasing the in-plane resolution

- Challenges
  - heat deposition
  - susceptibility differences
  - greater inherent sensitivity to motion artifacts

Slice Thickness (illustrating SNR)

5 mm

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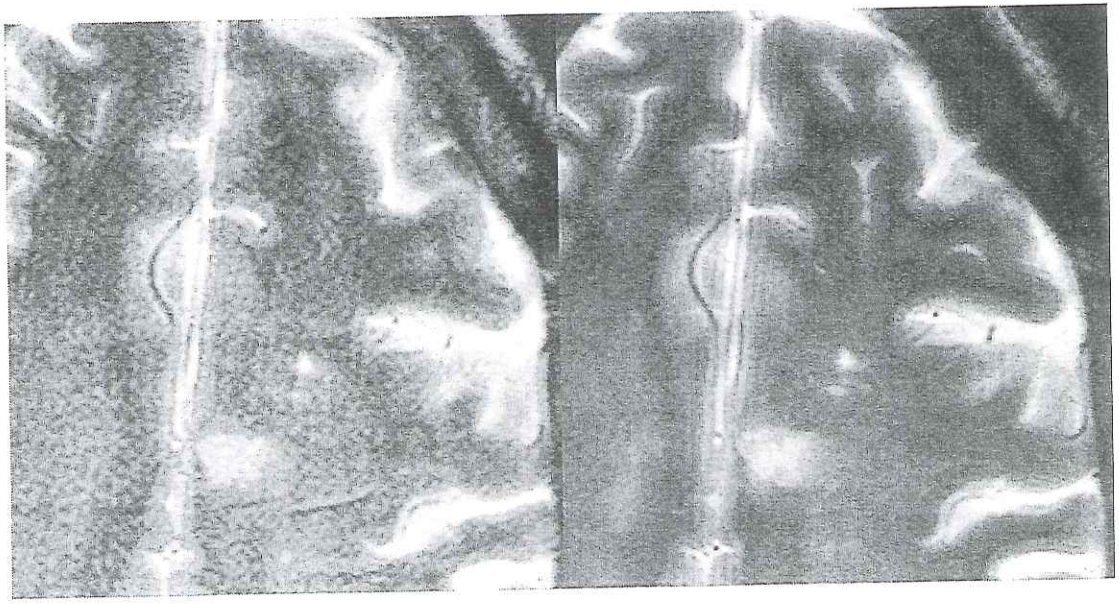
1.5 T

3 T



Scan Time vs Spatial Resolution
Brainstem (pontine) glioma

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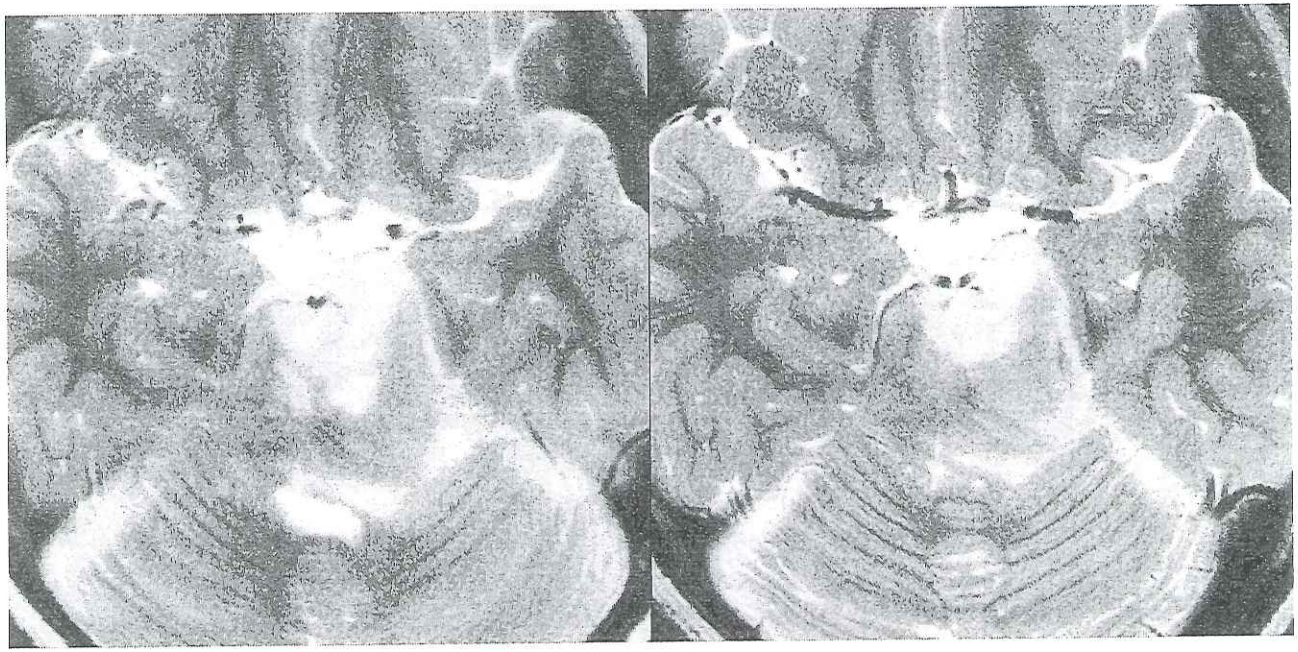
3 T



3 T

TA =	59 sec	vs	2:39 min:sec
Voxel =	.5x.4x5	vs	.4x.4x2.5 mm^3

Routine Screening

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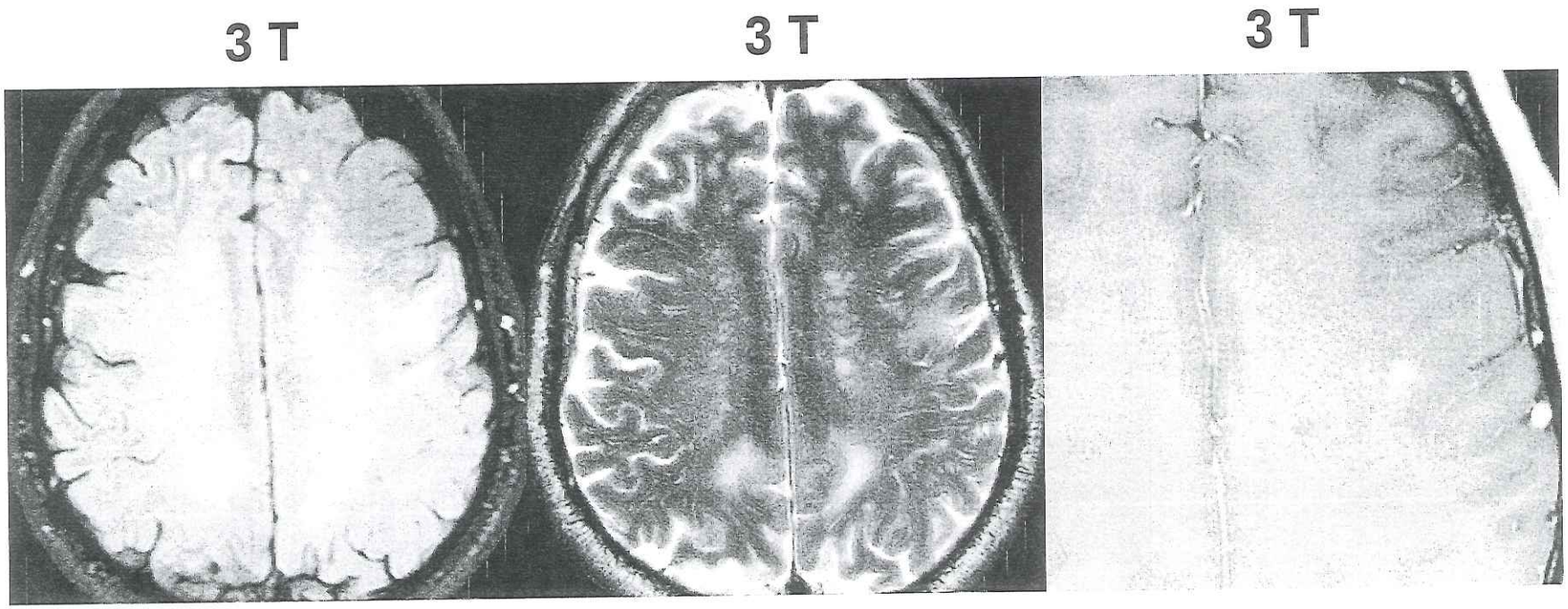
Glioblastoma multiforme multifocal



	FLAIR	T2	T1
TA	1:03	00:59	5:22
	3mm	3mm	3 mm .5x.5 mm2

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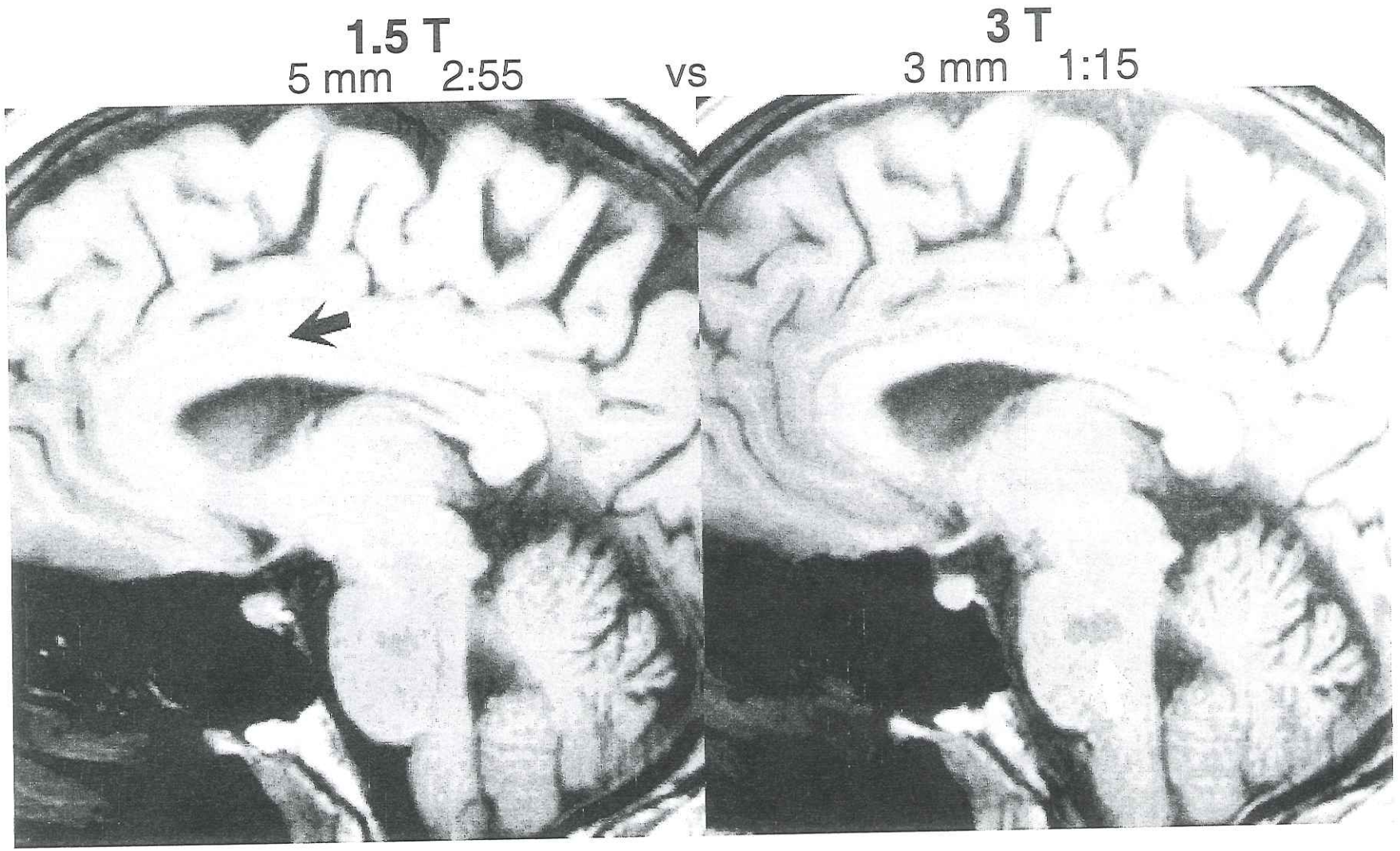
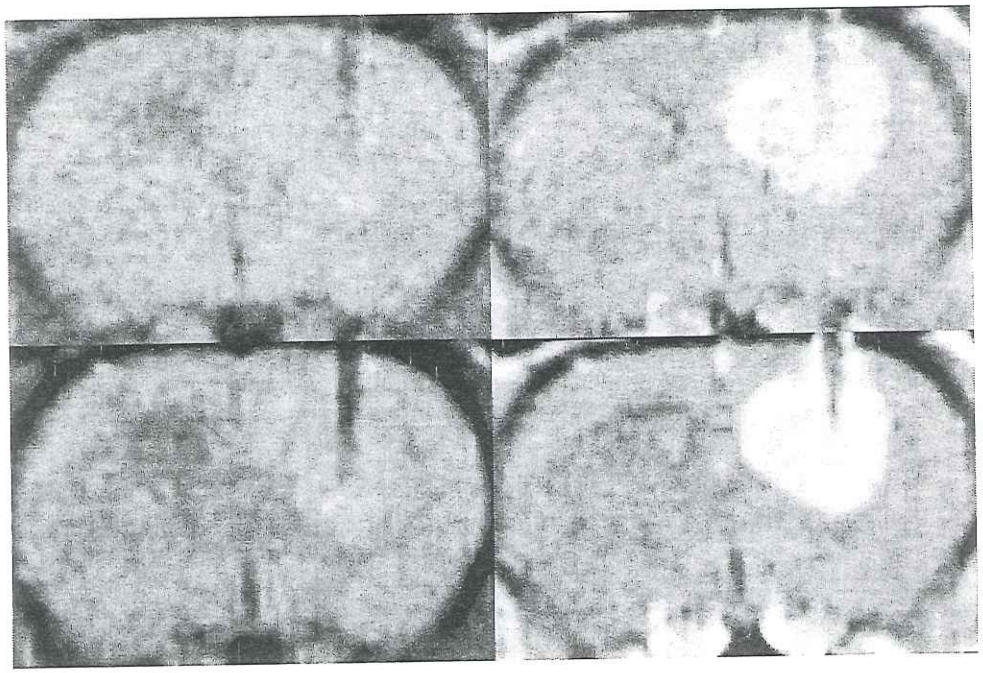
T1-weighted Imaging, pontine infarct



Contrast Enhancement

1.5 T



3 T

3T increases:

- CE +106% -137%
- SNR brain +66% -76%

- Maximum CE occurring at 5 minutes for both 1.5 and 3 T (9.8±2.2 vs 21.1±3.5; P<0.0004)
- The highest CNR for both 1.5 T and 3 T occurred 5 minutes after contrast (1.5 T: 9.4±1.1 vs 3 T: 20.3±2.4; P<0.0004)

Invest Radiol 2005;40:792

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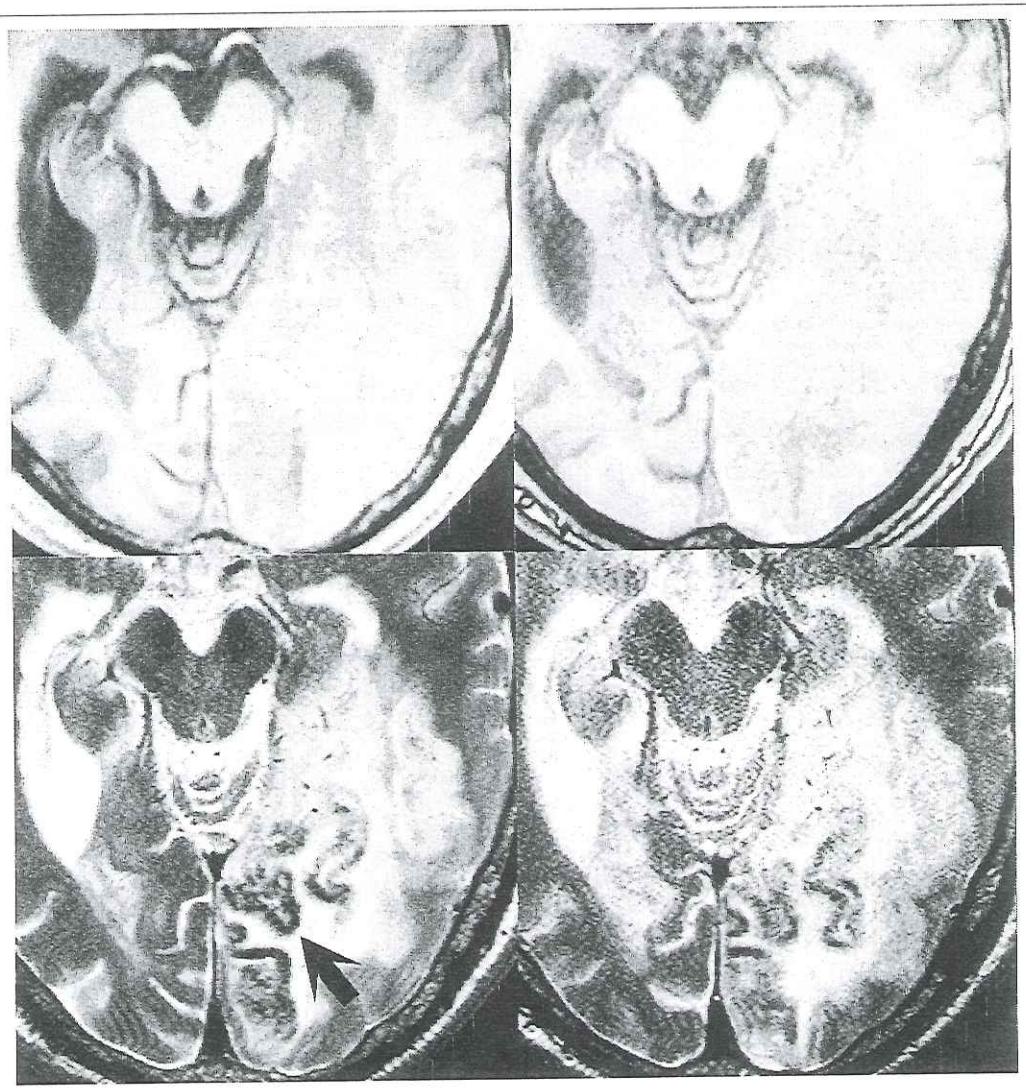
Early subacute PCA infarct – all parameters set equal

3 T
3 mm

TA=1:05



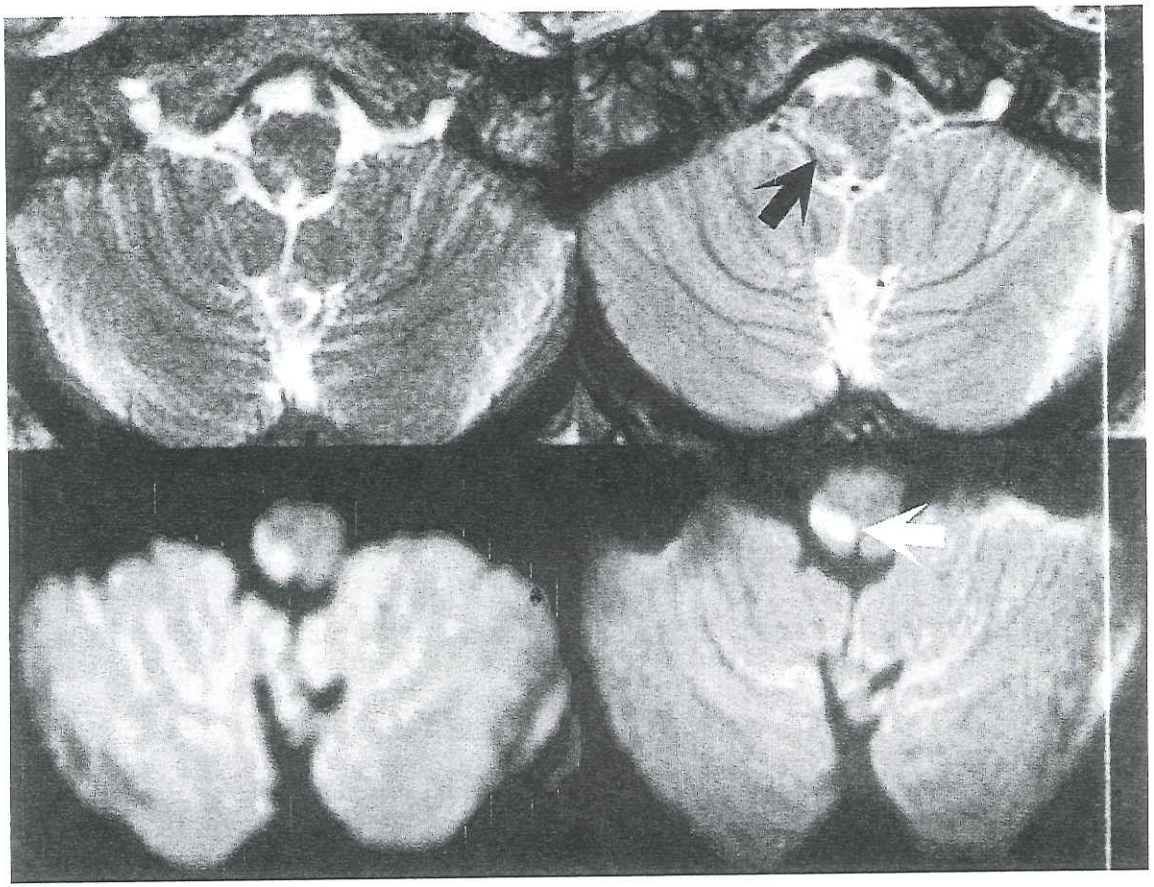
1.5 T

3 mm

Improved Lesion Detectability at 3 T (due to improved SNR)

Early subacute medullary infarct

1.5 T

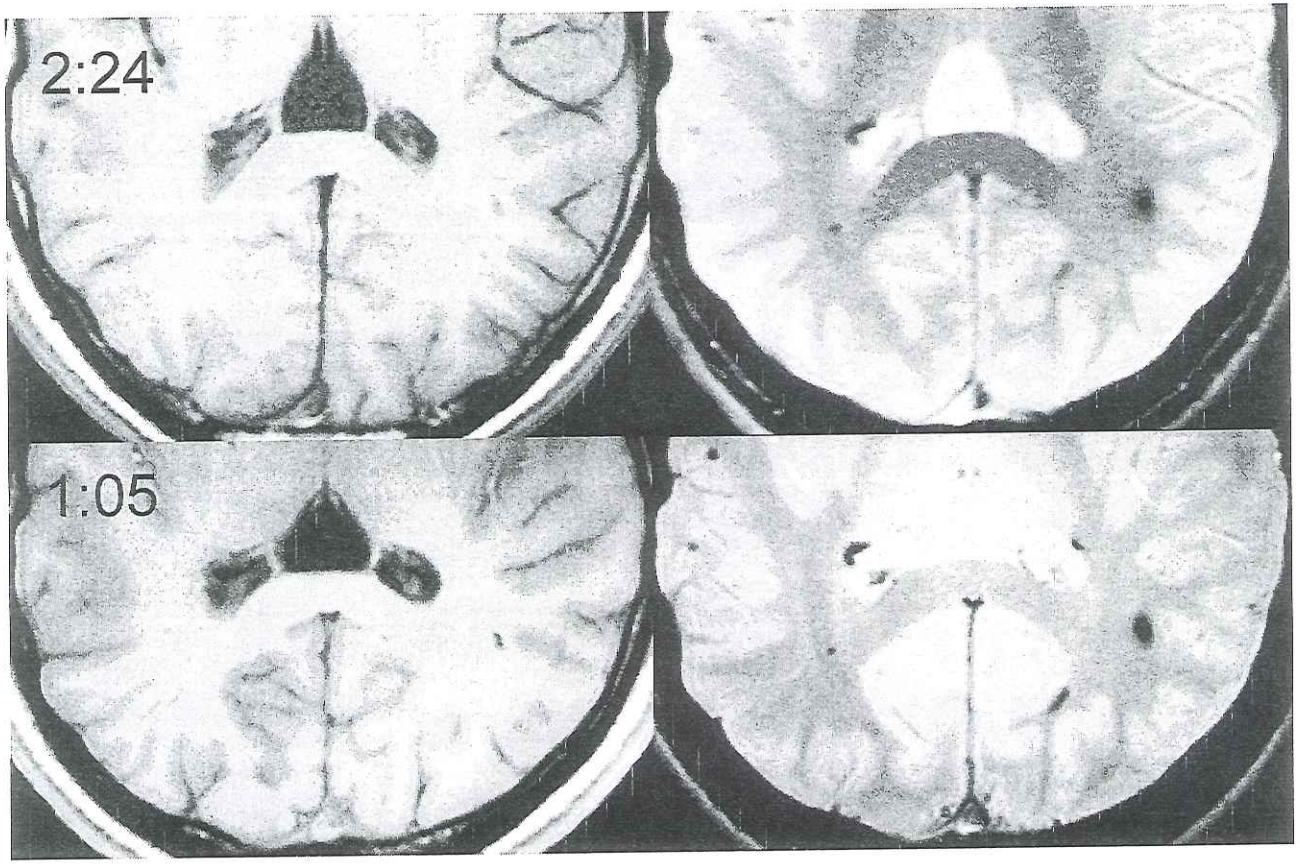


3 T

Hemosiderin (T2*)

1.5 T

3 T



5 mm

3 mm

The effect of magnetic susceptibility increases linearly with field strength

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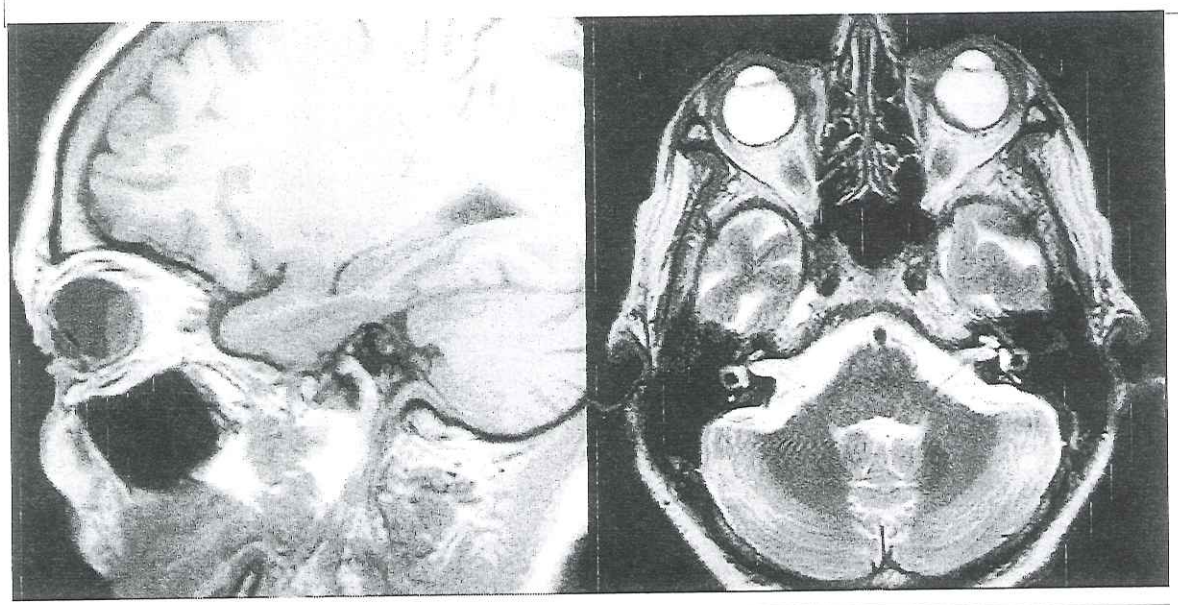
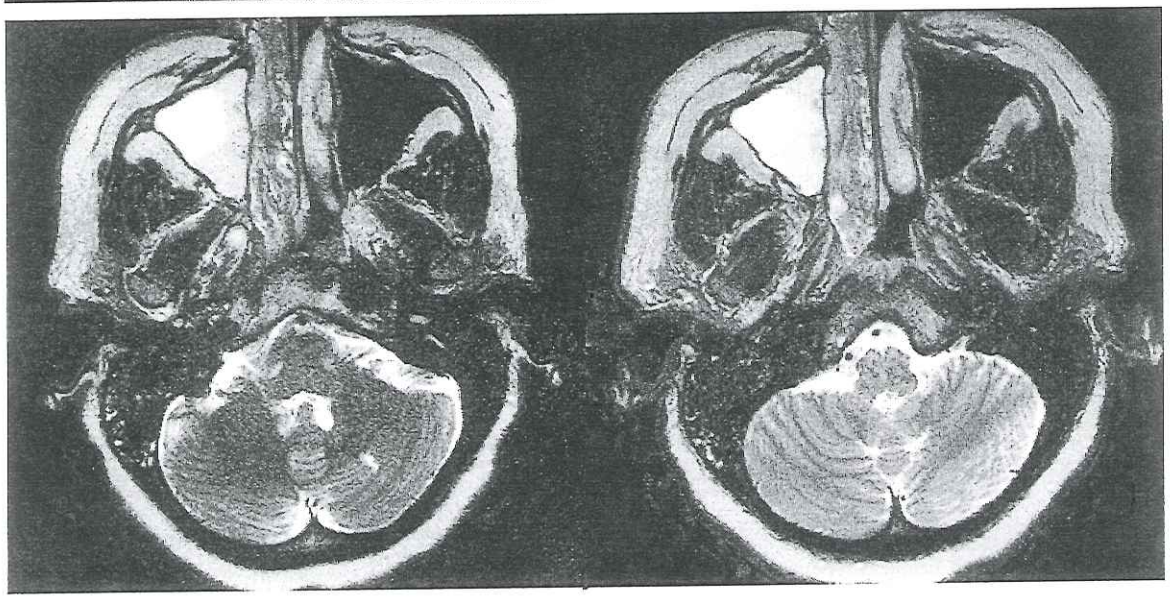
Due to shorter scan times, 3 T offers improved imaging in ENT



Ocular metastasis,
SL = 3mm
TA = 1:15 and 1:22



Inverted papilloma
SL = 3mm
TA = 2:48 at 1.5 vs 1:36 at 3 T

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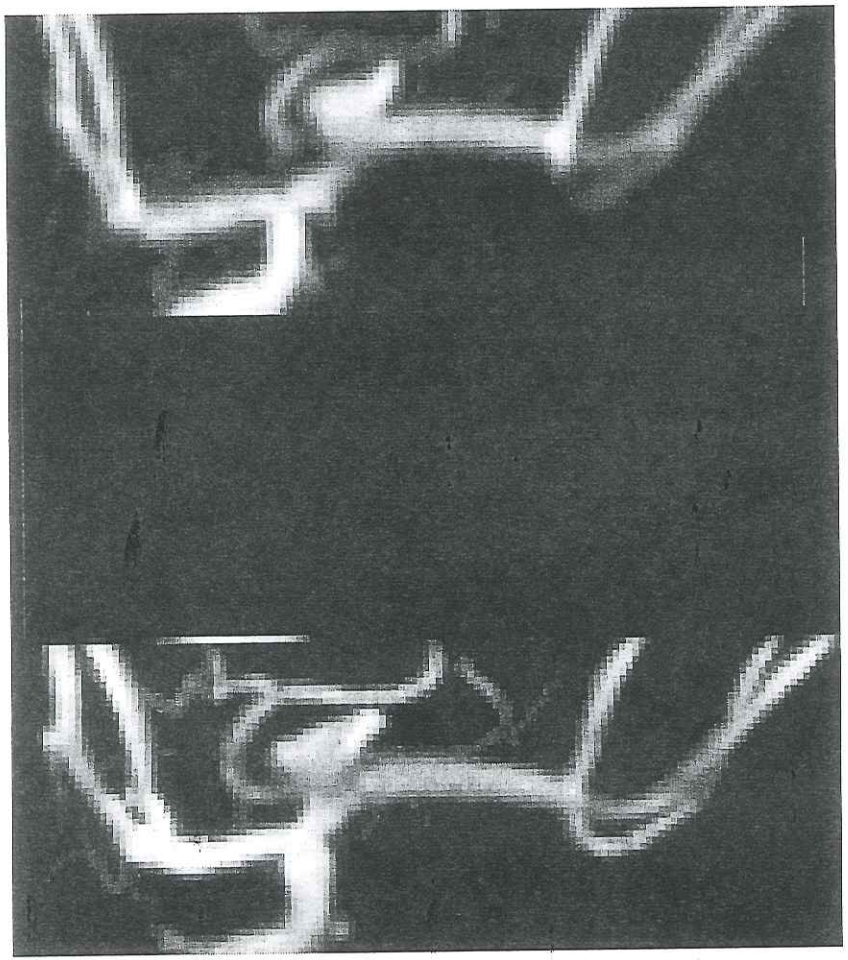
3D TOF MR Angiography



MIP projections of the left internal carotid artery from 3D time-of-flight MRA demonstrate a multilobed aneurysm arising from the left M1 segment of the MCA. The 1st image was obtained at 1.5 T with a voxel size of 0.8 x 0.4 x 1.0 mm^3. The 2nd image was obtained at 3 T with voxel size of 0.4 x 0.4 x 0.4 mm^3

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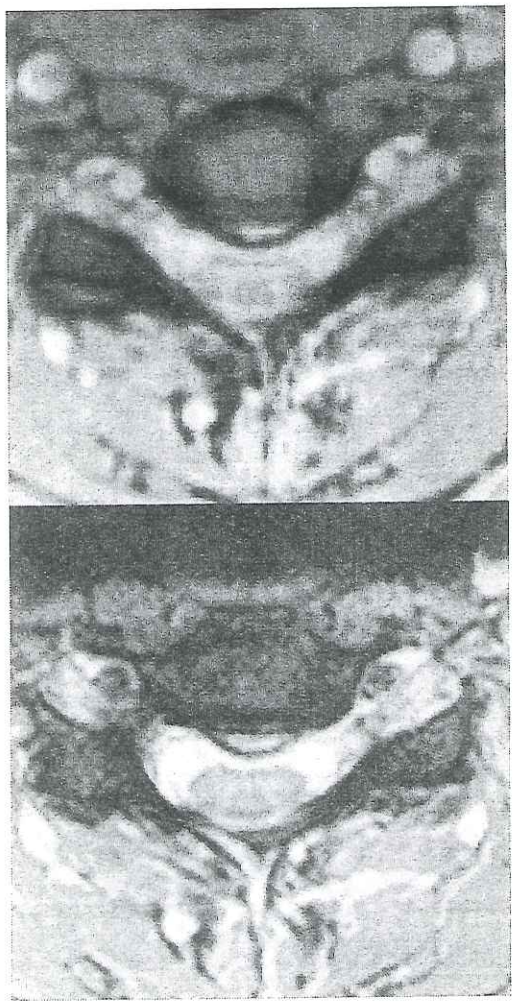
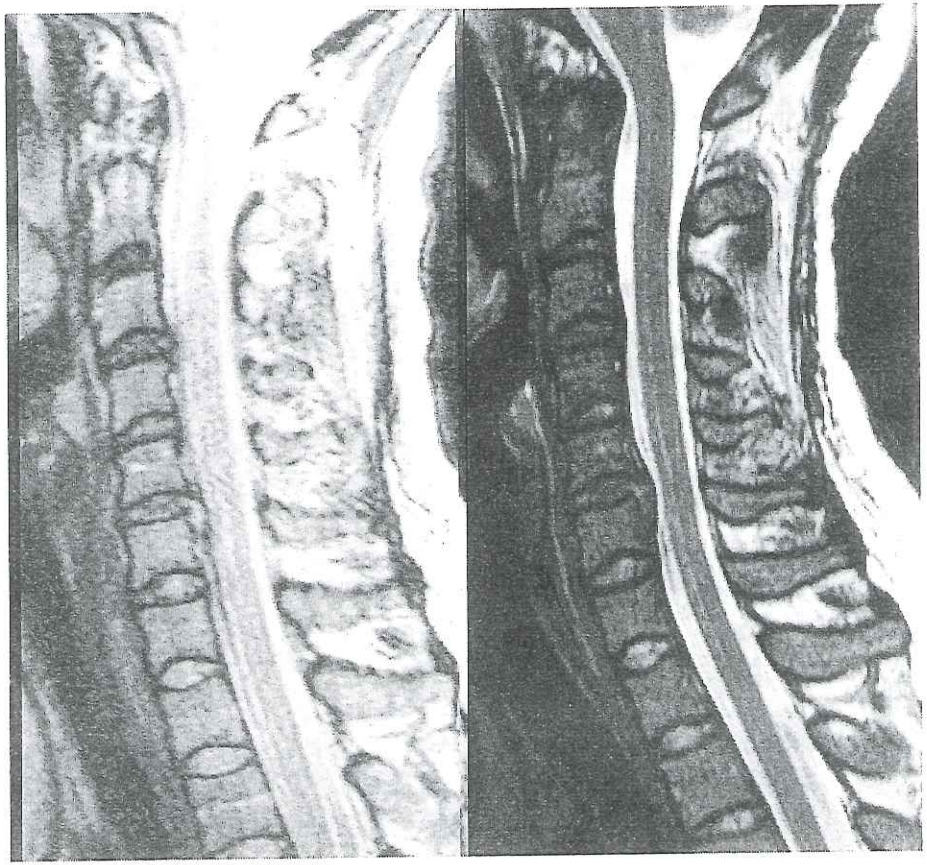
Acute C5-6 Disk Herniation

1.5 T

3 T



1.5 T (our apology for image quality)



3 T

Lumbar Spine
L5-S1 disk herniation

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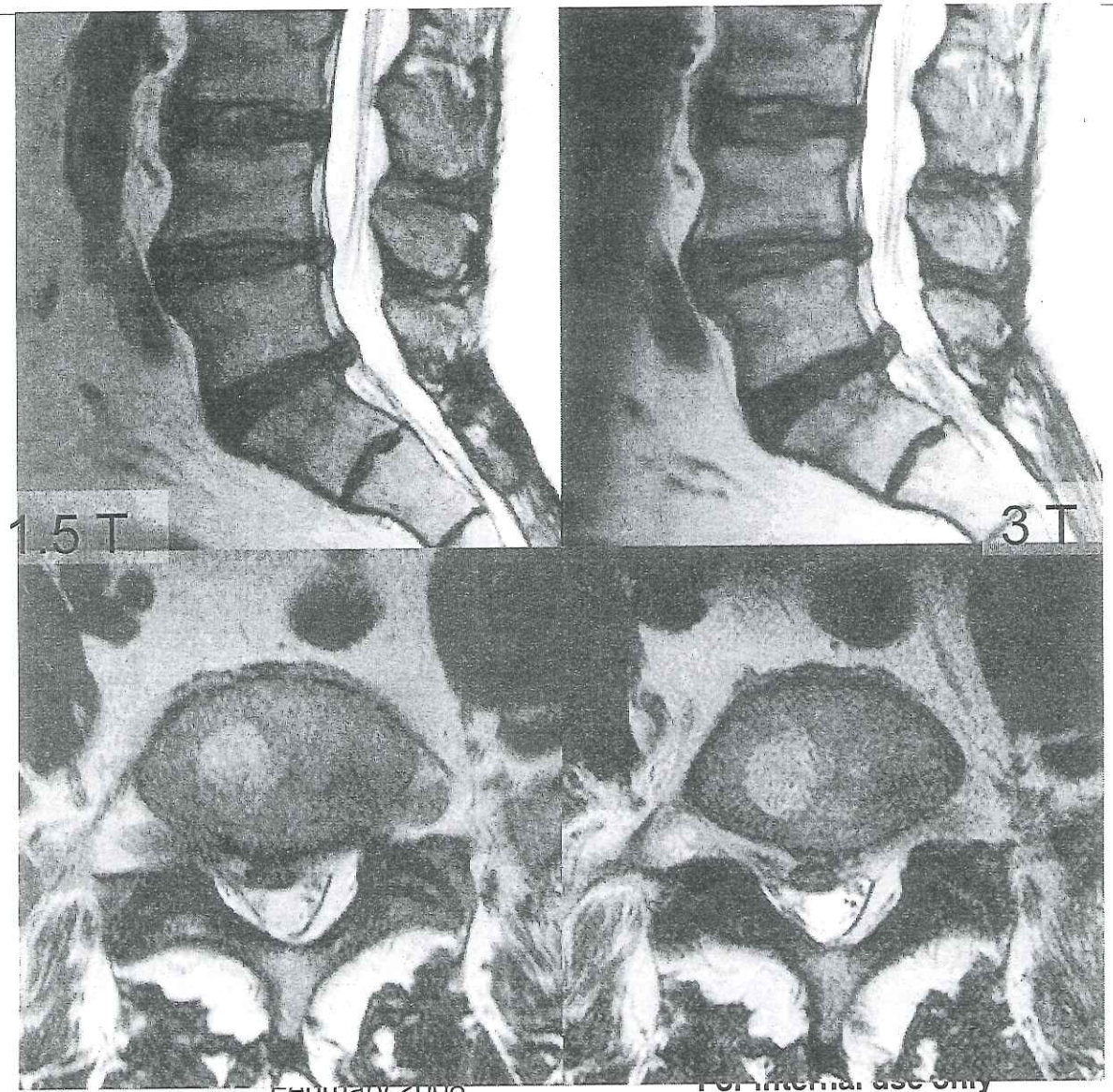
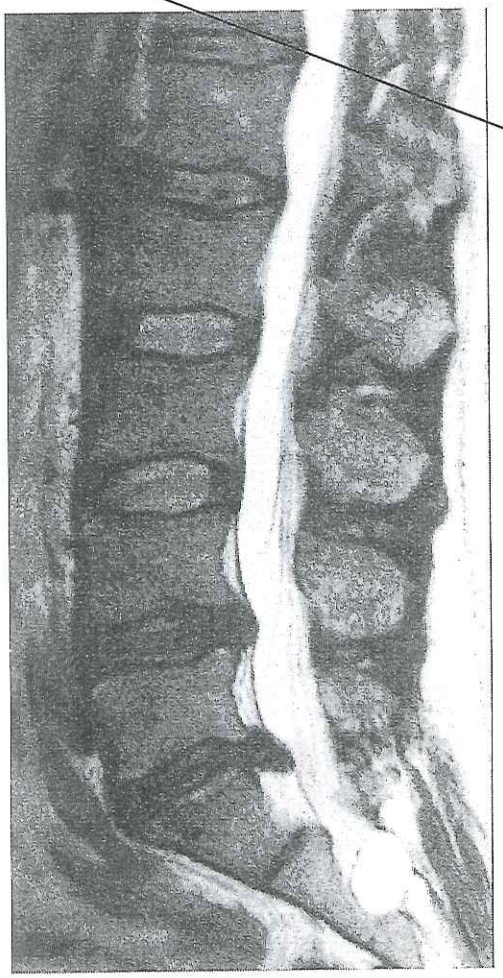


TA =

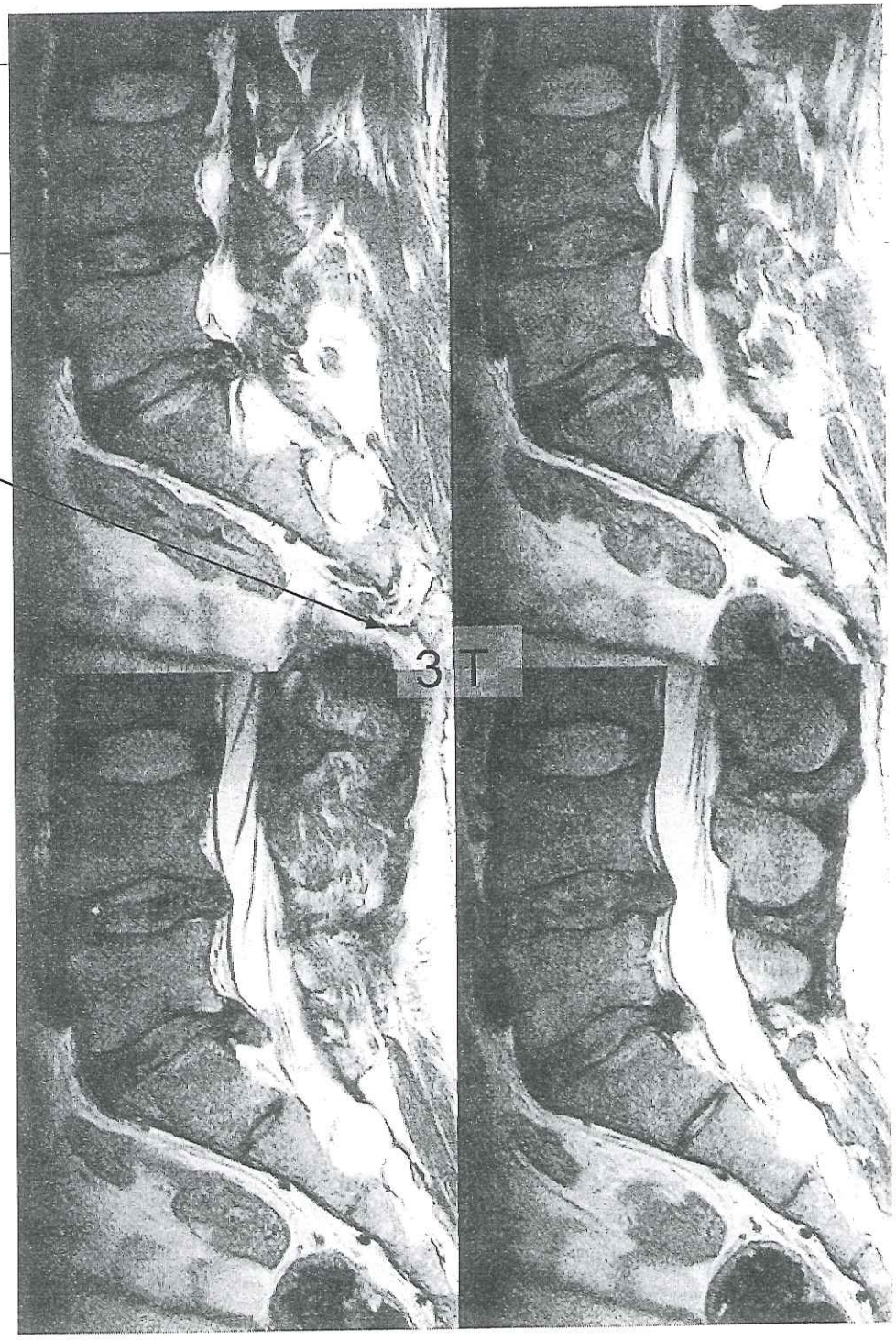
1.5 T
4:14
5:02

3 T
2:44*2
1:56*2

L5-S1 disk herniation
4 vs 2.4 mm slice thickness



1.5 T



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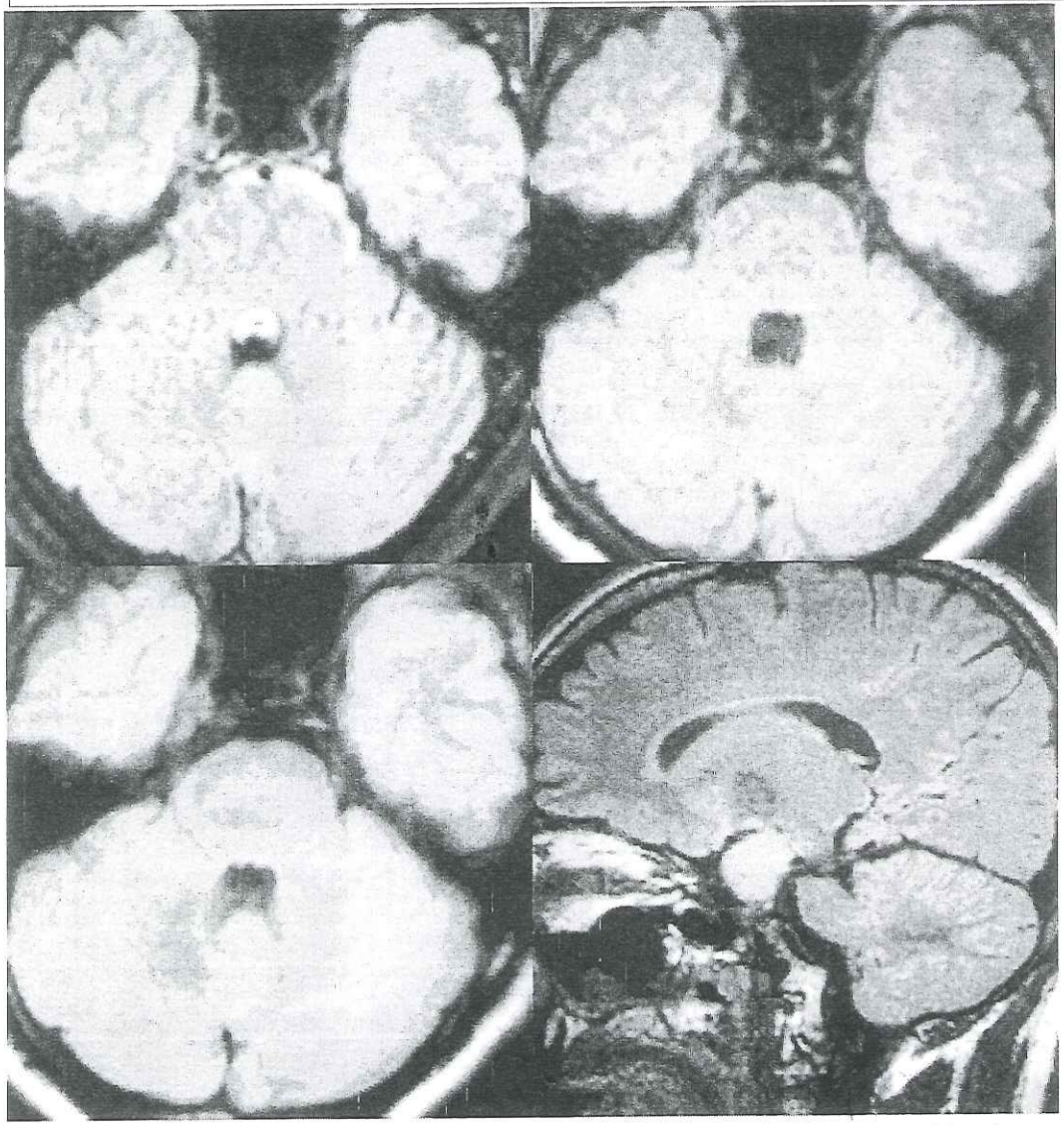
SPACE (at 3 T)



Another related solution is SPACE (Sampling Perfection with Application of Optimized Contrasts using different flip angle Evolutions)

Attachment F

National Utilization Studies

Imaging Performance Partnership

Outlook for Outpatient Imaging Growth

Executive Briefing for Hospital Executives and Radiology Leaders

October 2010

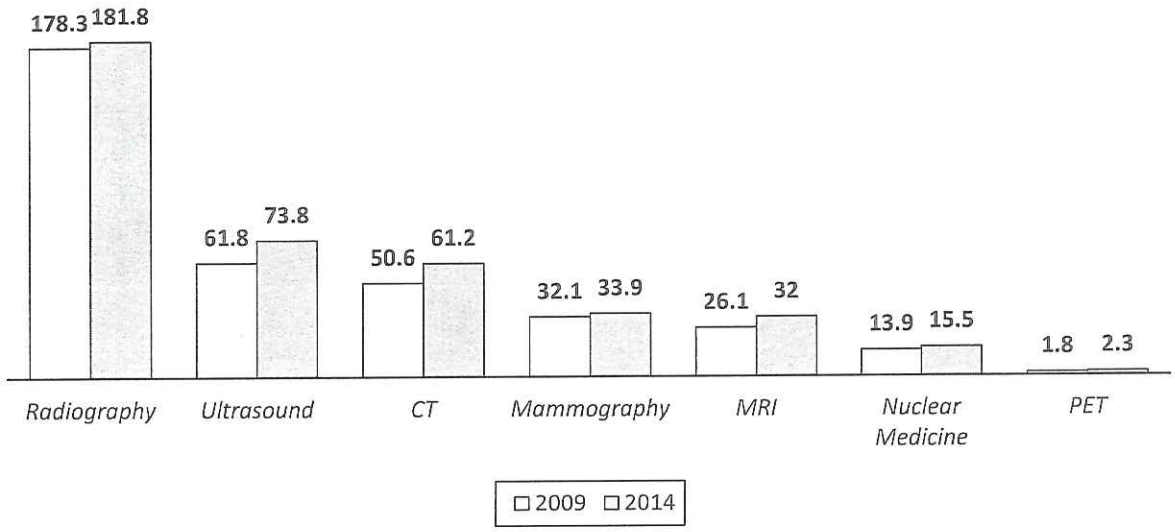
- Imaging Payment Changes
- Imaging Center Market
- Outpatient Volume Volatility
- Emerging Barriers to Growth
- Impact of Reform
- Outpatient Imaging Forecasts

Growth Expected to Recover with Economy

As the labor market improves, outpatient volume growth should largely rebound. Advanced imaging modalities in particular are expected to see healthy incremental volumes through 2014. However, outpatient volumes are estimated to grow at less than half their peak rates from the mid-2000s.

Estimated Outpatient Imaging Market Growth

Procedure Volume in Millions[1]



Obtain Customized Volume Forecasts

To obtain customized volume estimates for your markets, please access our online tool, the Outpatient Imaging Market Estimator, available at www.advisory.com/IPP.

[1] Includes emergency imaging volume

Source: Imaging Performance Partnership interviews and analysis.

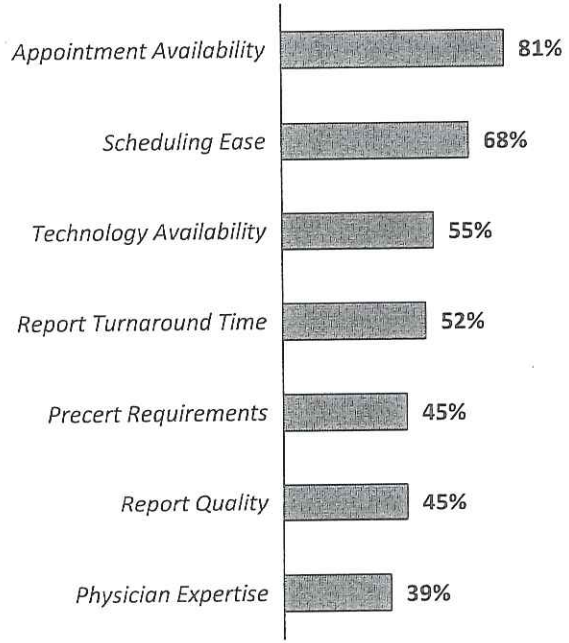
Superior Service Required on All Fronts

With several new barriers to volume growth now emerging, improving customer service and managing referral relationships will continue to be the critical priority for outpatient strategy. While hospitals in general have made considerable strides in recent years to ensure appointment availability and improve the ease of scheduling, few institutions excel at all phases of the referral chain. As the competitive position of hospitals improves due to a hardening freestanding market, a comprehensive approach to service will be essential to compete effectively for volumes.

Patient Satisfaction, Referral Strategy as Critical as Ever

"Importance of Competitive Factors in Your Market"

Percent of Partnership Respondents Strongly Agreeing



Falling Short of Freestanding Performance

Imaging Center Benchmarks

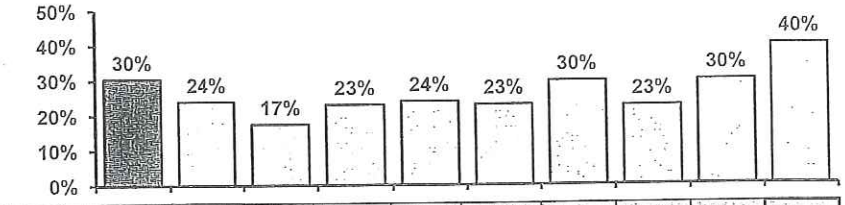
Metric	Benchmark
Number of rings before call is answered	<3
Seconds caller is hold	<20
Minutes patient is waiting in lobby	<15
Minutes patient is waiting in procedure room	0
Hours between study and report delivery to physician	<24
Number of staff with whom customer must register complaint	<2
Hours between complaint and response	Within 24 hours

Source: Imaging Performance Partnership Member Survey; Imaging Performance Partnership interviews and analysis.

Strong Growth Expected Across All Outpatient Services

Outpatient Procedure Groups

10-Year Growth Rates, US Market, 2010–2020

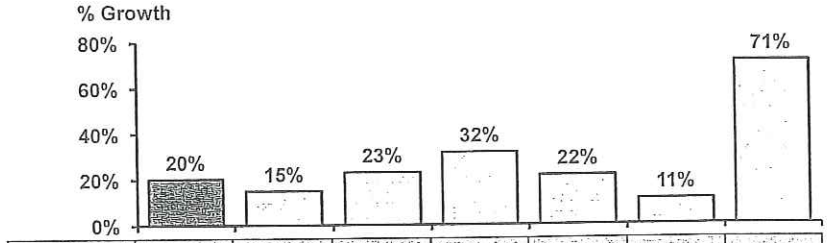


Volumes	Overall	Rehab	Standard Imaging	Procedures	Specialist	Diagnostics	Advanced Imaging	Endoscopy	Oncology	Visits
2010 Volume (Millions)	3,008.75	524.12	417.87	210.44	286.90	190.65	111.19	53.80	25.20	1,188.20
10-Year Absolute Growth (Millions)	897.23	125.77	72.64	49.36	69.50	44.44	32.98	12.14	7.52	481.14

Note: Analysis excludes ages 00–17.
Sources: Impact of Change® v9.0; Pharmetrics; CMS; Sg2 Analysis, 2010.

Standard Modalities Dominate Despite Strong Gains in Advanced Imaging

Outpatient Imaging Modalities
10-Year Growth Rates, US Market, 2010–2020



Volumes	Overall	X-ray	U/S	CT	MRI	Nuclear Med/SPECT	PET
2010 National Volume (Millions)	529.06	282.74	119.91	76.69	32.20	15.21	2.30
10-Year Absolute Growth (Millions)	105.62	44.08	27.94	24.34	7.00	1.62	1.63

Analysis excludes ages 00-17. U/S = ultrasound; CT = computed tomography; MRI = magnetic resonance imaging; PET = positron emission tomography.
Sources: Impact of Change® v9.0; Pharmetrics; CMS; Sg2 Analysis, 2010.

Attachment G

Curriculum Vitae

Lawrence & Memorial Hospital

President / Chief Executive Officer

Bruce D. Cummings

Mr. Cummings was named Chief Executive Officer at Lawrence & Memorial Hospital on October 31, 2005. Prior to that, he served as President and Chief Executive Officer of Olean General Hospital in Olean, New York. From September 1990 to March 2002, Mr. Cummings served as the CEO of Blue Hill Memorial Hospital in Maine. Mr. Cummings also spent 10 years at Mid-Maine Medical Center in Waterville, Maine as Director of Ambulatory Care; and from November 1985 to 1990 as Vice President for Strategic Planning, Marketing and Corporate Development. From 1978 to 1980, Mr. Cummings served as the City of Danbury's first full-time Director of Health.

Mr. Cummings received a Bachelor of Arts in Sociology from Colby College and a Master of Public Health degree from Yale University School of Medicine, Department of Epidemiology and Public Health. He is board-certified in healthcare management through the American College of Healthcare Executives, a member of the Board of Directors of the Connecticut Hospital Association, a director of the Visiting Nurse Association of Southeastern Connecticut, and a delegate to the American Hospital Association's Regional (New England) Policy Board.

Daniel Rissi, MD
365 Montauk Avenue
New London, CT 06320
(860) 442-0711

Professional Experience

Febuary 2008 to present; Lawrence & Memorial Hospital; Vice President/Chief Medical & Clinical Operations Officer
June 2006 to February 2008; Lawrence and Memorial Hospital; Vice President and Chief Operating Officer
October 2005 to January 2006; Olean General Hospital; Interim President and Chief Executive Officer
January 2003 to June 2006; Olean General Hospital; Vice President for Medical Affairs
March 2002 to August 2002: Blue Hill Memorial Hospital; Interim Chief Executive Officer
1990 to 2002: Blue Hill Memorial Hospital; Medical Director (full time since 1998); Chief of Staff
1996 to 2002: Maine Network for Health; Medical Director (1998-2002)

Additional Professional Activities

2003-2006: Olean General Hospital, Olean, New York; active medical staff
1980-2003: Blue Hill Memorial Hospital, Blue Hill, Maine; active medical staff
1980-2003: Eastern Maine Medical Center, Bangor, Maine; affiliate medical staff
1980-1994: Island Medical Center Doctors, Stonington, Maine; physician, managing partner

Education and Training

American Board of Family Medicine; certified 1980, recertified 1986,1992, 1998, 2004
Certificate of added Qualification in Geriatrics, AAFP; certified 1988; recertified 1998
Medical Review Officer; certified by AAMRO 2003
Aviation Medical Examiner (FAA); certified 1981, recertified 1986, 1991
State of Maine Medical Examiner; certified 1977
1977-1980 Eastern Maine Medical Center; Residency in Family Medicine
1973-1977 Johns Hopkins University School of Medicine; MD
1969-1973 Yale University; BA

Professional Memberships

American College of Physician Executives; member since 1996
American Academy of Family Physicians; member since 1980; Fellowship 1994
American Geriatrics Society; member since 1989
National Board of Medical Examiners; diplomate 1977
American College of Healthcare Executives; member since 2006

Lawrence & Memorial Hospital

Vice President / Chief Financial Officer

Lugene Inzana, MBA, CPA

Mr. Inzana became Vice President/Chief Financial Officer at Lawrence & Memorial Hospital in January 2008. Prior to joining Lawrence & Memorial, he served as Vice President of Finance/CFO 2004-2007 at Olean General Hospital, a 186 bed Rural Referral Center located in Olean, NY. From 2002-2004, Mr. Inzana was Vice President Finance – MIS/CFO at Jones Memorial Hospital in Wellsville, NY. From 1991 to 2002 he served as Controller of Olean General Hospital and from 1989 to 1991 he served as Controller of St. Francis Hospital in Olean, NY.

Mr. Inzana holds an Associate's Degree in Accounting from the State University of New York, a Bachelors Degree in Accounting and a Masters Degree in Finance, both from St. Bonaventure University and is a Certified Public Accountant.

Mr. Inzana is the Past President of the Western New York Chapter of Healthcare Financial Management Association, representing approximately 200 financial executives across Western New York.

CURRICULUM VITAE

TODD M. BLUE, M.D.

Home Address:
4 Vaccinium Way
Old Lyme, CT 06371
(860) 434-8889

Business Address:
Lawrence & Memorial Hospital
Department of Radiology
365 Montauk Avenue
New London, CT 06320
(860) 442-0711, ext. 2214

EMAIL:
dblue@lmhosp.org

CERTIFICATION:	American Board of Radiology	1998
LICENSURE:	Connecticut	
PROFESSIONAL ORGANIZATIONS:	AMA	
EDUCATION:	Temple University School of Medicine M.D. Degree	1989 - 1993
	Ursinus College B. S. Degree, Biology	1985 - 1989
POST GRADUATE TRAINING:	Yale – New Haven Hospital Interventional Radiology Fellowship	1998 – 1999
	Yale – New Haven Hospital Diagnostic Imaging Residency	1994 – 1998
	Albert Einstein Medical Center Transitional Year Residency	1993 – 1994
PROFESSIONAL EXPERIENCE:	Lawrence & Memorial Hospital New London, CT Chair, Department of Radiology	2010 – present
	Lawrence & Memorial Hospital New London, CT Staff Radiologist	1999 – 2009

	Veterans Memorial Medical Center Meriden, CT Part-Time Medical Staff Diagnostic Radiology	1997 – 1999
	Milford Hospital Milford, CT Part-Time Medical Staff Diagnostic Radiology	1998 – 1999
	Yale - New Haven Hospital New Haven, CT Chief Resident	1995 – 1996

PERSONAL DATA:

Date of Birth: 11/10/1967
Place of Birth: Chester, SC

ARUN BASU, MD

curriculum vitae
365 Montauk Avenue
New London, CT 06320
(860)449-0548(H) • (860)857-8736(C)
arun_basu@hotmail.com
Place of Birth: Derby, CT
Citizenship: U.S.A.

PROFESSIONAL EXPERIENCE

Radiologist, Ocean Radiology Associates, New London, CT, 7/2007 – present.
Vice Chaiman
Section Chief, General Radiology

POSTGRADUATE EDUCATION

ACGME Accredited Musculoskeletal Fellow, University of Rochester Medical Center, Department of Radiology, Division of Musculoskeletal Imaging,– Rochester, NY. 7/2006 – 6/2007.

Resident, University of Rochester Medical Center, Department of Radiology– Rochester, NY. 7/2002 - 6/2006.

Medicine Internship, Boston University, Roger Williams Medical Center, Department of Internal Medicine, Providence, RI. 7/2001 - 6/2002.

GRADUATE EDUCATION

University of Vermont College of Medicine – Burlington, VT 1997-2001.
Degree: Medical Doctor

UNDERGRADUATE EDUCATION

Vassar College – Poughkeepsie, NY 1991-1995
Degree: Bachelor of Arts, Biology

PROFESSIONAL CERTIFICATIONS/MEMBERSHIPS

Coronary CTA Level II Certified
CT Colonography Trained
American Board of Radiology certification, 2006-2016
Radiologic Society of North America, 2002-present
American Roentgen Ray Society, 2007-present
American College of Radiology, 2002-present
Society of Skeletal Radiology, 2007-present
European Society of Radiology, 2007-present

AWARDS

Resident Exhibit - First Place, *Annual Meeting of the Association of University Radiologists*, Miami Beach, FL. April 2003.

Freeman Scholar, University of Vermont College of Medicine, 2001.

RESEARCH EXPERIENCE

Fellow research, University of Rochester Medical Center (2006-2007)
Mentor: Johnny Monu, MD, Director of Musculoskeletal Imaging
Evaluating diagnostic accuracy of common sports-related pathology of the knee using Fast Spin-Echo MR imaging compared to arthroscopy

Resident research, University of Rochester Medical Center and Eastman Kodak Company Health Imaging Research & Development Laboratories (2002-04)
Mentor: Arvin Robinson, MD, Program Director/Pediatric Radiologist
Developed/assessed image enhancement techniques for plain radiographs to accentuate subtle radiograph findings.

Medical research, University of Vermont Medical Center, Pulmonary Medicine - laboratory technician (1995-1997)
Mentor: David Gannon, MD, Critical Care/Pulmonary Physician
Improved cell synchronization/growth techniques for hepatocytes.

Undergraduate research, Vassar College, Long Biomechanics Laboratory, *Elasticity of the butterfish spinal column and its contribution to locomotion* (1995)
Mentor: John Long, Ph.D. Associate Professor
Designed and built an apparatus to measure elastic components of fish spinal columns.

Undergraduate research, American Heart Association, Pfizer Inc., Groton, CT (1993)
Mentor: Delvin Knight, Ph.D. Senior Research Scientist
The effects of nitric oxide inhibition (L-NAME) on blood distribution in hemorrhagic shock.
Presented at the 1993 Annual American Heart Association Scientific Meeting - Wallingford, CT.

Undergraduate research, American Heart Association, Pfizer Inc., Groton, CT (1992)
Mentor: Delvin Knight Ph.D. Senior Research Scientist
The use of dye extraction microspheres for regional blood flow measurements in anesthetized rats.
Presented at the 1992 Annual American Heart Association Scientific Meeting – Wallingford, CT.

POSTGRADUATE PUBLICATIONS

A. Basu, J. Strang "Fusion PET/CT" Chapter in *CT Radiology Secrets* (J. Strang, V. Dogra Eds.), Hanley & Belfus Publishing, Philadelphia, PA 2006.

A. Basu. "Chapter 4: Bronchial artery embolization" in *Interventional Radiology Secrets* (D. Waldman, N. Patel, W. Saad Eds.), Hanley & Belfus Publishing, Philadelphia, PA 2004.

A. Basu. *Synovial Osteochondromatosis: A case report*, Veterans Health System Journal - Boston University, Fall 2001.

POSTGRADUATE PRESENTATIONS

A. Basu, S. Cassar, I. Mikityansky, S. Meyers, J. Monu. *Evaluating diagnostic accuracy of common sports-related pathology of the knee using Fast Spin-Echo MR imaging compared to arthroscopy* – accepted for presentation at the Association of University Radiologists Annual Meeting. April 2007.

C. Timberlake, J. Lee, A. Basu, J. Monu. *Calcific Tendinitis of the Shoulder: Management Options Revisited* – accepted presentation at the Annual Meeting of the Radiologic Society of North America, Chicago, IL. November 2006.

M. Bakman, K. Chan, C. Bang, A. Basu, G. Seo, J. Monu. *Upper Cervical Spine - Occult Injury and Trigger for CT Exam* – Annual Meeting of American Roentgen Ray Society Vancouver, CA. May 2006.

A. Basu, W. J. Sehnert, A. Robinson. *Evaluating subtle findings of chest radiography using reverse-polarity tone scale imaging (P-tone).* - Presented at the Annual Meeting of the Association of University Radiologists, San Francisco, CA. April 2004.

This study was supported in part by a grant from Eastman Kodak Company Health Imaging Research & Development Laboratories.

A. Basu, D. Davis, W. J. Sehnert, L. Fletcher-Heath, J. Doran, W. J. Quinlan, D. Foos, A. Robinson. *Manipulation of full fidelity digital images for disease-specific scenarios: A resource for junior residents in the emergency radiology setting.*

Presented as a scientific exhibit at the Annual Meeting of the Association of University Radiologists, Miami Beach, FL. April 2003– Awarded Best Resident Exhibit.

Presented at the Annual Association of Emergency Radiologists, Las Vegas, NV. October 2003.

This study was supported in part by a grant from Eastman Kodak Company Health Imaging Research & Development Laboratories.

GRANTS

American Heart Association Undergraduate Research Grant, 1993.
American Heart Association Undergraduate Research Grant, 1992.

References available on request.

CURRICULUM VITAE

LOUIS MAZZARELLI, M.D.

Business Address:
Lawrence & Memorial Hospital
Department of Radiology
365 Montauk Avenue
New London, CT 06320
(860) 442-0711, ext. 2214

EMAIL:
lmazzarelli@lmhosp.org

CERTIFICATION:	American Board of Radiology	2006
LICENSURE:	Connecticut	
EDUCATION:	Albert Einstein College of Medicine, Bronx, NY M.D. Degree	1997 - 2001
	Yale University Combined B.S., M.S., Biology, *Cum Laude* B.A. History of Art, Distinction in the Major	1992 - 1996
POST GRADUATE TRAINING:	Columbia Presbyterian Medical Center Clinical Fellow and Assistant Attending Musculoskeletal Radiology	2006 – 2007
	Columbia Presbyterian Medical Center Residency, Diagnostic Radiology	2002 – 2006
	St. Vincent's Medical Center Internship, Preliminary Year	2001 – 2002
PROFESSIONAL EXPERIENCE:	Lawrence & Memorial Hospital New London, CT Staff Radiologist	2007 – present

CURRICULUM VITAE

FARUK H. SOYDAN, M.D.

Home Address:
77 Balsam Road
Groton, CT 06340
(860) 536-7507

Business Address:
Ocean Radiology Associates
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320
(860) 444-5189

EMAIL:
fsoy@aol.com

EDUCATION:

B.A., 1970 Summa Cum Laude
Boston University
Boston, Massachusetts

M.D., 1974
State University of New York
Upstate Medical Center
Syracuse, New York

POST GRADUATE TRAINING:

Medical Internship, 1974 – 1975
State University Hospital
Syracuse, New York

Residency in Diagnostic Radiology, 1975 – 1978
Peter Bent Brigham Hospital
Boston, Massachusetts

Fellowship in Neuroradiology, 1978 – 1979
Tufts – New England Medical Center
Boston, Massachusetts

CERTIFICATION:

Diplomate, National Board of Medical Examiners, 1974
Diagnostic Radiology, American Board of Radiology, 1978

PROFESSIONAL LICENSES:

Connecticut, 021522 (active)
Kansas, 04-31153 (inactive)
Massachusetts, 42499 (inactive)
Rhode Island, 11759 (active)

APPOINTMENTS:

2002 – Present	Staff Radiologist Department of Radiology Lawrence & Memorial Hospital New London, Connecticut
1997 – 2002	Staff Radiologist, Neuroradiology Department of Radiology Lawrence & Memorial Hospital New London, Connecticut
1995 – 1997	Chairman Department of Radiology Lawrence & Memorial Hospital New London, Connecticut
1994 – 1995	Vice-Chairman Department of Radiology Lawrence & Memorial Hospital New London, Connecticut
1979 – 1994	Staff Radiologist, Neuroradiology Department of Radiology Lawrence & Memorial Hospital New London, Connecticut
1978 – 1979	Clinical Instructor Diagnostic Radiology Tufts – New England Medical Center Boston, Massachusetts

HONORS:

1973 – 1974	Research Grant, American Cancer Society Intracellular Localization of Oncogenic Viruses

MEMBERSHIPS:

American College of Radiology
Radiological Society of North America
Radiological Society of Connecticut
American Medical Association
Connecticut State Medical Society

Donna-Marie Blakely
104 Satari Drive
Coventry, CT 06238
(860) 742-0743 or (860) 742-1945

Objective: Director Radiology
Professional Experience

Administrative Director, 09/06 to Present
Lawrence and Memorial Hospital, New London, CT

- Returned to Lawrence and Memorial Hospital in my previous position after 3 plus years at Jefferson Radiology.
- Responsible for 10 cost centers including: 4 satellite outpatient centers, MRI (2), Radiology, Ultrasound (cardiac, vascular, Ob, GYN, Abdominal), CAT Scan (4), Nuclear Medicine (general and cardiac), Special Procedures and Digital Mammography.
- Over 170,000 procedures performed annually.
- Participate in strategic planning, renovations, CON, equipment/vendor negotiation and selection.
- Operational reorganization and improvements.
- Human resource issues for over 100 FTE. (Union environment).
- Direct supervision of 8 Modality Managers
- Supervision of student education and rotation through hospital with the Gateway Community College (US and Nuclear Med), Quinnipiac College (US and Radiology), University of Hartford (MRI and CT), and Windham Hospital School or Radiologic Technology (Radiology).
- Digital film-less environment. Sectra PACS, McKesson CPACS and Fuji CR.

Director of Operations, 06/03 to 08/06
Jefferson Radiology Group, P.C., East Hartford, CT

- Responsible for overseeing day-to-day operational activities of 175 FTEs in 6 full service offices and for overall operational success in meeting quality, productivity and financial goals. Equipment and operations include 6 MRIs, 5 CT Scanners, 7 digital mammography units, 11 ultrasound units, 4 nuclear medicine cameras and numerous other x-ray and fluoroscopy systems. Total volume in excess of 150,000 procedures per year.
- Ensure optimal work environment for JXR physicians and staff, ensuring that appropriate facilities, equipment, and other required resources are available to support service delivery goals in the most cost-effective manner.
- Manage staff of 10-15 supervisors and/or managers. Handle day to day human resource issues for staff of 175 FTEs.
- Strong financial analysis skills and experience with corporate budget management and business plans. Negotiate all capital equipment purchases and non salary contracts system wide.
- Strategic thinker, strong decision maker, knowledgeable of trends in healthcare industry. Participate in Certificate of Need process and Performa development for new projects and offices.

- Successfully implemented new RIS. Participated in PACS selection and implementation team. PACS go live Fall 2005.
- Oversaw opening of new Enfield Office and significant expansion of an existing office in Wethersfield. In the planning stages for additional full service office in Farmington.
- Co-Chairman of the Operations Committee. Member of the Planning and IT committees.
- ACR and FDA Accreditation process.
- Introduced student rotations with University of Hartford (MRI and CT), Windham Hospital and Hartford Hospital Schools of Radiologic Technology, resulting in lower recruitment costs and filled positions.

Administrative Director, 01/01 to 05/03
Lawrence and Memorial Hospital, New London, CT

- See current job responsibilities
- Passed Diagnostic and Nuclear Medicine State, JCAHO, Medicare and NRC inspections with no recommendations or citations including Quality Improvement initiatives.
- Salary, non-salary and capital budgets and cost containment.
- Pro forma/business plan development.
- C.P.T. Coding/Reimbursement.
- PACs Committee Co-chair.

Executive Director 5/98 to 12/00
Women's Center for Wellness, Vernon, CT
Separate Corporation under ECHN umbrella

- Services include: Gynecological well women exams, mammography, bone density, massage, nutritional counseling, behavioral health, exercise, educational programs, and complementary therapy.
- Billing, CPT4, ICD9 and E&M coding.
- Computerized billing and scheduling systems; selection and implementation.
- Planning and marketing of Center.
- FDA and ACR accreditation of mammography program.
- Pro forma/business development.
- Complete financial responsibility for Center.
- Human Resource issues.
- State inspections.
- Direct Board responsibility.

Director of Business Development, Medical Imaging 5/98 to 12/00
Eastern Connecticut Healthcare Network *(ECHN)*

- Negotiate, select, purchase and install all capital equipment for ECHN Medical Imaging sites (MMH, RGH, GWC, WCW).
- Vendor contract negotiations.
- Planning and marketing of imaging services.
- Reimbursement and coding (interventional price master, superbills, APCs).
- Information Technology: PACs project, transcription systems and RIS.
- Special Projects: Project planning, renovations, capital equipment installs, new business ventures, C.O.N.'s.

Administrative Director, Medical Imaging 11/89 to 5/98
Manchester Memorial Hospital, Manchester, CT
Part of Eastern Connecticut Health Network *(ECHN)*

- Administration of 6 cost centers: M.R.I., Diagnostic, C.T., Ultrasound (Vascular Lab), Nuclear Medicine, Echocardiography
- C.O.N. development and long-range planning.
- Selection and negotiation of equipment purchases.
- Salary, non-salary, and capital budgets.
- Director of 50+ full-time employees.
- Quality Assessment (physician and technical components).
- Market analysis and marketing.
- Construction and renovation of major projects.
- C.P.T. Coding/Reimbursement.
- R.I.S. Selection.
- Passed Diagnostic and Nuclear Medicine State, JCAHO, Medicare and NRC inspections with no recommendations or citations.
- Passed ACR and FDA mammography accreditation process.
- Medical Imaging Transcription.
- New Office Development.
- Pro forma/business plan development.

Assistant Director, Medical Imaging 12/88 to 11/89
Manchester Memorial Hospital, Manchester, CT

- Responsible for diagnostic portion of Medical Imaging.
- Reduced overtime and over-budgeted hours.
- Scheduling/Payroll
- Quality Control and Quality Assurance
- Equipment maintenance
- Personnel issues, including: merit reviews, interviews, disciplinary measures and staff meetings.

Technical Manager 9/87 to 12/88
Medical Imaging Centers, Bloomfield, CT

- Supervision of over 20 technologists in five offices.

- Developed Quality Control and Quality Assurance to meet State standards.
- Implemented in-service education and staff meetings.
- Scheduling/Payroll
- Personnel issues, including: hiring and disciplinary measures.
- Involved in design and layout of additional office.
- Participated in design of new Imaging Center.

CT Scan and Special Procedure Technologist 1987
Bradley Memorial Hospital, Southington, CT

Clinical Instructor, School of Radiologic Technology 8/85 to 4/87
Responsible for teaching the clinical portion of the program, including positioning and anatomy classes. Supervised clinical rotations and check offs. Film Critique.
Middlesex Memorial Hospital, Middletown, CT

Head of Special Procedures and Quality Control Technologist 9/81 to 8/85
Bradley Memorial Hospital, Southington, CT

Education

July 2002 **Certified Radiology Administrator** Boards by the American Healthcare Radiology Administrators.

October 1995 **Mammography Certification Boards** by American Registry of Radiologic Technology

Hartford Graduate Center, Hartford, CT GPA: 4.0.
June 1994 **Master of Science**, Health Care Management

New Hampshire College, Springfield, MA
May 1989 **Bachelor of Science**, Human Services; Administration

New Britain General Hospital, School of Radiologic Technology
May 1980 **Registered** by American Registry of Radiologic Technology

Personal Achievements and Professional Affiliations

2010 Member, American Healthcare Radiology Administrators (AHRA)
Member, American Society of Radiologic Technology (ASRT)
Member, Radiology Business Management Society
AHRA Liaison to RSNA Associate Sciences Consortium

1997 Chairperson, Manchester Memorial Hospital Quality Assessment Committee

1996 Vice Chairperson, Manchester Memorial Hospital Quality Assessment Committee
Recipient, "AHRA Partners in Learning" Program

Chairman, American Healthcare Radiology Administrators (AHRA) Membership Committee, North Atlantic Region.
Member, Membership Committee of American Healthcare Radiology Administrators (AHRA), North Atlantic Region.

1994 Recipient, Rotary International, "Team Finland", Business Exchange Program.
Chairperson, Membership Committee, AHRA, North Atlantic Region

1993 Chairperson, Connecticut Hospital Association, Directors of Diagnostic Imaging Conference.
Member, Membership Committee, American Healthcare Radiology Administrators
Member, Educational Committee, American Healthcare Radiology Administrators
Recipient, Connecticut Society of Radiologic Technologists Scholarship Award
Winner, First Place in New England Conference of Radiologic Technologists Essay Contest.

1992 Educational Chairperson, Connecticut Hospital Association, Directors of Diagnostic Imaging Conference

1989 Vice President, Connecticut Society of Radiologic Technologists

1988 District Representative, Connecticut Society of Radiologic Technologists

1985 Employee of the Quarter, Bradley Memorial Hospital (July)

Mary Wadsworth
294 Chesterfield Road
East Lyme, CT 06333
(860) 739-9179 (H)
(860) 442-8800 (W)
mwadsworth@lmhosp.org

Areas of Effectiveness: Established communication skills, conflict resolution skills, customer service and customer relations, patient care, responsibility and organizing

Education

01/07 – present **Three Rivers Community College,** Mohegan Campus
7 Mahon Drive, Norwich, CT 06360
Actively pursuing an Associate Degree

07/94 – 07/06 **Lawrence & Memorial Hospital School of Radiologic Technology**
365 Montauk Avenue
New London, CT 06320
Radiologic Technologist, (Registered)

09/80 – 05/81 **University of Wisconsin – Stevens Point**
Stevens Point, WI 54481
General Studies

Career Experience

10/09 - present **Imaging Manager, Satellite Facilities,** L&M Diagnostic Imaging at Crossroads, 196 Parkway South, Waterford, CT 06385
Responsibilities include:

- Managing operating budget
- Hiring, training and retaining qualified staff for satellite facilities
- Addressing employee performance issues
- Developing and maintaining department quality and productivity standards
- Developing and monitoring quality indicators
- Scheduling staff to maintain optimum staffing, patient safety within budgetary guidelines
- Writing policies, protocols and procedures per hospital and regulatory guidelines
- Developing and presenting educational presentations to students and hospital employees
- Meeting performance expectations for customer service, teamwork, resource utilization, staff and self development as outlined in performance review
- Supervising clerical staff at satellite facilities

03/04 - present

Manager, CT Scan Department, Lawrence & Memorial Hospital, 365 Montauk Avenue, and New London, 06320
Responsibilities include:

- Managing operating budget
- Hiring, training and retaining qualified staff
- Addressing employee performance issues
- Developing and maintaining department quality and productivity standards
- Developing and monitoring quality indicators
- Acting as a technical expert/resource for the department and must maintain a high level of clinical competence
- Scheduling technical staff to maintain optimum staffing, patient safety within budgetary guidelines
- Maintaining appropriate level of supplies
- Writing policies, protocols and procedures per hospital and regulatory guidelines
- Developing and presenting educational presentations to students and hospital employees
- Meeting performance expectations for customer service, teamwork, resource utilization, staff and self development as outlined in performance review
- Supervising technical staff in CT Scan

05/97 – 03/04

CT Specialist, Lawrence & Memorial Hospital, 365 Montauk Avenue, New London, 06320
Responsibilities included:

- Provided education to patient in form of explanation of exam, completion of intravenous contrast worksheet, take medical history
- Maintained IV start proficiency per nursing guidelines
- Facilitated smooth patient workflow of Inpatients, Outpatients, Emergency Room patients, Urgent add-on patients
- Completed all paperwork and patient documentation in accurate and timely manner
- Operated all equipment according to manufacturer specifications and safe radiation guidelines
- Assisted in orientation and training of new staff and radiology students

07/96 – 05/97

Radiologic Technologist, Lawrence & Memorial Hospital, 365 Montauk Avenue, New London, 06320
Responsibilities included:

- Provided education to patient in form of explanation of exam, take medical history
- Facilitated smooth patient workflow of Inpatients, Outpatients, Emergency Room patients, Urgent add-on patients

- Completed all paperwork and patient documentation in accurate and timely manner
- Operated all equipment according to manufacturer specifications and safe radiation guidelines
- Assisted in orientation and training of new staff and radiology students

05/95 – 05/97 **Radiologic Technologist**, North Stonington Walk-in Medical Center, North Stonington, CT
Responsibilities included:

- Provided x-rays to patients in small medical center
- Registered patients
- Maintained day-log for all patients

Licenses, Accomplishments, Special Recognitions, etc.

07 - 96 ARRT Radiologic Technologists, Registered RT(R)

07 – 96 Jean Steele Award for Clinical Excellence,
Lawrence & Memorial Hospital School of Radiologic Technology
Class of 1996

04 – 98 ARRT Certified CT Scan Technologist, CT

References available upon request

MARCI J GWIAZDOWSKI, RT (R)(CT)(MR)
180 NEWENT ROAD
LISBON, CT 06351
860-917-9909

POSITION DESIRED — SUPERVISOR MRI DEPARTMENT

OBJECTIVE — To utilize my experience in MRI to improve department by capitalizing on new capabilities. Work as a liaison between radiologists, technical staff, and senior leadership to provide best service possible

EDUCATION — Windham Community Memorial Hospital 10/85-10/87 Program of RT

EXPERIENCE — Had 2100 clinical hours. Performed routine radiographic and Fluoroscopic exams. Training included OR, portables and mammo.

EMPLOYMENT

Jan 2009 – PRESENT Manager CT/MRI Dept. L&M Hospital
Responsibilities include staffing 4 CT units and 2 MR units at 3 different facilities, payroll, budgeting, scheduling, planning, QA/QC projects, continued ACR accreditation for 6 units, training /orienting staff, managing 30 techs and 4 secretaries, scanning, venipuncture.

Sept 2000- Jan 2009 Manager MRI dept. L&M Hospital
Responsibilities included are same as above for 2 MR units

March 1995- Sept 2000 MRI technologist
Duties include daily operation of machine, screening and scanning Patients, venipuncture, scheduling add on exams. Working with Other dept to maximize patient through put.

August 1991-March 1995 MRI Technologist Signal Medical Services
Technologist on busy mobile route. Sites include WW BACKUS, DAY

KIMBALL HOSPITAL and L&M. Daily operation with limited supervision.

QUALITIES

Work well with others. Maintain positive outlook and attitude

Empathetic, lead by example

REFERENCES

Faruk Soydan MD	L&M Hospital
Ira Sitko MD	L&M Hospital
Arun Basu MD	L&M Hospital

Attachment H

Documentation of Non-Profit Status

Internal Revenue Service

Department of the Treasury

Washington, DC 20224

Person to Contact:

Telephone Number:

Refer Reply to:
OP:E:EO:R:3-CCH
Date:
FEB 27 1985

Lawrence and Memorial Hospitals
365 Montauk Avenue
New London, CT 06320

Employer Identification Number: 06-0646704

Legend:

M = Lawrence and Memorial Hospitals
N = Lawrence and Memorial Corporation
O = Lawrence and Memorial Foundation, Inc.
P = L & M Health Care, Inc.
Q = L & M Systems, Inc.

Dear Applicant:

This letter is in reference to your joint request for rulings, with three other organizations, regarding a proposed corporate reorganization and proposed transactions relating thereto.

Currently, M, N, O, and P are organizations recognized as exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. M is a public charity described in sections 170(b)(1)(A)(iii) and 509(a)(1) of the Code. N is a supporting organization described in section 509(a)(3). O is a public charity described in sections 170(b)(1)(A)(vi) and 509(a)(1). P is a public charity described in section 509(a)(2). Q is a for-profit organization.

M is a voluntary and not-for-profit hospital considering a reorganization. M's plan of reorganization is proposed in order to:

(1) assure M's continued leadership role in the community and continued capacity to provide patient care at a lower cost;

(2) facilitate compliance with governmental reporting requirements;

(3) segregate hospital assets from non-hospital assets so as to limit third party liability;

(4) separate regulated and non-regulated activities;

(5) isolate unrelated business activities from exempt activities;

(6) remove the management of non-hospital activities and assets from hsopital management;

(7) increase investment opportunitites;

(8) improve recruitment opportunities;

(9) increase flexibility in undertaking capital expenditure projects; and

(10) facilitate long range planning.

After the proposed reorganization, M, N, O, P, and Q will, as a group, conduct the activities formerly conducted by M alone.

In order to implement the proposed reorganization, M will amend its organizing instruments to designate N as its sole member. M will continue to operate the general acute care hospital and provide medical and hospital care. N was formed to benefit, perform the functions of, carry out the purposes of, and uphold, promote, and further the welfare, programs, and activities of M. All of N's members are currently persons who are members of M. In the future, a majority of N's trustees will also be trustees of M. N will function as the parent corporation in the new structure and will provide overall direction and control to M, O, P, and Q.

O was formed to assist M, N, and other section 501(c)(3) organizations associated with M and N, by soliciting and receiving contributions, grants, donations, bequests, and devises, and to make distributions to such organizations for proper purposes. P was formed, among other purposes, to operate and maintain programs directed toward improving the efficiency of utilization of health care facilities, including the education for health professionals, the public, nursing, and residency training, and delivery of health care services. P may assume certain of the outpatient medical care programs or community health education programs previously performed by M, as well as outpatient programs unexplored by M. N is the sole member of both O and P.

Q is a stock corporation with N as its sole shareholder. Q's primary purpose is to render health care related and other services which M has avoided since such services would constitute an unrelated business activity. It is not anticipated that M, N, O, or P will provide any services to Q, but if services are provided, an arm's-length fee will be charged.

M will transfer sufficient cash to provide working capital to N, O, and P at the consummation of the reorganization. Following the initial transfer, it is anticipated that there will be further cash transfers among the exempt organizations. M may also transfer philanthropic monies previously raised

by M to O on the condition that O hold these dollars in a separate, segregated fund that will be used solely for the benefit of M. After the reorganization, M, N, O, and P will share some assets, personnel, and services in an effort to reduce, through economies of scale, the overall cost of providing health care services. To the extent there are transactions between the exempt organizations and Q, such transactions will be conducted on an arm's-length basis and it is anticipated that the charges for goods or services provided in connection with such transactions would be at fair market value.

Section 501(c)(3) of the Code provides for the exemption from federal income tax of organizations that are organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. In the law of charity, the promotion of health is considered to be a charitable purpose.

Section 509(a)(1) of the Code provides that organizations described in section 170(b)(1)(A) (other than in clauses (vii) and (viii)) are excepted from classification as private foundations.

Section 170(b)(1)(A)(iii) of the Code, in part, describes an organization the principal purpose or functions of which are the providing of medical education or medical research, if the organization is a hospital.

Section 170(b)(1)(A)(vi) of the Code describes an organization which normally receives a substantial part of its support (exclusive of income received in the exercise or performance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 501(a)) from a governmental unit referred to in section 170(c)(1) or from direct or indirect contributions from the general public.

Section 1.170A-9(e)(6)(ii) of the regulations provides that unusual grants may be excluded from the calculation used to determine whether an organization is normally supported by direct or indirect contributions from the general public. Section 1.170A-9(e)(6)(iii) provides that all pertinent facts and circumstances will be taken into consideration to determine whether a particular contribution may be excluded.

Section 509(a)(2)(A) of the Code provides that an organization which normally receives more than one-third of its support from any combination of gifts, grants, contributions, or membership fees; and gross receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in an activity which is not an unrelated trade or business, is excepted from classification as a private foundation.

Lawrence and Memorial Hospitals

Section 509(a)(3) of the Code, in part, provides for exception from classification as private foundations for organizations organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of organizations described in section 509(a)(1), and which are operated, supervised, or controlled by or in connection with one or more organizations described in section 509(a)(1).

Section 511(a) of the Code imposes a tax on the unrelated business taxable income of organizations described in section 501(c).

Section 512(a)(1) of the Code defines the term "unrelated business taxable income" as the gross income derived by any organization from any unrelated trade or business regularly carried on by it, less certain allowable deductions and modifications. Section 512(b)(1) provides that dividends are excluded from this definition.

Section 513(a) of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of the functions constituting the basis for its exemption.

Section 1.513-1(d)(2) of the regulations provides that trade or business is "related" to exempt purposes, in the relevant sense, only where the conduct of the business activities has causal relationship to the achievement of exempt purposes; and it is "substantially related" only if the causal relationship is a substantial one. The regulation continues that for the conduct of trade of business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the production or distribution of the goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes.

Section 514 of the Code provides for the taxation under section 512 of income from debt-financed property. Section 514(b)(1)(A)(i), however, provides that the definition of debt-financed property does not include any property substantially all the use of which is substantially related to the exercise or performance by such organization of its charitable purpose constituting the basis for its exemption under section 501.

Subsequent to the proposed reorganization and transfer of activities and funds, M, N, O, and P will operate exclusively for the charitable purpose of promotion of health within the meaning of section 501(c)(3) of the Code. The transfers and sharing of assets, personnel, and services described, in themselves, will have no adverse effect on a determination of exempt status or exception from private foundation status.

Further, the proposed transfers and sharing of assets, personnel, and services do not involve the regular carrying on of unrelated trade or business within the meaning of section 513 of the Code, and do not involve the use of assets other than substantially in furtherance of exempt purposes within the meaning of section 514.

Based on the above, we rule as follows:

(1) M, after its amendments of its organizing instruments and the proposed reorganization, will continue to qualify as an organization described in sections 501(c)(3), 509(a)(1), and 170(b)(1)(A)(iii) of the Code.

(2) N, after the proposed reorganization, will continue to qualify as an organization described in sections 501(c)(3) and 509(a)(3) of the Code.

(3) O, after the proposed reorganization, will continue to qualify as an organization described in section 501(c)(3) of the Code and, provided the requisite public support is received, sections 509(a)(1) and 170(b)(1)(A)(vi).

(4) P, after the proposed reorganization, will continue to qualify as an organization described in section 501(c)(3) of the Code and, provided it meets the support tests thereunder, section 509(a)(2).

(5) N's ownership of 100% of the issued and outstanding voting stock of Q and N's receipt of dividends from Q will have no adverse effect on N's status under sections 501(c)(3) and 509(a)(3) of the Code, and the taxable income of Q will not be construed to be unrelated business income to N.

(6) The proposed transfers of cash and other assets and the sharing of personnel, services, facilities, and expenses by and between M, N, O, and P will not:

(a) jeopardize the continued status of M, N, O, and P as organizations described in section 501(c)(3) of the Code;

(b) adversely affect the status of M, N, O, and P as organizations described in section 509(a); or

(c) give rise to unrelated business taxable income under sections 511-514 to M, N, O, or P.

(7) M's transfer of philanthropic monies to O will qualify as an unusual grant within the meaning of section 1.170A-9(e)(6)(ii) of the regulations and may be excluded from the calculation used to determine public support for purposes of section 170(b)(1)(A)(vi) of the Code.

(8) After the amendments to M's organizing instruments and the proposed reorganization, contributions to M, N, O, and P will continue to be deductible by donors as provided in section 170 of the Code.

These rulings are based on the understanding that there will be no material changes in the facts upon which they are based. Any such change should be reported to your key District Director. A copy of this ruling is being sent to your key District Director. Because it could help resolve questions concerning your federal income tax status, this ruling should be kept in your permanent records.

This ruling is directed only to the organization that requested it. Section 6110(j)(3) of the Code provides that it may not be used or cited as precedent.

Sincerely yours,

(Signed) J. E. Griffith

J. E. Griffith
Chief, Exempt Organizations
Rulings Branch

Attachment I

Hospital License

STATE OF CONNECTICUT

Department of Public Health

License No. 0047

General Hospital

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

Lawrence and Memorial Corporation of New London, CT, d/b/a Lawrence and Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Lawrence and Memorial Hospital is located at 365 Montauk Avenue, New London, CT 06320

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

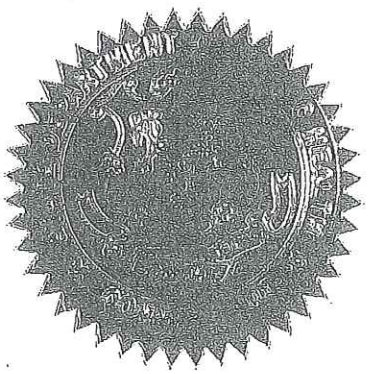
28 Bassinets
280 General Hospital beds

This license expires **March 31, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2009. RENEWAL.

Satellites

Pequot Health Center, 52 Hazelnut Hill Road, Groton, CT
Joslin Diabetes Center, 14 Clara Drive, Mystic, CT



J Robert Galvin MD, MPH, MBA

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

Attachment J

Hospital's Audited Financial Statements

Lawrence & Memorial Hospital

Consolidated Financial Statements
September 30, 2010 and 2009

Lawrence & Memorial Hospital
Index
September 30, 2010 and 2009

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
185 Asylum Street, Suite 2400
Hartford, CT 06103-3404
Telephone (860) 241 7000
Facsimile (860) 241 7590

Report of Independent Auditors

To the Board of Trustees of
Lawrence & Memorial Hospital

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, changes in net assets, and cash flows present fairly, in all material respects, the financial position of Lawrence & Memorial Hospital (a subsidiary of Lawrence & Memorial Corporation, the "Hospital") at September 30, 2010 and 2009, and the results of their operations, their changes in net assets, and of their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These consolidated financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information, on pages 25 through 30, is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations of the individual organizations. Accordingly, we do not express an opinion on the financial position, results of operations, and changes in net assets, of the individual organizations. However, the consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, in our opinion, based on our audits is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

PricewaterhouseCoopers LLP

December 17, 2010

Lawrence & Memorial Hospital
Consolidated Balance Sheets
September 30, 2010 and 2009

	2010	2009
Assets		
Current assets		
Cash and cash equivalents	$ 33,160,240	$ 22,869,913
Investments	106,795,008	99,233,961
Patient accounts receivable, net of allowance for doubtful accounts of $6,760,213 and $6,535,167, respectively	30,942,261	30,054,404
Other receivables	5,765,211	5,995,236
Inventories	3,796,086	3,506,113
Due from affiliates	6,243,476	2,903,156
Prepaid expenses and other current assets	1,624,613	2,312,579
Debt service fund	1,248,032	1,295,094
Total current assets	189,574,927	168,170,456
Assets limited as to use		
Cash	179,215	177,710
Construction fund	-	6,170
Investments held in trust	11,986,573	12,678,851
Endowment investments	14,741,092	14,150,668
Funds held in trust by others	5,876,049	5,611,568
Contributions receivable	46,092	48,469
Funds held in escrow by agreement with State of Connecticut Health and Educational Facilities Authority and trustees	7,156,167	7,159,610
Total assets limited as to use	39,985,188	39,833,046
Deferred financing costs and other assets, net	1,330,365	1,418,292
Property, plant and equipment, net	109,171,111	106,053,228
	$ 340,061,591	$ 315,475,022
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 19,524,046	$ 15,377,893
Accrued vacation and sick pay	11,220,455	10,641,451
Salaries, wages, payroll taxes and amounts withheld from employees	5,023,219	4,184,333
Due to affiliates	4,764,147	1,682,710
Due to third party payors	8,559,110	9,089,438
Current portion of long-term debt	2,866,493	2,640,000
Total current liabilities	51,957,470	43,615,825
Accrued pension and other postretirement benefits	52,131,286	43,029,547
Other liabilities	12,279,482	12,202,253
Long-term debt, less current portion	61,883,130	64,249,223
Total liabilities	178,251,368	163,096,848
Net assets		
Unrestricted	137,908,558	129,621,224
Temporarily restricted	18,251,340	17,211,837
Permanently restricted	5,650,325	5,545,113
Total net assets	161,810,223	152,378,174
	$ 340,061,591	$ 315,475,022

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence & Memorial Hospital
Consolidated Statements of Operations
Years Ended September 30, 2010 and 2009

	2010	2009
Unrestricted revenues, gains and other support:		
Net revenues from services to patients	$ 314,168,301	$ 283,933,518
Other operating revenues	9,926,307	8,924,533
Net assets released from restriction used for operations	412,940	460,320
Total unrestricted revenues, gains and other support	324,507,548	293,318,371
Expenses:		
Salaries and wages	143,999,074	135,533,992
Employee benefits	40,325,006	35,728,800
Supplies	33,524,606	31,017,186
Purchased services	21,093,240	21,328,169
Other	38,810,996	29,002,754
Interest	2,332,245	2,570,991
Depreciation and amortization	16,728,407	15,891,356
Bad debts	15,052,335	15,807,846
Total expenses	311,865,909	286,881,094
Income from operations	12,641,639	6,437,277
Non-operating gains		
Unrestricted investment income	175,335	266,039
Income/(loss) from investments	2,341,396	(691,170)
Total non-operating gains (losses)	2,516,731	(425,131)
Excess of revenues over expenses	15,158,370	6,012,146
Transfers to affiliated entity	(4,900,000)	-
Net unrealized gains on investments	5,459,058	4,304,504
Net assets released from restriction used for purchase of property, plant and equipment	181,470	208,519
Pension - related changes other than periodic pension costs	(7,611,564)	(22,254,106)
Donated equipment	-	60,000
Increase/(decrease) in unrestricted net assets	$ 8,287,334	$ (11,668,937)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence & Memorial Hospital
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2010 and 2009

	2010	2009
Unrestricted net assets		
Excess of revenues over expenses	$ 15,158,370	$ 6,012,146
Transfers to affiliated entity	(4,900,000)	-
Net unrealized gains on investments	5,459,058	4,304,504
Net assets released from restrictions used for purchase of property and equipment	181,470	208,519
Pension - related changes other than periodic pension costs	(7,611,564)	(22,254,106)
Donated equipment	-	60,000
Increase/(decrease) in unrestricted net assets	8,287,334	(11,668,937)
Beginning of year unrestricted net assets	129,621,224	141,290,161
End of year unrestricted net assets	$ 137,908,558	$ 129,621,224
Temporarily restricted net assets		
Income from investments	$ 268,083	$ 445,602
Net assets released from restrictions	(594,410)	(668,839)
Contributions received	191,238	254,173
Change in value of irrevocable trust	159,705	(108,819)
Net realized and unrealized gains/(losses) on investments	1,014,887	(579,243)
Increase/(decrease) in temporarily restricted net assets	1,039,503	(657,126)
Beginning of year temporarily restricted net assets	17,211,837	17,868,963
End of year temporarily restricted net assets	$ 18,251,340	$ 17,211,837
Permanently restricted net assets		
Change in value of funds held in trust by others	$ 105,212	$ (63,111)
Increase/(decrease) in permanently restricted net assets	105,212	(63,111)
Beginning of year permanently restricted net assets	5,545,113	5,608,224
End of year permanently restricted net assets	$ 5,650,325	$ 5,545,113
Increase/(decrease) in net assets	$ 9,432,049	$ (12,389,174)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence & Memorial Hospital
Consolidated Statements of Cash Flows
Years Ended September 30, 2010 and 2009

	2010	2009
Cash flows from operating activities		
Change in net assets	$ 9,432,049	$ (12,389,174)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	16,728,407	15,891,356
Receipt of contributed securities	(427,788)	(125,724)
Net unrealized and realized gain on investments	(6,340,835)	(5,010,566)
Provision for bad debts	15,052,335	15,807,846
(Increase)/decrease in funds held in trust by others	(264,481)	172,314
Decrease in contributions receivable	2,377	48,492
Changes in other operating accounts		
Patient accounts receivable, net	(15,940,192)	(9,559,699)
Other receivables, net	230,025	(2,060,664)
Inventories	(289,973)	(149,064)
Due from affiliates	(3,340,320)	(1,714,456)
Prepaid expenses and other current assets	687,966	(406,074)
Deferred financing costs and other assets	87,927	210,788
Accounts payable	4,355,867	(2,183,593)
Accrued vacation and sick pay	579,004	475,554
Salaries, wages, payroll taxes and amounts withheld from employees	838,886	483,413
Due to affiliates	3,081,437	1,109,557
Due to third party payors	(530,328)	1,095,823
Pension, postretirement and other liabilities	9,178,968	22,838,209
Net cash provided by operating activities	33,121,331	24,534,338
Cash flows from investing activities		
Purchase of property, plant and equipment, net	(19,933,142)	(23,003,127)
Purchase of investments	(94,425,145)	(45,924,191)
Sales of investments	93,311,452	51,214,482
Decrease/(increase) in debt service fund	47,062	(1,057)
Income from temporarily and permanently restricted investments	427,788	125,724
Decrease in funds held in escrow	3,443	181,397
Net cash used in investing activities	(20,568,542)	(17,406,772)
Cash flows from financing activities		
Principal payments of long term debt	(2,262,462)	(2,515,000)
Net cash used in financing activities	(2,262,462)	(2,515,000)
Net increase in cash and cash equivalents	10,290,327	4,612,566
Cash and cash equivalents		
Beginning of year	22,869,913	18,257,347
End of year	$ 33,160,240	$ 22,869,913
Supplemental disclosure of non cash activities		
Construction in process included in accounts payable	$ 1,526,923	$ 1,317,209
Contributed securities	$ 427,788	$ 125,724

The accompanying notes are an integral part of these consolidated financial statements.

1. Significant Accounting Policies and Organization

Organization
Lawrence & Memorial Hospital (the "Hospital"), a nonprofit organization incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Lawrence & Memorial Corporation (the "Corporation"). The Board of the Corporation elects a Board of Directors who manages the property and affairs of the Hospital.

Principles of Consolidation
The consolidated financial statements include the accounts of the Hospital and its wholly owned subsidiary, Associated Specialists of Southeastern Connecticut, Inc.("Associated Specialists"). All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates
The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital's significant estimates include the collectibility of patient accounts receivable, useful lives of fixed assets, estimated settlements due to third party payors, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

Regulatory Matters
The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access ("OHCA").

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital and its subsidiary in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

Donor Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statement of operations.

Cash and Cash Equivalents
The Hospital and its subsidiary consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

Investments
Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner's interest is more than minor (3-5%).

Fair Value Measurements
Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Hospital for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets.

- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.

- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Assets Held in Trust by Others
The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates.

Assets Limited as to Use
Assets limited as to use include assets set aside by the Board of Directors to fund the deductible portion of malpractice insurance coverage (maintained in an irrevocable trust) and for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, funds held in trust by others, unexpended bond proceeds for construction purposes, and assets held by trustees under indenture agreements relating to financing activities with the State of Connecticut Health and Education Facilities Authority ("CHEFA") are also included therein.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost, or, if received as a donation, at the fair value on the date received. The Hospital provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

Non-Operating Gains and Losses
Activities other than in connection with providing health care services are considered to be non-operating.

Excess of Revenues over Expenses
The consolidated statement of operations includes excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

Fair Value of Financial Instruments
Investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long-term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Hospital for debt of the same remaining maturities.

Benefit Plans
The Hospital has a defined benefit plan and a defined contribution plan (see Note 8).

Medical Malpractice Self-Insurance
The Hospital purchases occurrence-based professional and general liability insurance to cover medical malpractice claims. The Hospital has adopted the policy of self-insuring the deductible portion of its malpractice insurance coverage up to certain per claim and aggregate limits. The Hospital has established an irrevocable trust for the purpose of setting aside assets which can only be used for the payment of malpractice losses, related expenses, and the cost of administering the trust. Management accrues its best estimate of losses as incidents which give rise to potential losses occur.

Income Taxes
The Hospital and its wholly owned subsidiary, Associated Specialists are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code.

Inventories
Inventory consists of supplies, both medical and general pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

Accrued Vacation and Sick Pay
Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. This payout is only upon termination of employment.

Subsequent Events
The Hospital has performed an evaluation of subsequent events through December 17, 2010, which is the date the financial statements were issued.

Reclassifications
Certain 2009 information was reclassified to conform with 2010 presentation.

2. Revenues from Services to Patients and Charity Care

The following summarizes net revenues from services to patients:

	2010	2009
Gross charges from services to patients	$ 651,382,509	$ 592,625,075
Less: Charity care	5,279,619	4,820,444
Charges from services to patients, net of charity care	646,102,890	587,804,631
Deductions		
Allowances	333,840,923	305,921,290
State of Connecticut uncompensated care system (receipts)	(1,906,334)	(2,050,177)
Total deductions	331,934,589	303,871,113
Net revenues from services to patients	$ 314,168,301	$ 283,933,518

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Hospital, and these differences are accounted for as allowances. The Hospital receives cash from the State of Connecticut Uncompensated Care Pool. The Hospital records this as an increase to their net revenues from services to patients.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements increased the Hospital's revenues by approximately $16,000 and $385,000 in 2010 and 2009, respectively.

During 2010 and 2009, approximately 32% and 31%, respectively, of net patient service revenue was received under the Medicare program, and 9% and 8%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and egulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines, but also includes certain cases where incurred charges are significant when compared to income. These charges are not included in net patient service revenues for financial reporting purposes.

3. Investments

Investments at September 30 consist of:

	2010	2009
Pooled endowment funds		
Cash and cash equivalents	$ 432,604	$ 33,303
Bonds	2,259,321	2,942,940
Hedge funds	3,527,534	2,540,801
Marketable equities	8,521,633	8,633,624
Total pooled endowment funds	14,741,092	14,150,668
Investments held in trust by others		
Cash and cash equivalents	168,922	195,198
Bonds	1,949,338	1,811,440
Marketable equities	3,580,952	3,453,625
Other investments	176,837	151,305
Total investments held in trust by others	5,876,049	5,611,568
Other investments		
Cash and cash equivalents	842,700	5,971,472
Bonds	25,490,811	32,561,346
Hedge funds	36,420,934	17,226,555
Marketable equities	44,026,882	43,462,694
Connecticut Hospital Laboratory Network	13,681	11,894
Total other investments	106,795,008	99,233,961
	$ 127,412,149	$ 118,996,197

The Hospital's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the valuation hierarchy defined above:

	2010			
	Level 1	Level 2	Level 3	Total Fair Value
Pooled endowment funds				
Cash and cash equivalents	$ 432,604	$ -	$ -	$ 432,604
Bonds	115,698	2,143,623	-	2,259,321
Hedge funds	-	-	3,527,534	3,527,534
Marketable equities	5,300,337	3,221,296	-	8,521,633
Total pooled endowment funds	5,848,639	5,364,919	3,527,534	14,741,092
Held in trust by others				
Cash and cash equivalents	-	-	168,922	168,922
Bonds	-	-	1,949,338	1,949,338
Marketable equities	-	-	3,580,952	3,580,952
Other investments	-	-	176,837	176,837
Total held in trust by others	-	-	5,876,049	5,876,049
Other investments				
Cash and cash equivalents	842,700	-	-	842,700
Bonds	-	25,490,811	-	25,490,811
Hedge funds	-	-	36,420,934	36,420,934
Marketable equities	20,965,635	23,061,247	-	44,026,882
Connecticut Hospital Laboratory Network	-	-	13,681	13,681
Total other investments	21,808,335	48,552,058	36,434,615	106,795,008
	$ 27,656,974	$ 53,916,977	$ 45,838,198	$ 127,412,149

	2009			
	Level 1	Level 2	Level 3	Total Fair Value
Pooled endowment funds				
Cash and cash equivalents	$ 33,303	$ -	$ -	$ 33,303
Bonds	105,204	2,837,736	-	2,942,940
Hedge funds	-	-	2,540,801	2,540,801
Marketable equities	4,890,475	3,743,149	-	8,633,624
Total pooled endowment funds	5,028,982	6,580,885	2,540,801	14,150,668
Held in trust by others				
Cash and cash equivalents	-	-	195,198	195,198
Bonds	-	-	1,811,440	1,811,440
Marketable equities	-	-	3,453,625	3,453,625
Other investments	-	-	151,305	151,305
Total held in trust by others	-	-	5,611,568	5,611,568
Other investments				
Cash and cash equivalents	5,971,471	-	-	5,971,471
Bonds	-	32,561,347	-	32,561,347
Hedge funds	-	-	17,226,554	17,226,554
Marketable equities	12,624,134	30,838,561	-	43,462,695
Connecticut Hospital Laboratory Network	-	-	11,894	11,894
Total other investments	18,595,605	63,399,908	17,238,448	99,233,961
	$ 23,624,587	$ 69,980,793	$ 25,390,817	$ 118,996,197

Fair value for Level 1 is based upon quoted prices in active markets that the Hospital has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Hospital does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Hospital's ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value ("NAV") of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by

third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Hospital within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2009	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Net Purchases	Ending September 30, 2010
Investment pool							
Hedge funds	$ 19,767,355	$ 161,672	$ 115,119	$ 1,692,231	$ (63,366)	$ 18,275,457	$ 39,948,468
Partnerships	11,894	-	1,787	-	-	-	13,681
Funds held in trust	5,611,568	-	-	264,481	-	-	5,876,049
Total	$ 25,390,817	$ 161,672	$ 116,906	$ 1,956,712	$ (63,366)	$ 18,275,457	$ 45,838,198

A summary of the pooled endowment investment return is presented below:

	2010	2009
Investment income	$ 267,855	$ 424,804
Realized and unrealized gains/(losses)	1,014,886	(579,258)
Management fees and other costs	(40,275)	(13,096)
Total return on pooled endowment investments	$ 1,242,466	$ (167,550)

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2010.

	Strategy	Fair Value	# of Investments	Remaining Life	$ Amount of Unfunded Commitments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions	Restrictions in Place at Year End
Equity securities	Global developed and emerging market equity	$ 7,512,200	1	N/A	$ -	No remaining commitments	Monthly with 10 day's notice		None
Absolute return	Long/short and long-biased equity and credit hedge funds	11,881,309	1	N/A	-	No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date	None
Directional hedge	Long/short and long-biased equity and credit hedge funds	16,732,460	1	N/A	-	No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date	None
Commodities	Commodity index	3,822,501	1	N/A	-	No remaining commitments	Monthly with 5 day's notice		None

4. Endowments

The Hospital's endowment consists of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

The Hospital understands net asset classification guidance requires that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Hospital classified as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Hospital considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund
- The purposes of the Hospital and donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the Hospital
- The investment policies of the Hospital

Changes in endowment net assets for year ended September 30:

	2010			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ -	$ 11,222,301	$ 2,839,683	$ 14,061,984
Investment return	-			
Investment income	-	55,426	-	55,426
Net realized and unrealized loss	-	1,014,887	-	1,014,887
Total investment return	-	1,070,313	-	1,070,313
Income distribution	-	(158,010)	-	(158,010)
Endowment net assets, end of year	$ -	$ 12,134,604	$ 2,839,683	$ 14,974,287

	2009			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ -	$ 11,921,077	$ 2,839,683	$ 14,760,760
Investment return				
Investment income	-	80,589	-	80,589
Net realized and unrealized loss	-	(579,243)	-	(579,243)
Total investment return	-	(498,654)	-	(498,654)
Income distribution	-	(200,122)	-	(200,122)
Endowment net assets, end of year	$ -	$ 11,222,301	$ 2,839,683	$ 14,061,984

The portion of perpetual endowment funds retained permanently either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2010	2009
Temporarily restricted net assets		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	$ 12,134,604	$ 11,222,301
Total endowment funds classified as Temporarily restricted net assets	$ 12,134,604	$ 11,222,301
Permanently restricted net assets		
Corpus of permanently restricted contributions for purchase of equipment and healthcare services	$ 2,839,683	$ 2,839,683
Total endowment funds classified as permanently restricted net assets	$ 2,839,683	$ 2,839,683

Endowment Funds with Deficits
From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets. The Hospital analyzed the endowments and notes there are no deficits as of September 30, 2010 and 2009.

Endowment Investment Return Objectives and Risk Parameters
The Hospital has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Endowment Investment Objectives
To achieve its long-term rate of return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Hospital targets a diversified asset allocation to achieve its long-term objectives within prudent Hospital risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives
Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment, Kitchings and operating funds. The Hospital will designate the spending amount on an as-needed basis for the special account.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
Funds held in trust by others	$ 3,086,274	$ 2,924,192
Contributions receivable	46,092	48,469
Free beds and plant replacement and expansion	12,134,604	11,222,301
Specific purpose reserves	2,984,370	3,016,875
	$ 18,251,340	$ 17,211,837

Permanently restricted net assets at September 30 are restricted to:

	2010	2009
Funds held in trust by others	$ 2,810,642	$ 2,705,430
Donor restricted endowment funds	2,839,683	2,839,683
	$ 5,650,325	$ 5,545,113

6. Property, Plant and Equipment

Property, plant and equipment consists of the following:

	2010	2009
Land and land improvements	$ 5,212,649	$ 5,128,782
Buildings	107,593,741	105,218,566
Equipment	180,454,333	170,465,895
	293,260,723	280,813,243
Less: Accumulated depreciation	(193,724,896)	(180,112,431)
	99,535,827	100,700,812
Construction in progress (estimated cost to complete at September 30, 2010 is $23,718,310)	9,635,284	5,352,416
	$ 109,171,111	$ 106,053,228

7. Long-Term Debt

	2010	2009
CHEFA Series D revenue bonds		
5.0% Term bonds due, 2009 to 2013	$ 8,750,000	$ 11,390,000
5.0% Term bonds due, 2014 to 2022	33,870,000	33,870,000
CHEFA Series E revenue bonds		
Variable rate bonds, due 2023 to 2034	22,990,000	22,990,000
Capital lease obligation	377,538	-
	65,987,538	68,250,000
Less: Bond discount	1,237,916	1,360,777
Less: Amounts classified as current	2,866,493	2,640,000
Long term portion of long term debt	$ 61,883,129	$ 64,249,223

On June 24, 2004 CHEFA issued $22,990,000 of Series E Bonds (the "Series E Bonds") on behalf of the Hospital and Lawrence & Memorial Corporation (collectively referred to as the "Obligated Group" under the Series E Bond agreement). The Series E Bonds are structured with a term bond due July 1, 2034, with annual sinking fund payments due each July 1st commencing July 1, 2023. Interest on the Series E Bonds accrues at the weekly rate and is payable on the first business day of each month commencing July 1, 2004.

The proceeds of the Series E Bonds were used to finance the acquisition, construction, capital improvements, renovation, and/or equipping of the expansion of the Hospital's Pequot Health Center, including a new 37,000 square foot building addition to house an ambulatory surgery unit, MRI series, and mobile medical technologies. The proceeds were also used to fund the debt service reserve fund and costs related to the issuance and interest related to the Series E Bonds. Under the terms of the trust indenture for the Series E Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series E Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined, and certain real property of the Hospital.

Effective January 16, 2008, the Hospital refinanced its CHEFA Series E bonds with JPMorgan Chase Bank, N.A. This reoffering does not update information contained in the original official statement but provides a new letter of credit, which expires in January 2013.

The Series E Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are equal quarterly installments beginning in the first quarter that is at least 367 days after the initial draw down on the letter of credit. The Series E Bonds have been successfully remarketed and there have been no draws on the letter of credit.

In accordance with the long-term loan agreement with CHEFA, certain trusteed funds are required to be maintained. These funds provide for debt service and other related payments. The income derived from these funds is required to be reinvested in the trusteed funds and is not available for current operating purposes.

The agreements will remain in force until principal and interest on the bonds and any other costs of the Authority with respect to the project have been fully paid or provided for. Annual payments due under the loan agreements include interest on the outstanding bonds.

The fair value of the Series E Bonds, using discounted cash flow analyses approximates carrying value at September 30, 2010 and 2009. The fair value of the Series D Bonds is approximately $64.5 million and $45.4 million as of September 30, 2010 and 2009, respectively.

Principal repayments on the CHEFA bonds are as follows:

Year	Annual Principal Repayment
2011	$ 2,775,000
2012	2,915,000
2013	3,060,000
2014	3,210,000
Thereafter	53,650,000
	$ 65,610,000

The Hospital made cash interest payments of $2,314,076 and $2,500,964 in fiscal year 2010 and 2009, respectively. No interest was capitalized during 2010 or 2009.

8. Pension and Other Postretirement Benefits

The Hospital has a defined benefit plan covering all employees who elected to stay in the plan. The plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment. Assets of the plan include mutual funds, marketable equity securities, corporate and government bonds, notes and hedge funds. The investments have been selected to generate a return on the investments and protect the principal.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pension as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

The following table sets forth the plans' funded status and amounts recognized in the consolidated statement of financial position at September 30, 2010 and 2009 (measurement date of September 30):

	Pension Benefits		Other Postretirement Benefits	
	2010	2009	2010	2009
Change in benefit obligation				
Benefit obligation at beginning of year	$ 117,330,146	$ 92,839,307	$ 1,290,578	$ 1,305,378
Service cost	1,927,395	1,456,782	-	-
Interest cost	6,646,772	6,784,733	70,433	85,675
Employee contributions	180,479	184,560	-	-
Benefits paid	(5,267,983)	(4,825,526)	(130,095)	(141,246)
Actuarial loss	10,384,113	20,890,290	46,604	40,771
Benefit obligation at end of year	$ 131,200,922	$ 117,330,146	$ 1,277,520	$ 1,290,578
Change in plan assets				
Fair value of plan assets at beginning of year	$ 76,344,572	$ 74,130,658	$ -	$ -
Actual return on plan assets	7,130,751	4,690,576	-	-
Employee contributions	180,479	184,560	-	-
Employer contributions	3,000,000	2,164,304	130,095	141,246
Benefits paid	(5,267,983)	(4,825,526)	(130,095)	(141,246)
Fair value of plan assets at end of year	$ 81,387,819	$ 76,344,572	$ -	$ -
Funded status of the plan	(49,813,103)	(40,985,574)	(1,277,520)	(1,290,578)
Unrecognized net loss from past experience different from that assumed and effects of changes in assumptions	37,618,950	29,882,430	(531,764)	(639,914)
Unrecognized prior service cost	596,549	721,505	-	-
Accrued benefit costs recognized in the statement of financial position	$ (11,597,604)	$ (10,381,639)	$ (1,809,284)	$ (1,930,492)
Components of net periodic benefit costs				
Service cost	$ 1,927,395	$ 1,456,782	$ -	$ -
Interest cost	6,646,772	6,784,733	70,433	85,675
Expected return on plan assets	(6,350,382)	(6,179,348)	-	-
Gain	-	-	(61,546)	(82,822)
Net amortization and deferral	124,956	124,956	-	-
Benefit cost	$ 2,348,741	$ 2,187,123	$ 8,887	$ 2,853

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2010	2009
Discount rate	5.80%	7.50%
Average rate of compensation increases	4.25%	4.25%
Expected return on assets	8.50%	8.50%

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

	2010	2009
Discount rate	5.07%	5.80%
Average rate of compensation increases	4.25%	4.25%

The Plan's asset allocations as of September 30, 2010 and 2009 are as follows:

Asset Category	2010	2009
Cash	2%	4%
Bonds	24%	33%
Hedge Funds	30%	26%
Marketable Equities	44%	37%
Total	100%	100%

The expected rate of return on assets is calculated based on past experience.

Expected benefits to be paid under the plans are as follows:

Fiscal Years Beginning October 1	Expected Benefits
2010	$ 5,759,993
2011	6,267,258
2012	6,545,984
2013	6,961,595
2014	7,201,011
Expected Aggregate for 5 fiscal years beginning 2015	41,672,965

Annual contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the Pension and Retiree Health Plan for 2010 are approximately:

Pension	$ 4,000,000
Retiree Health	132,780

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 9.0% in 2010 reducing to 5.0% by the year 2016 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated post-retirement benefit obligation and service cost plus interest cost by approximately $94,000 and $98,000, respectively, at September 30, 2010 and 2009. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $86,000 and $76,000, respectively, at September 30, 2010 and 2009.

Plan Assets

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

The following table summarizes the fair values of investments by major type held by the staff pension plan at September 30, 2010:

	Level 1	Level 2	Level 3	2010
Investments, at fair value				
Cash	$ 1,873,724	$ -	$ -	$ 1,873,724
Bonds	-	19,609,144	-	19,609,144
Hedge Funds	-	-	24,333,144	24,333,144
Marketable Equities	14,103,283	21,468,524	-	35,571,807
Total investments, at fair value	$ 15,977,007	$ 41,077,668	$ 24,333,144	$ 81,387,819

The following table summarizes the fair values of investments by major type held by the staff pension health plan at September 30, 2009:

	Level 1	Level 2	Level 3	2009
Investments, at fair value				
Cash	$ 2,889,101	$ -	$ -	$ 2,889,101
Bonds	2,581	25,256,126	-	25,258,707
Hedge Funds	-	-	19,719,016	19,719,016
Marketable Equities	11,890,189	16,587,559	-	28,477,748
Total investments, at fair value	$ 14,781,871	$ 41,843,685	$ 19,719,016	$ 76,344,572

The table below represents the change in fair value measurements for Level 3 investments held by the staff pension plans' year ended September 30, 2010 and 2009 respectively:

	2010	2009
Beginning Balance	$ 19,719,016	$ -
Realized and unrealized gain, net	1,629,862	2,946,715
Purchases (sales), net	2,984,266	16,772,301
Ending Balance	$ 24,333,144	$ 19,719,016

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations for both plans combine tested theory and informed market judgment to balance investment risks with the need for high returns.

The Hospital's 401(k) plan covers eligible employees who elect to participate in the plan. Eligible employees may contribute a percentage of their salary to the plan. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Plan contributions charged to operations were approximately $3,247,418 and $2,977,019 for 2010 and 2009, respectively.

9. Medical Malpractice Self-Insurance

There have been malpractice claims that fall within the Hospital's self-insured program which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2010 that may result in the assertion of claims. The Hospital has engaged independent actuaries to estimate the ultimate cost of the settlement of such claims. Accrued malpractice losses have been discounted at 5.0% for 2010 and 2009. The Hospital maintains a trust to fund these liabilities on a long-term basis.

10. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2010	2009
Health care services	$ 237,018,091	$ 223,767,253
General and administrative	74,847,818	63,113,841
	$ 311,865,909	$ 286,881,094

11. Contingency

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position, results of operations, changes in net assets or cash flows.

Lawrence & Memorial Hospital
Consolidating Balance Sheet
September 30, 2010

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash	$ 29,002,112	$ 4,158,128	$ -	$ 33,160,240
Investments	106,795,008	-	-	106,795,008
Accounts receivable	29,686,477	1,255,784	-	30,942,261
Other receivables	5,607,525	157,686	-	5,765,211
Inventories	3,796,086	-	-	3,796,086
Due from affiliates	10,399,677	-	(4,156,201)	6,243,476
Prepaid expenses	1,624,613	-	-	1,624,613
Debt service fund	1,248,032	-	-	1,248,032
Total current assets	188,159,530	5,571,598	(4,156,201)	189,574,927
Assets limited as to use				
Cash	179,215	-	-	179,215
Construction funds	-	-	-	-
Investments held in trust	11,986,573	-	-	11,986,573
Endowment investments	14,741,092	-	-	14,741,092
Funds held in escrow	5,876,049	-	-	5,876,049
Contributions receivable	46,092	-	-	46,092
Debt Service fund	7,156,167	-	-	7,156,167
Total assets limited as to use	39,985,188	-	-	39,985,188
Other assets				
Deferred financing costs	1,330,365	-	-	1,330,365
Property, plant and equipment	109,171,111	-	-	109,171,111
Total assets	$ 338,646,194	$ 5,571,598	$ (4,156,201)	$ 340,061,591

Lawrence & Memorial Hospital
Consolidating Balance Sheet
September 30, 2010

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 19,524,046	$ -	$ -	$ 19,524,046
Accrued vacation and sick pay	10,275,147	945,308	-	11,220,455
Salaries, wages and payroll taxes	4,746,675	276,544	-	5,023,219
Due to affiliates	4,764,147	4,156,201	(4,156,201)	4,764,147
Due to third parties	8,559,110	-	-	8,559,110
Current portion of long-term debt	2,866,493	-	-	2,866,493
Total current liabilities	50,735,618	5,378,053	(4,156,201)	51,957,470
Accrued pension and other postretirement benefits	52,131,286	-	-	52,131,286
Other liabilities	12,279,482	-	-	12,279,482
Long-term debt, less current portion	61,883,130	-	-	61,883,130
Total liabilities	126,293,898	-	-	178,251,368
Net assets				
Unrestricted	137,717,053	191,505	-	137,908,558
Temporarily restricted	18,249,300	2,040	-	18,251,340
Permanently restricted	5,650,325	-	-	5,650,325
Total net assets	161,616,678	193,545	-	161,810,223
	$ 338,646,194	$ 5,571,598	$ (4,156,201)	$ 340,061,591

Lawrence & Memorial Hospital
Consolidating Balance Sheet
September 30, 2009

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash	$ 17,038,903	$ 5,831,010	$ -	$ 22,869,913
Investments	99,233,961	-	-	99,233,961
Accounts receivable	29,149,008	905,396	-	30,054,404
Other receivables	5,800,680	194,556	-	5,995,236
Inventories	3,506,113	-	-	3,506,113
Due from affiliates	20,140,708	-	(17,237,552)	2,903,156
Prepaid expenses	2,312,579	-	-	2,312,579
Debt service fund	1,295,094	-	-	1,295,094
Total current assets	178,477,046	6,930,962	(17,237,552)	168,170,456
Assets limited as to use				
Cash	177,710	-	-	177,710
Construction funds	6,170	-	-	6,170
Investments held in trust	12,678,851	-	-	12,678,851
Endowment investments	14,150,668	-	-	14,150,668
Contributions receivable	5,611,568	-	-	5,611,568
Funds held in escrow	48,469	-	-	48,469
Debt Service fund	7,159,610	-	-	7,159,610
Total assets limited as to use	39,833,046	-	-	39,833,046
Other assets				
Deferred financing costs	1,418,292	-	-	1,418,292
Property, plant and equipment	106,053,228	-	-	106,053,228
Total assets	$ 325,781,612	$ 6,930,962	$ (17,237,552)	$ 315,475,022

Lawrence & Memorial Hospital
Consolidating Balance Sheet
September 30, 2009

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 15,377,893	$ -	$ -	$ 15,377,893
Accrued vacation and sick pay	9,798,961	842,490	-	10,641,451
Salaries, wages and payroll taxes	3,934,850	249,483	-	4,184,333
Due to affiliates	1,682,710	17,237,552	(17,237,552)	1,682,710
Due to third parties	9,089,438	-	-	9,089,438
Current portion of long-term debt	2,640,000	-	-	2,640,000
Total current liabilities	42,523,852	18,329,525	(17,237,552)	43,615,825
Accrued pension and other postretirement benefits	43,029,547	-	-	43,029,547
Other liabilities	12,202,253	-	-	12,202,253
Long-term debt, less current portion	64,249,223	-	-	64,249,223
Total liabilities	162,004,875	18,329,525	(17,237,552)	163,096,848
Net assets				
Unrestricted	141,020,827	(11,399,603)	-	129,621,224
Temporarily restricted	17,210,797	1,040	-	17,211,837
Permanently restricted	5,545,113	-	-	5,545,113
Total net assets	163,776,737	(11,398,563)	-	152,378,174
	$ 325,781,612	$ 6,930,962	$ (17,237,552)	$ 315,475,022

Lawrence & Memorial Hospital
Consolidating Statement of Operations
September 30, 2010

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues	$ 306,562,977	$ 7,605,324	$ -	$ 314,168,301
Other operating revenues	14,292,897	20,732,875	(25,099,465)	9,926,307
Net assets released from restriction	412,940	-	-	412,940
	321,268,814	28,338,199	(25,099,465)	324,507,548
Operating expenses				
Salaries and wages	134,554,159	9,513,214	(68,299)	143,999,074
Employee benefits	39,948,123	1,747,633	(1,370,750)	40,325,006
Supplies	33,399,993	124,613	-	33,524,606
Purchased services	20,028,640	3,416,826	(2,352,226)	21,093,240
Other	38,276,193	1,273,647	(738,844)	38,810,996
Interest	2,332,245	-	-	2,332,245
Depreciation and amortization	16,728,407	-	-	16,728,407
Bad debts	14,381,176	671,159	-	15,052,335
	299,648,936	16,747,092	(4,530,119)	311,865,909
Income from operations	21,619,878	11,591,107	(20,569,346)	12,641,639
Nonoperating gains and losses				
Unrestricted income	175,335	-	-	175,335
(Loss)/Income from investments	(18,227,950)	-	20,569,346	2,341,396
	(18,052,615)	-	20,569,346	2,516,731
Excess of revenues over expenses	3,567,263	11,591,107	-	15,158,370
Transfer to affiliate	(4,900,000)	-	-	(4,900,000)
Net unrealized gains on investments	5,459,058	-	-	5,459,058
Net assets released from restriction used for the purchase of property, plant and equipment	181,470	-	-	181,470
Minimum pension liability adjustment	(7,611,564)	-	-	(7,611,564)
Decrease in unrestricted net assets	$ (3,303,773)	$ 11,591,107	$ -	$ 8,287,334

Lawrence & Memorial Hospital
Consolidating Statement of Operations
September 30, 2009

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues	$ 280,126,452	$ 3,807,066	$ -	$ 283,933,518
Other operating revenues	12,473,743	104,661	(3,653,871)	8,924,533
Net assets released from restriction	460,320	-	-	460,320
	293,060,515	3,911,727	(3,653,871)	293,318,371
Salaries and wages	128,119,767	7,414,225	-	135,533,992
Employee benefits	35,453,540	1,897,584	(1,622,324)	35,728,800
Supplies	30,981,518	35,668	-	31,017,186
Purchased services	20,689,716	1,993,733	(1,355,280)	21,328,169
Other	28,732,892	946,129	(676,267)	29,002,754
Interest	2,570,991	-	-	2,570,991
Depreciation and amortization	15,891,356	-	-	15,891,356
Bad debts	15,090,955	716,891	-	15,807,846
	277,530,735	13,004,230	(3,653,871)	286,881,094
Income from operations	15,529,780	(9,092,503)	-	6,437,277
Nonoperating gains and losses				
Unrestricted income	266,039	-	-	266,039
Income from investments	(691,170)	-	-	(691,170)
	(425,131)	-	-	(425,131)
Excess of revenues over expenses	15,104,649	(9,092,503)	-	6,012,146
Net unrealized gains on investments	4,304,504	-	-	4,304,504
Net assets released from restriction used for the purchase of property, plant and equipment	208,519	-	-	208,519
Minimum pension liability adjustment	(22,254,106)	-	-	(22,254,106)
Donated equipment	60,000	-	-	60,000
Decrease in unrestricted net assets	$ (2,576,434)	$ (9,092,503)	$ -	$ (11,668,937)

Attachment K

Description of Proposed Building Work, Including Floor Plans

Description of Proposed Building Work

Construction/Renovation Description

The proposed implementation of a fixed-site 3T MRI unit at the L&M Diagnostic Imaging at Crossroads involves renovations to approximately 1,500 gross square feet of existing spaces to accommodate the installation of the MRI unit and the required support spaces. The spaces include: the MRI treatment room, MRI equipment room, MRI control room, patient changing areas, patient injection area, and staff work spaces. A floor plan depicting the existing spaces at the site is included in this section. The existing vacant space was designed for the future installation of a MRI unit at the time of the construction of the building; however, a MRI unit was not installed at the time of the opening of the imaging center, nor to date. A schematic floor plan indicating a possible layout and space configuration is also included in this section. Actual locations may vary slightly due to changes implemented during design development of construction documents.

Square Footage

1,500 gross square feet

Schedule

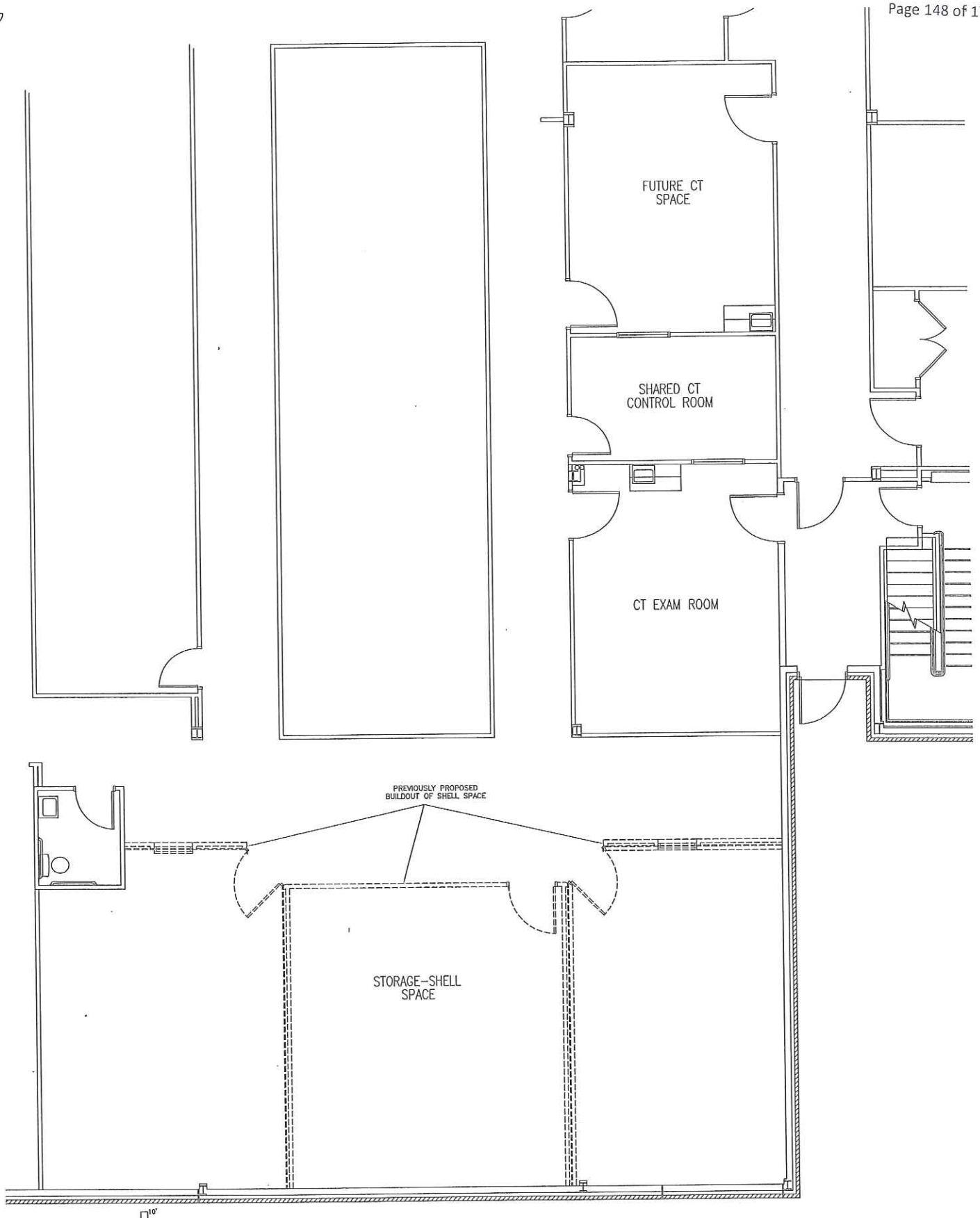
The proposed schedule for implementation of this project is as follows:

Construction/renovation commencement date*	June 6, 2011
Equipment lead time	July 5, 2011 to September 30, 2011
Construction/renovation completion date	September 9, 2011
Equipment installation commencement date**	October 3, 2011
Equipment installation completion date	October 28, 2011
MRI applications commencement date	October 31, 2011
MRI applications completion date	November 4, 2011
Commencement of operations	November 7, 2011

* Contingent on CON approval
** Contingent of FY 2012 capital budget approvals

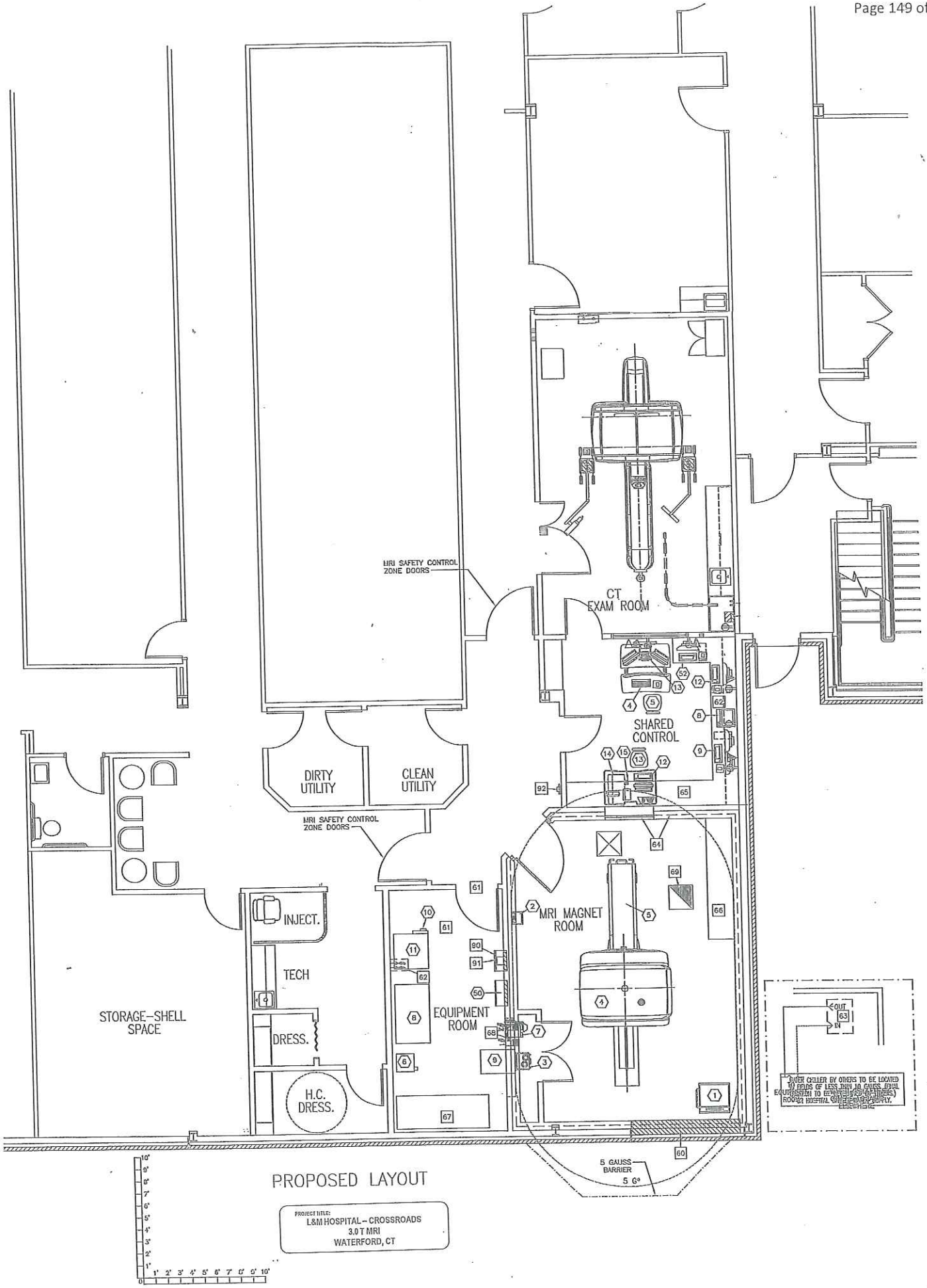
Floor Plans

Please refer to following pages in this section.



EXISTING CONDITIONS

PROJECT TITLE:
L&M HOSPITAL – CROSSROADS
3.0 T MRI
WATERFORD, CT


MRI SAFETY CONTROL ZONE DOORS
CT EXAM ROOM
SHARED CONTROL
DIRTY UTILITY
CLEAN UTILITY
MRI SAFETY CONTROL ZONE DOORS
INJECT.
TECH
STORAGE–SHELL SPACE
DRESS.
H.C. DRESS.
EQUIPMENT ROOM
MRI MAGNET ROOM
OUT
IN
5 GAUSS BARRIER
5 G
PROPOSED LAYOUT
PROJECT TITLE:
L&M HOSPITAL – CROSSROADS
3.0 T MRI
WATERFORD, CT

Attachment L

Equipment Vendor Quote

SIEMENS

Siemens Medical Solutions USA, Inc.
51 Valley Stream Parkway, Malvern, PA 19355
Fax: (866) 309-6992

SIEMENS REPRESENTATIVE
Gordon Wilhelm - (610) 448-1736

PRELIMINARY PROPOSAL

Customer Number: 0000007432

Date: 1/5/2011

LAWRENCE & MEMORIAL HOSPITALS
365 MONTAUK AVE.
NEW LONDON, CT 06320

Quote Nr: **1-28GF2W Rev. 0**

MAGNETOM Verio

All items listed below are included for this system:

Qty	Part No.	Item Description
1	14418565	**MAGNETOM Verio - System** Siemens is the proven innovator that brings 3T field strength, 70 cm Open Bore and Tim (Total imaging matrix) together in one powerful system, MAGNETOM Verio. Powerful. Affordable. Comfortable. Today's market demands MRI systems that deliver high performance and a large application range while also representing a sound investment for the future: - More than 10 years of experience in 3T, including the introduction of the world's first 3T whole-body MRI with Open Bore - Unique Tim(tm) technology that expands the potential of 3T - 3TCare, the most comprehensive solution for Specific Absorption Rate (SAR) enabling maximum efficiency MAGNETOM Verio Brings New Benefits - A unique combination of 3T and 70 cm Open Bore - A new short, ultra-light magnet with zero helium boil-off - Large field of view, which supports a full range of clinical applications - Better image quality by reducing unusable edges due to unique cylindrical homogeneity made possible by the TrueForm(tm) magnet design - Higher speed and superb image quality powered by a new VQ-engine gradient. The system including magnet, electronics and control room can be installed in 33 sqm space. The basic system includes: - with a short system length of 173 cm a whole-body superconductive 3T magnet - Actively shielded water-cooled Siemens gradient system - Digital RF Transmit and Receive System - RF Coils (Head, Neck, Spine and Body Matrix Coil, 4-channel Flex Coils large/ small) - High performance host computer and image processor - Wireless physiological Measurement Unit (PMU) - syngo MR SW including Inline Technology, 1D/2D PACE, iPAT, iPAT Extensions, syngo BLADE, CISS/DESS and Phoenix - Tim Application Suite including the dedicated Neuro Suite, Angio Suite, Cardiac Suite, Body Suite, Onco Suite, Breast Suite, Ortho Suite, Pediatric Suite and Scientific Suite. For system cooling either the predefined chiller option or the Separator is required.
1	14405343	**I-class #Tim** I-class is the new generation of Tim-based MRI scanners, which enables innovative applications and workflow efficiency. The I-class package comprises: - 3D Distortion Correction - MPPS - ImageFilter SW - PhoenixZIP - DICOM Study Split
1	14409112	**Tim [102x32] VQ-engine #V** Tim [102x32] VQ-engine performance level Tim [102x32] is Total imaging matrix with 102 seamlessly integrated coil elements, combinable to 32 RF channels. This is leading edge technology with Top-of-the-line matrix technology. It is for most demanding high-end applications of today and in the future. The system allows highest flexibility to plug-in "self-made" coils. Tim [102x32] has highest flexibility in Parallel Imaging. Maximum SNR is ensured through the new matrix coil technology. VQ-engine Gradient System with noise reduction features. Innovative integrated measures comprehensively reduce acoustic noise without compromising strongest gradient performance.
1	14409114	**Cover Zebra #V** The color of the main face plate cover with integrated control panel and table display is Translucent Teal. The table elevator cover and adjoining upper left cover are presented in an optically appealing Zebra design, consiting of horizontal white and light grey stripes.

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	14409118	**Standard Patient Matrix Table #V** The patient table is mounted directly to the magnet assembly. The table can support up to 250 kg (551 lbs) patients with unrestricted vertical and horizontal movement.
1	08464872	**PC Keyboard US english #Tim** Standard PC keyboard with 101 keys.
1	14401561	**Flow Quantification #3T** Special sequences for quantitative assessment of flow.
1	14405328	**TWIST syngo #Tim** This package contains a Siemens unique sequence and protocols for time-resolved (4D) MR angiographic and dynamic imaging in general with high spatial and temporal resolution. syngo TWIST supports comprehensive dynamic MR angio exams in all body regions. It offers temporal information of vessel filling in addition to conventional static MR angiography, which can be beneficial in detecting or evaluating malformations such as shunts. In case of general dynamic imaging, for example an increase in spatial resolution by a factor of up to 2 at 60 seconds temporal resolution (compared to conventional dynamic imaging) is possible due to intelligent k-space sampling strategies. Alternatively, increased temporal resolution at constant spatial resolution is possible.
1	14409198	**Native syngo #Tim** Integrated software package with sequences and protocols for non-contrast enhanced 3D MRA with high spatial resolution. syngo NATIVE particularly enables imaging of abdominal and peripheral vessels and is an alternative to MR angiography techniques with contrast medium, especially for patients with severe renal insufficiency.
1	14402527	**SWI #Tim** Susceptibility Weighted Imaging is a high-resolution 3D imaging technique for the brain with ultra-high sensitivity for microscopic magnetic field inhomogeneities caused by deoxygenated blood, products of blood decomposition and microscopic iron deposits. Among other things, the method allows for the highly sensitive proof of cerebral hemorrhages and the high-resolution display of venous cerebral blood vessels.
1	14401554	**Inline Perfusion #3T** Automatic real-time calculation of Global Bolus Plot (GBP), Percentage of Baseline at Peak map (PBP), and Time-to-Peak map (TTP) with Inline technology.
1	07585818	**Neuro Perfusion Evaluation syngo** Neuro Perfusion Evaluation syngo provides a task card for detailed post-processing of brain perfusion data sets. Color display of the relative Mean Transit Time (relMTT), relative Cerebral Blood Volume (relCBV), and relative Cerebral Blood Flow (relCBF) is supported. Flexible selection of the Arterial Input Function (AIF) for more reliable analysis taking into account the dynamics over time of the contrast agent enhancement. The detailed evaluation of brain perfusion data sets generates parameter maps for TTP and PBP and for the hemodynamic parameters relMTT, relCBV, and relCBF. These may show perfusion deficits and assist in the diagnosis and grading of e.g. vascular deficiencies and brain tumors. Creation of RGB Color Maps for storage on a PACS is not available on Non-Tim Systems until VA35.
1	14401553	**Inline Diffusion #3T** Automatic real-time calculation of trace-weighted images and ADC maps with Inline technology. Compatible to single-shot diffusion-weighted EPI.
1	14418550	**DTI Package #Tim** The following SW components are already included in the DTI Package: - Diffusion Tensor Imaging - DTI Tractography - DTI Evaluation
1	14401557	**Single Voxel Spectroscopy #3T** Integrated software package including sequences and protocols for proton spectroscopy to examine metabolic changes in the brain (e.g. in tumors and degenerative diseases).
1	07365385	**Spectroscopy Evaluat.syngo**
1	14413617	**2D Chemical Shift Imaging #3T** Integrated software package with sequences and protocols for proton 2D Chemical Shift Imaging (2D CSI) to examine metabolic changes in the brain (e.g. in tumors and degenerative diseases).

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	14413623	**3D Chemical Shift Imaging #3T** Integrated software package with sequences and protocols for proton 3D Chemical Shift Imaging (3D CSI) to examine metabolic changes in the brain (e.g. in tumors and degenerative diseases) as well as in the prostate.
1	14418484	**2/4/8-ch Sentinelle BreastCoil #V** The 2-/4-/8-channel Sentinelle Breast Coil consists of a positioning frame with exchangeable coils with different numbers of channels as described in detail in the E text. The 2-/4-/8-channel Sentinelle Breast Coil can be used as 8-channel imaging coil, 4-channel biopsy coil for lateral biopsy access as well as 2-channel biopsy coil for medial biopsy access. This coil provides a large biopsy access, which is even larger at the MAGNETOM Verio. The preamplifiers are integrated into the coil. The coil is iPAT-compatible. A positioning guidance is provided. MAGNETOM Verio is delivered with a base plate for extended biopsy access. This plate replaces the height of the Spine Coil.
1	14409126	**Body Matrix Coil #V** The multi-element Matrix coil technology is an essential part supplementing the most innovative Total imaging matrix. Matrix coils have multiple receive coil elements that can be clustered in groups. Each receive coil element is equipped with a low noise preamplifier to maximize signal-to-noise ratio. The Body Matrix Coil features: - 6-element design with 6 integrated preamplifiers, with 2 clusters of 3 elements each - Operated depending on the Matrix Coil Mode as a 2-channel coil (CP Mode), 4-channel coil (Dual Mode) or 6-channel coil (Triple Mode) - Operates in an integrated fashion with the Spine Matrix coil (2 rings of 6 elements each = 12-element design) - Can be combined with further Body Matrix coils for larger coverage - No coil tuning - iPAT-compatible Applications: - Thorax (incl. heart) - Abdomen - Pelvis - Hip Can be combined with: - Head Matrix coil - Neck Matrix coil - Spine Matrix coil - Additional Body Matrix coils (typically 2-3 in total) for additional anatomical coverage - PA Matrix coil (Peripheral Angio Matrix; optional)
1	14409129	**Shoulder Array Coil #V** Receive array coil consisting of two different sized, anatomically adapted coil tops attached to a base plate, either for the left or for the right shoulder.
1	14409131	**8-channel Foot/ Ankle Coil #V** The 8-channel foot-ankle coil is an iPAT-compatible "no-tune" receiver coil for the examination of the foot and the ankle joint.
1	14409132	**8-channel Wrist Coil #V** The 8-channel wrist coil is an iPAT-compatible "no-tune" receiver coil for the examination of the wrist.
1	14413592	**Tx/Rx 15-channel Knee Coil #3T** New 15-channel transmitter/receiver coil for joint examinations in the area of the lower extremities. Main features : - 15-element design (3x5 coil elements) with 15 integrated preamplifiers, - iPAT-compatible
1	14407258	**MR Workplace Table 1.2m** Table suited for syngo Acquisition Workplace and syngo MR Workplace based on syngo Hardware.
1	14407261	**MR Workplace Container, 50cm** 50 cm wide extra case for the syngo host computer with sliding front door to allow change of storage media (CD/DVD/USB).
1	14409145	**Cable Set syngo 8/12 #V** Cable length inside the cabin 8 m, cable length outside the cabin 12 m. Inclusive Ethernet Twisted Pair Adapter and 10 m cable.
1	05672105	**Helium Fill 30/70 #S,Tim**
1	14402480	**Chiller, 60 Hz #3T** The KKT KSC 215 is a dedicated MAGNETOM Trio, A Tim System and MAGNETOM Verio 20°C chiller. The chiller has to be used in combination with the IFP (Interface Panel). This applies if no chilled water supply is available at all on-site. The IFP is included in delivery.
1	08857828	**UPS Cable #Tim** Power cable for connecting the UPS Powerware PW 9130-3000i (14413662) to the ACC of MAGNETOM Tim and MAGNETOM Tim+Dot systems for backing up the computer. Standard cable length: 9 m.

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SIEMENS REPRESENTATIVE
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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
1	14413662	**UPS Powerware PW9130G-3000T-XLEU** UPS system Eaton PW9130G-3000T-XLEU for MAGNETOM Tim, MAGNETOM Tim+Dot and MAGNETOM Symphony systems for safeguarding computers. Power output: 3.0 kVA / 2.7 kW Bridge time: 5 min full load / 14 min half load Input voltage: 230 VAC
1	MR_STD_RIG_INST	**MR Standard Rigging and Installation**
1	MR_BTL_INSTALL	**MR Standard Rigging & Install**
1	MR_CRYO	**Standard Cryogens**
1	MR_PM	**MR Project Management**
1	MR_INITIAL_32	**Initial onsite training 32 hrs**
1	MR_FOLLOWUP_24	**Follow-up training 24 hrs**
1	MR_INT_SYN_BCLS	**Basic syngo MR Class**
2	MR_ADD_CLASS	**Additional Training Class**
1	MR_ADD_24	**Additional onsite training 24 hours**
3	MR_ADD_16	**Additional onsite training 16 hours**
3	MR_MDWSP	**Physician 3T Workshop Siemens Train Ctr**
1	4MR5142869	**Armrest #MR**
1	M3SSMREPICBC	**Spectris Solaris EP Injector iCBC**

System Total: $2,525,209

OPTIONS:

Qty	Part No.	Item Description	Extended Price
1	14401555	**Inline BOLD Imaging #3T** The BOLD imaging package is based on blood oxygen level dependent (BOLD) contrast-sensitive single-shot EPI sequences. Inline technology enables the automatic real-time calculation and display of statistical (t-value) images during the measurement of BOLD paradigms (including 3D motion correction and spatial filtration). The mosaic image format is supported. Clinical protocols are prepared. With Inline BOLD Imaging, functional brain mapping can be optimally integrated into clinical routine, e.g. prior to neurosurgical interventions.	+ $16,750
1	14405330	**3D PACE syngo #Tim** 3D PACE (Prospective Acquisition CorrEction) enhances Inline BOLD imaging with motion correction during the acquisition of a BOLD exam. In contrast to a retrospective motion correction that corrects previously acquired data, the unique 3D PACE tracks the head of the patient, correcting for motion in real time during the acquisition.	+ $5,896
1	14405332	**BOLD 3D Evaluation syngo #Tim** BOLD 3D Evaluation syngo is the comprehensive processing and visualization package for BOLD fMRI. It provides a full set of features for clinical fMRI, as well as advanced features for more research oriented applications. The package provides statistical map calculations from BOLD datasets. It enables the visualization of task-related areas of activation with 2D or 3D anatomical data, allowing, in real time, to assess the spatial relation of eloquent cortices with cortical landmarks or brain lesions.	+ $13,400

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PRELIMINARY PROPOSAL

Qty	Part No.	Item Description	Extended Price
1	14405316	**fMRI Trigger Converter** An optical trigger signal is available to trigger external stimulation devices in fMRI experiments. With the "fMRI Trigger Converter" this signal can be converted to an electrical signal (TTL/BNC and RS 232 interface for PC; modes: toggle or impulse).	+ $2,680
1	14409126	**Body Matrix Coil #V** The multi-element Matrix coil technology is an essential part supplementing the most innovative Total imaging matrix. Matrix coils have multiple receive coil elements that can be clustered in groups. Each receive coil element is equipped with a low noise preamplifier to maximize signal-to-noise ratio. The Body Matrix Coil features: - 6-element design with 6 integrated preamplifiers, with 2 clusters of 3 elements each - Operated depending on the Matrix Coil Mode as a 2-channel coil (CP Mode), 4-channel coil (Dual Mode) or 6-channel coil (Triple Mode) - Operates in an integrated fashion with the Spine Matrix coil (2 rings of 6 elements each = 12-element design) - Can be combined with further Body Matrix coils for larger coverage - No coil tuning - iPAT-compatible Applications: - Thorax (incl. heart) - Abdomen - Pelvis - Hip Can be combined with: - Head Matrix coil - Neck Matrix coil - Spine Matrix coil - Additional Body Matrix coils (typically 2-3 in total) for additional anatomical coverage - PA Matrix coil (Peripheral Angio Matrix; optional)	+ $30,150
1	08465028	**Coil Storage Cart #Tim** Specially designed non-ferromagnetic cart for easy storage of some of the most commonly used coils and accessories.	+ $3,350
1	14413614	**GRACE syngo #3T** Integrated software package including sequences and protocols for proton spectroscopy, optimized for breast studies. SVS (Single Voxel Spectroscopy) technique (spin echo sequence) optimized for breast spectroscopy. - The technique contains a special spectral lipid suppression pulse (user definable) for lipid signal reduction. - Water reference detection (to visualize the normalized choline signal) (Siemens unique) - Online frequency shift correction for reduction of breathing related artifacts, inline implementation, no additional user interaction is required. Clinical applications: - Can help the physician improve the specificity for tumor diagnoses - Predicting clinical response to neoadjuvant chemotherapy in an early stage (24 hours after receiving the first dose) Specific characteristic starting with SW version syngo MR B15: - includes reference tube for quantitative spectroscopy The Siemens Breast Matrix Coil, the 16-channel Al Breast Coil and the 2-, 4-, 8- ch Sentinelle coils are recommended to obtain best spectral quality.	+ $7,839
1	14409127	**PA Matrix Coil #V** The multi-element Matrix coil technology is an essential part supplementing the most innovative Total imaging matrix. Matrix coils have multiple receive coil elements that can be clustered in groups. Each receive coil element is equipped with a low noise preamplifier to maximize signal-to-noise ratio. The PA Matrix Coil features: - 36-element design with 36 integrated preamplifiers, distributed over 6 levels with 6 elements each - Operates in an integrated fashion with the Body Matrix coils/ mMR Body and Spine Matrix coil/ mMR Spine and for Whole-Body examinations also with the Head and Neck Matrix coil/ mMR Head/Neck (for Whole-Body examinations the optional Tim Whole Body Suite is required, standard with Biograph mMR) - Can be utilized Head and Feet First - Both legs are independently covered with coil elements, maximizing the coil filling factor and the signal-to-noise ratio - No coil tuning - Includes special non-ferromagnetic coil cart for safe, user-friendly storage - iPAT-compatible Applications: - High-resolution angiography of both legs incl. pelvis with highest signal-to-noise ratio - Visualization of the iliac arteries and aorta Can be combined with: - Neck Matrix/ mMR Head/Neck coil - Spine Matrix/ mMR Spine coil - Body Matrix/ mMR Body coils (up to 3/ 4)	+ $43,550

FINANCING: The equipment listed above may be financed through Siemens. Ask us about our full range of financial products that can be tailored to meet your business and cash flow requirements. For further information, please contact your local Sales Representative.

Siemens Healthcare is pleased to submit this Preliminary Pricing Proposal. To place an order for the above listed items, please notify your Siemens Healthcare Sales Representative who will submit to you a formal Siemens

SIEMENS

Siemens Medical Solutions USA, Inc.
51 Valley Stream Parkway, Malvern, PA 19355
Fax: (866) 309-6992

SIEMENS REPRESENTATIVE
Gordon Wilhelm - (610) 448-1736

PRELIMINARY PROPOSAL

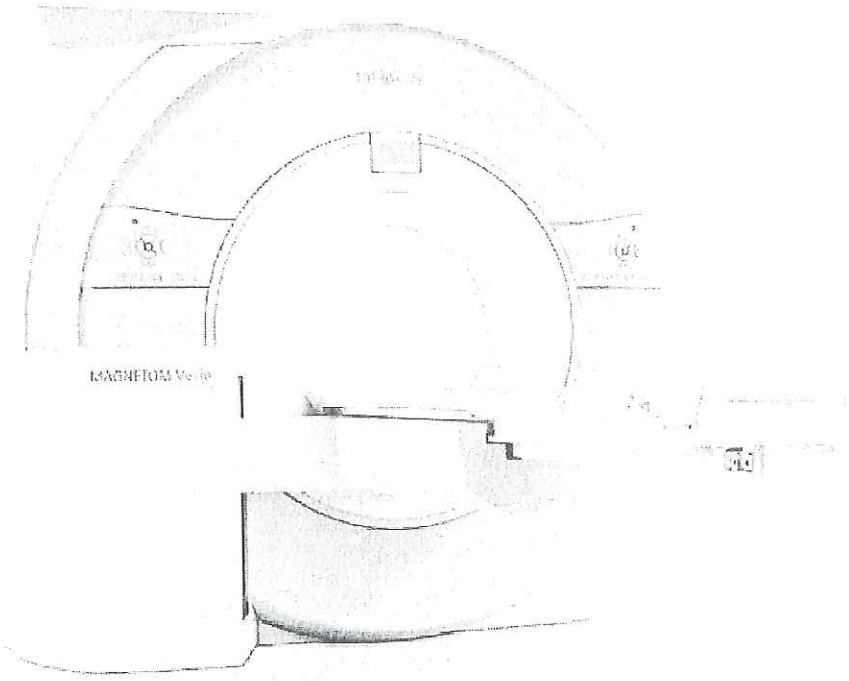
Healthcare Proposal, inclusive of Terms, Conditions, and Warranty coverage. Only a formal Siemens Healthcare Proposal may be used to create a binding order for this equipment.

Siemens Healthcare
Gordon Wilhelm
(610) 448-1736
gordon.wilhelm@siemens.com

SIEMENS

MAGNETOM VERIO
TYPICAL ROOM PLAN

MR



The intended use for this Cut Sheet is to communicate the spatial requirements as well as the basic architectural, electrical, structural, and mechanical requirements for this piece of imaging equipment. The information provided in this document is for reference only, during the pre-planning stage, and therefore does not contain any site specific detailed requirements. This information is subject to change without notice. Federal, state and/or local requirements may impact the final placement of the components. It is the customer's responsibility to ensure that the final layout and placement of the equipment complies with all applicable requirements.

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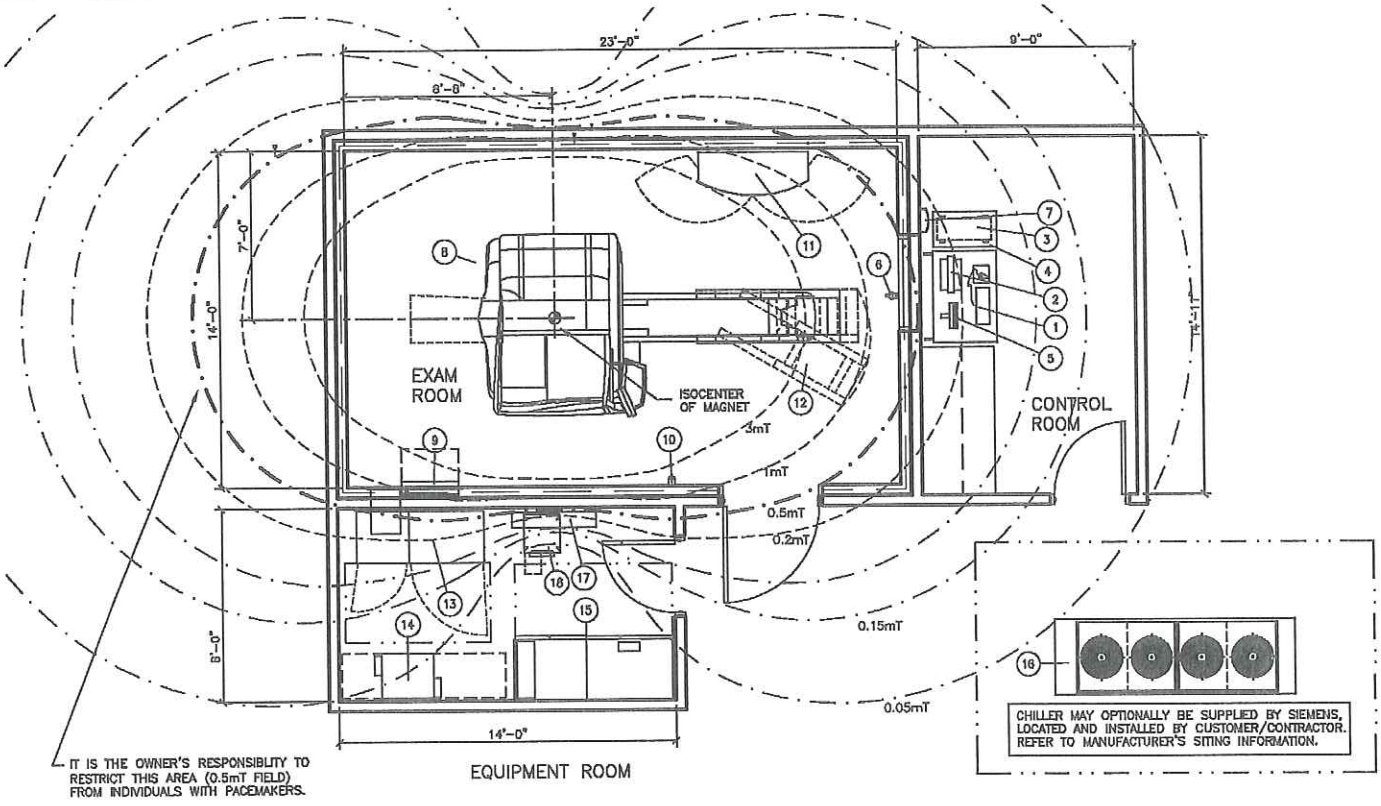
MAGNETOM VERIO

TYPICAL ROOM PLAN

MR



TYPICAL PLAN SCALE: 1/8" = 1'-0"

EQUIPMENT LEGEND

NO	DESCRIPTION	SMS SYM	WEIGHT (LBS)	BTU/HR TO AIR	DIMENSIONS (INCHES) W	D	H	REMARKS
1	MRC OPERATING CONSOLE AND KEYBOARD	MRC	132	---	45 11/16	35 1/4	28 3/8	
2	COLOR MONITOR FOR MRC		22	239	18 5/16	16 15/16	4 3/4	ON CONSOLE/COUNTER
3	HOST PC MRC	HPC	49	2389	11	27	18 1/8	
4	CONTAINER FOR HOST 450		230	---	17 3/4	31 1/2	27 5/8	
5	PATIENT MONITOR (OPTION)	PM	30	---	13	8	12 1/2	
6	PATIENT SUPERVISION CAMERA (OPTION)	PSC	TBA	TBA	TBA	TBA	TBA	WALL MOUNTED
7	ALARM BOX	AB	2	---	9	4	9	
8	3.0T AS-MAGNET WITH COVERS AND PATIENT TABLE	B	18298	9383	90 1/2	168 5/8	87 3/8	
9	RF-FILTER PLATE	F1	285	853	46 1/2	21 3/4	21 1/2	
10	MAGNET STOP	MS	1	---	3	5	3	
11	SURFACE COIL CART (OPTION)	SCC	110	---	55 1/8	21 1/8	47 5/8	WEIGHT WITHOUT COILS
12	PATIENT TRANSPORT TROLLEY (OPTION)	PTT	291	---	26 1/2	71 1/2	39 1/2	
13	ELECTRONICS CABINET (GPA/ACC CABINET)	GPA	2756	13649	61 1/2	26	77 1/2	
14	RF CABINET	RF	1102	25591	22 1/8	25 5/8	60 5/8	
15	POWERWARE 9390 U.P.S. WITH BATTERY (OPTION)	UPS	5880	43800	78 3/8	32	74	
16	KKT KRAUS KCC 215 CLOSED LOOP WATER CHILLER	CH	2425	---	120 1/2	37 7/8	72	CUST. TO LOCATE/INSTALL
17	KKT KRAUS INTERFACE PANEL	FP	88	---	41 3/8	7 7/8	31 1/2	WALL MTD. IN EQUIP. ROOM
18	COLD HEAD COMPRESSOR	CHC	284	---	17 3/4	21 5/8	20 7/8	

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MAGNETOM VERIO

SPECIFICATIONS

MR

POWER REQUIREMENTS

VOLTAGE RANGE: 480 VAC ±10% FOR ALL LINE AND LOAD CONDITIONS.
VOLTAGE BALANCE: 2% MAXIMUM DIFFERENCE BETWEEN PHASES

FREQUENCY:	60 Hz ± 1.0 Hz
LINE IMPEDENCE:	0.20 OHMS
STAND BY POWER:	13 kVA
HIGHEST AVERAGE POWER (6	56 kVA
CONNECTION VALUE (LESS THAN 5 MINUTES) (1	110 KVA
MOMENTARY POWER (4	140 KVA
RECOMMENDED TRANSFORMER (1	150 KVA
RECOMMENDED UPS (1	160 KVA
MR SYSTEM OVERCURRENT PROTECTION (3	175 A
UPS SYSTEM OVERCURRENT PROTECTION (7	200 A
MAX. ALLOWABLE VOLTAGE DROP AT MAX. POWER (5	6.0%

POWER REQUIREMENTS

DEMAND AND CAPACITY REQUIREMENTS NOTES

1) IF EQUIPMENT UPGRADE IS ANTICIPATED, INSTALLING ELECTRICAL POWER TO MEET THE REQUIREMENTS OF THE HIGHER POWER GRADIENT PACKAGE AT THE TIME OF INITIAL INSTALLATION WILL REDUCE THE COST TO UPGRADE THE ELECTRICAL SYSTEM LATER.

2) RECOMMENDED TRANSFORMER SIZE (SYSTEM WITHOUT UPS) IS BASED ON INDUSTRY STANDARD ISOLATION TRANSFORMER KVA RATINGS. SOURCE IMPEDANCE FEEDING THE MAGNETOM SYSTEM, INCLUDING ANY ISOLATION TRANSFORMERS, MUST MEET EQUIPMENT REQUIREMENTS AS LISTED HERE. SIEMENS RECOMMENDS A TRANSFORMER WITH COPPER WINDINGS, AN ELECTRO-STATIC SHIELD, AND A LOW IMPEDANCE (<3%) TO ENSURE THAT SOURCE IMPEDANCE REQUIREMENTS ARE MET.

3) OVERCURRENT PROTECTION IS SPECIFIED FOR SYSTEMS WITHOUT AN UNINTERRUPTIBLE POWER SUPPLY (UPS). ADDITION OF A UPS REQUIRES A HIGHER CAPACITY MAINS CONNECTION (DEPENDENT UPON UPS MODEL AND SIZE).
MAXIMUM FAULT CURRENT IS DEPENDENT UPON THE IMPEDANCE OF THE FACILITY ELECTRICAL SYSTEM. CUSTOMER'S ARCHITECT OR ELECTRICAL CONTRACTOR TO SPECIFY AIC RATING OF OVERCURRENT PROTECTION BASED ON FACILTY IMPEDANCE CHARACTERISTICS.

4) MOMENTARY POWER IS BASED ON A MAXIMUM RMS VALUE FOR A PERIOD NOT TO EXCEED FIVE (5) SECONDS, AS DEFINED IN NEC 517.2. STAND-BY AND AVERAGE CURRENT ARE SUBSTANTIALLY LOWER.

5) THE CONDUCTOR SIZE SHOULD BE SELECTED TO MEET THE VOLTAGE DROP REQUIREMENTS, TAKING INTO CONSIDERATION THE MAINS CAPACITY, RUN LENGTH, AND ANY ADDITIONAL TRANSFORMERS USED TO OBTAIN THE PROPER EQUIPMENT VOLTAGE LEVEL. NEMA STANDARD XR-9-1989 (R1994,R2000) PROVIDES GENERAL GUIDELINES FOR SIZING CONDUCTORS, TRANSFORMERS, AND ELECTRICAL SYSTEMS FOR MEDICAL IMAGING SYSTEMS.

6) LONG-TIME POWER IS BASED ON THE HIGHEST AVERAGE RMS VALUES FOR A PERIOD EXCEEDING 5 MINUTES DURING CLINICAL SYSTEM OPERATION, AS DEFINED IN NEC 517.2.

7) A CIRCUIT BREAKER WITH A HIGH INRUSH RATING (>8x RATED CURRENT) IS REQUIRED TO PERMIT SWITCH-ON OF THE UPS SYSTEM WITHOUT SPURIOUS TRIPPING. CIRCUIT BREAKERS WITH AN ADJUSTABLE MAGNETIC TRIP (SIEMENS FD6 SERIES OR SIMILAR) ARE HIGHLY RECOMMENDED.

NOISE LEVELS

SYSTEM ROOM	NOISE LEVEL / dB(A)
CONTROL ROOM	<55
EXAMINATION ROOM	89.6 dB(A) AVERAGE VALUE 115 dB(A) WITH MAXIMUM GRADIENT AND MAXIMUM GRADIENT SLEW RATE.
EQUIPMENT ROOM	<65

IT IS THE CUSTOMER'S RESPONSIBILITY TO ENSURE THAT ALL LOCAL/STATE/OSHA NOISE REGULATIONS ARE ADHERED TO. ADDITIONAL NOISE DATA MAY BE PROVIDED BY SIEMENS PROJECT MANAGER UPON REQUEST.

TRANSPORTING REQUIREMENTS

LARGEST ITEM – MAGNET – 18,298 LBS.

MAGNET DIMENSIONS: 7'-4" HIGH x 7'-7" WIDE x 10'-5" LONG FOR STANDARD DELIVERY. BY REMOVING THE TABLE, THE LENGTH CAN BE REDUCED TO 6'-5". THE ROOF HATCH OPENING SHOULD BE 4" LARGER THAN THE MAGNET DIMENSIONS.

TO TRANSPORT THE GPA/ACC CABINET (2,756 POUNDS) A MINIMUM ROOM HEIGHT OF 6'-9" WITH TRANSPORT ROLLERS, OR 6'-5" WITHOUT TRANSPORT ROLLERS IS REQUIRED.

CEILING HEIGHTS

MAGNET EXAMINATION ROOM: 7-11" MINIMUM
EQUIPMENT ROOM: 7'-3" MINIMUM WITH RESTRICTION
ALL ANCILLARY AREAS: 6'-11" MINIMUM

REMOTE SYSTEM DIAGNOSTICS

SIEMENS REMOTE SERVICES (SRS) REQUIRES A CONNECTION BETWEEN THE SRS REMOTE SERVER AND SIEMENS SYSTEMS VIA REMOTE LOCAL AREA NETWORK ACCESS, TO ENSURE THE UPTIME OF YOUR SYSTEM.

THIS SERVICE REQUIRES ONE OF THE FOLLOWING CONNECTION METHODS:
1. (PREFERRED) VPN – WHERE THE CUSTOMER HAS AVAILABLE A VPN CAPABLE FIREWALL OR OTHER VPN APPLIANCE.
2. (OPTIONAL) *SRS ROUTER* – CONNECTED TO ANALOG PHONE LINE VIA *ANALOG MODEM*, ETHERNET CONNECTION TO CUSTOMER'S LAN, AND A POWER OUTLET. NOTE: = *SUPPLIED BY SIEMENS*

FOR MORE INFORMATION

FOR MORE DETAILED PLANNING REQUIREMENTS FOR THIS SYSTEM, SEE THE TYPICAL FINAL DRAWING SET NUMBER: 07137

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MAGNETOM VERIO
SPECIFICATIONS MR

CHILLED WATER SUPPLY

A CHILLED WATER SUPPLY IS REQUIRED TO THE MRI SYSTEM 24 HOURS A DAY, YEAR ROUND FOR THE COLD HEAD AND GRADIENT SYSTEMS. THIS CAN BE PROVIDED BY A CENTRAL CHILLED WATER SUPPLY OR A SEPARATE STAND ALONE CHILLER THAT MEETS THE STATED REQUIREMENTS. THE CHILLED WATER CAN ALSO BE SUPPLIED BY A DEDICATED KRAUS KSC 215 CHILLER AND INTERFACE PANEL.

WITHOUT THE USE OF A DEDICATED KRAUS CHILLER, A SEP (SYSTEM SEPARATOR CABINET), MUST BE INCLUDED WITH THE SIEMENS ORDER. THE PIPE SIZE BETWEEN THE KRAUS CHILLER AND INTERFACE PANEL, OR BETWEEN THE WATER SUPPLY AND SEP MUST BE 2 INCH UP TO 82 FEET, 2–1/2 INCH UP TO 148 FEET, CONSULT FOR LONGER PIPE. PERMISSIBLE MATERIALS THAT CAN BE USED FOR THE PIPING ARE: STAINLESS STEEL (V2A, V4A), NON–FERROUS METAL (COPPER, BRASS), SYNTHETIC MATERIAL, PLASTICS, BRAZING SOLDER, HARD SOLDER, OR FITTING SOLDER TYPE 3 AND 4. THERE ARE MATERIALS THAT MAY CAUSE DAMAGE TO THE COOLING SYSTEM AND CANNOT BE USED, THESE MATERIALS ARE ALUMINUM, IRON, CARBON STEEL, ZINC, ZINC PLATED STEEL, OR STANDARD STEEL PIPES.

THESE REQUIREMENTS ARE REQUIRED FOR NEW INSTALLATIONS, IF EXISTING WATER PIPES COMPLY WITH SIEMENS WATER SPECIFICATIONS, THEY DO NOT NEED TO BE REPLACED.

NORMAL TAP WATER MUST BE AVAILABLE FOR FILLING THE SECONDARY WATER CIRCUIT. THERE SHALL BE A HOSE BIB LOCATED WITHIN 65' OF THE SEP, IFP, ACC OR THE KRAUS CHILLER.

THE SUPPLY AND RETURN CHILLED WATER PIPES MUST BE LABELED. THE LOCATION OF THE LABELS MUST BE AT ALL CONNECTION AND REFILLING POINTS AND MUST CONTAIN FLOW DIRECTION AND CONTENTS.

ENVIRONMENTAL REQUIREMENTS

1) AIR CONDITIONING IS TO PROVIDE A TEMPERATURE OF 70°F ±5°F IN THE CONTROL & EQUIPMENT ROOMS 65°F–71°F IN EXAM ROOM. RELATIVE HUMIDITY OF 40–60% (NON–CONDENSING) IS REQUIRED EXAMINATION ROOM AND 40–80% (NON–CONDENSING) IN ALL OTHER AREAS WHERE SIEMENS EQUIPMENT IS INSTALLED. THESE CONDITIONS ARE TO BE MET AT ALL TIMES; 24 HOURS A DAY, 7 DAYS A WEEK.

2) A DEDICATED AIR CONDITIONING AND HUMIDIFICATION SYSTEM IS RECOMMENDED FOR THE EXAM ROOM. A MINIMUM FRESH AIR EX–CHANGE RATE OF 6 TIMES PER HOUR FOR THE EXAM ROOM IS REQUIRED. AIR SUPPLY AND RETURN ABOVE THE FINISHED CEILING IN THE EXAM ROOM IS RECOMMENDED. EACH ROOM SHOULD HAVE A DEDICATED CONTROL AND SENSOR TO MONITOR AND ADJUST THE AIR.

3) THE HEAT INTO THE EXAM ROOM IS LESS THAN 10,236 BTU/HR. THE HEAT INTO THE EQUIPMENT ROOM IS TYPICALLY 32,415 BTU/HR, MAXIMUM 40,946 BTU/HR. THIS HEAT DISSIPATION IS FROM THE SIEMENS EQUIPMENT ONLY. AUXILIARY SUPPORT EQUIPMENT (ie UPS) AND LIGHTING MUST BE CONSIDERED FOR TOTAL HEAT LOADS.

4) IT IS IMPORTANT FOR FRESH AIR INTAKE SYSTEMS TO EXHAUST AIR DIRECTLY OUT OF THE BUILDING. THE EXHAUST AIR MUST NOT BE DEFLECTED INTO ANOTHER ROOM. THE MAGNET ROOM EXHAUST AIR SHOULD BE INSTALLED AT LEAST 6'–6" ABOVE FINISHED FLOOR.

5) THE AIR INTAKE OF THE AIR CONDITIONING SYSTEM MUST NOT BE LOCATED IN THE VICINITY OF THE QUENCH VENT EXHAUST.

6) IF THE INPUT DRAWS UPON AIR FROM OUTSIDE THE BUILDING, IT IS RECOMMENDED TO INSTALL AN ON–SITE FILTER TO REMOVE DUST PARTICLES GREATER THAN 10 MICRONS.

QUENCH VENT NOTES

LIQUID AND GASSEOUS HELIUM ARE USED IN THE OPERATION OF A SUPERCONDUCTING MRI SYSTEM. THE MECHANICAL CONTRACTOR SHALL PROVIDE A VENT, ACCORDING TO SIEMENS SPECIFICATIONS, TO EXHAUST GASSEOUS HELIUM FROM THE MAGNET TO OUTSIDE THE BUILDING. PLEASE SEE THE SIEMENS TYPICAL DRAWINGS FOR DETAILS.

CHILLED WATER REQUIREMENTS

WATER REQUIREMENTS TO BE MEASURED AT THE SEP CABINET.

FLOW RATE:	23.78–29.05 GPM
WATER TEMPERATURE:	48°F ±4°F
BTU DISCHARGE TO THE WATER	214,964 BTU/HR
WATER PRESSURE	MAXIMUM 87 PSI
LOSS OF PRESSURE FOR SEP CABINET	14.5 PSI MAXIMUM
CHILLED WATER ACIDITY RANGE	6 pH TO 8 pH
CHILLED WATER HARDNESS	<250 ppm CALCIUM CARBONATE
CHLORINE GAS CONCENTRATION	<200 ppm
FILTRATION	500 µm

FOR INSTALLATION OF A KRAUS KSC 215 CHILLER, IT IS THE RESPONSIBILITY OF THE CUSTOMER/MECHANICAL CONTRACTOR TO PROVIDE A MIXTURE OF WATER WITH 35%–38% ETHYLENE GLYCOL PRIOR TO CHILLER START UP. DO NOT USE PROPYLENE GLYCOL OR AUTOMOTIVE ANTI–FREEZE.

THE AMOUNT OF THE MIXTURE MUST FILL THE CHILLER, MR SYSTEM AND PIPING (SUPPLY AND RETURN), SEE EXAMPLES BELOW.

(1) GALLON OF UNDILLUTED GLYCOL, OR (2) GALLONS OF WATER/GLYCOL MIXTURE MUST REMAIN ON SITE FOR USE AFTER START UP.

MIXTURE VOLUME INCLUDING SUPPLY & RETURN+15 GAL. CHILLER & MR

PIPE DIAMETER	TOTAL LENGTH	MIXTURE VOLUME	GLYCOL NEEDED
2"	100'	31.3 GALLONS	11.9 GALLONS
2"	200'	47.6 GALLONS	18.1 GALLONS
2.5"	100'	40.5 GALLONS	15.4 GALLONS
2.5"	200'	66.0 GALLONS	25.1 GALLONS

MIXTURE VOLUME = 3.14 x (PIPE RADIUS)^2 x PIPE LENGTH + 15 GALLONS.
GLYCOL AMOUNT = 35–38% OF MIXTURE VOLUME.

BUILDING VIBRATIONS

VIBRATION OF THE SITE HAS THE ABILITY TO AFFECT THE STABILITY AND HOMOGENEITY OF THE MAGNETIC FIELD. THEREFORE EXTERNAL VIBRATIONS OR SHOCKS AFFECTING THE MAGNET MAY DEGRAGE IMAGE QUALITY. IN THE THREE SPATIAL ORITENTATIONS THE BUILDING MUST NOT EXCEED ACCELERATION OF 0.001m/s² or –80dB(g) g=9.81 m/s²

THE REQUIREMENT FOR a_{max} IS MEASURED AS MAXIMUM RMS VALUE PER FREQUENCY COMPONENT <0.5Hz IN THE FOURIER TRANSFORMATION OF THE RECORDED SIGNAL (SPECTRUM).

THE VIBRATION LEVEL OF CONTINUOUS VIBRATIONS (CAUSED BY AIR CONDITIONER, COMPRESSOR, ETC.) AT THE LOCATION OF THE MAGNET MUST NOT EXCEED THE SPECIFED VALUES.
FOR ALL NON–CONTINOUS TRANSIENT VIBRATIONS THE FIGURES SHOULD BE MULTIPLIED BY 4 (OR 12dB).

CONTACT SIEMENS PROJECT MANAGER FOR MORE DETAILS.

ALL SITES MUST BE TESTED BY AN ACOUSTICAL/VIBRATION ENGINEER.

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MAGNETOM VERIO

SPECIFICATIONS MR

PROTECTING THE ENVIRONMENT

PROTECTING THE IMMEDIATE ENVIRONMENT FROM THE EFFECT OF THE MAGNETIC FIELD REQUIRES CONSIDERATION. INFORMATION STORED ON MAGNETIC DATA CARRIERS SUCH AS DISKS, TAPES, AND CREDIT CARDS MAY BE ERASED IF IN CLOSE PROXIMITY. CAUTION WITH REGARD TO HEART PACEMAKERS MUST BE EXERCISED. MOST PACEMAKER UNITS EMPLOY A REED RELAY WHICH MAY CHANGE OPERATING MODE WHEN EXPOSED TO AN EXTERNAL MAGNETIC FIELD. THEREFORE, PACEMAKER USERS MUST BE KEPT AT A SPECIFIED DISTANCE FROM THE MAGNET WHICH IS DETERMINED BY THE MAGNETIC FIELD STRENGTH.

PROTECTING THE MAGNETIC FIELD

THE SIEMENS MAGNETOM UTILIZES A SUPERCONDUCTIVE MAGNET WITH AN EXTREMELY HOMOGENEOUS FIELD WITHIN THE MAGNET TO PROVIDE DISTORTION–FREE IMAGING. THE PRESENCE OF FERROMAGNETIC MATERIAL WITHIN THE VICINITY OF THE MAGNET CAN ADVERSELY AFFECT THE UNIFORMITY OF THE USEFUL MAGNETIC FIELD. THIS APPLIES TO STATIONARY FERROUS MATERIAL (STRUCTURAL STEEL) WHICH IS TO BE MINIMIZED. STATIONARY STEEL COMPENSATION MAY BE ACHIEVED BY MAGNET POSITIONING AND SELECTIVE USE OF SHIMS. FIELD DISTORTION ENCOUNTERED BY MOVING FERROMAGNETIC OBJECTS IS MORE DIFFICULT TO COMPENSATE AND MAY REQUIRE THE USE OF MAGNETIC SHIELDING.

MAGNETIC FRINGE FIELDS

MAGNETIC FIELDS MAY AFFECT THE FUNCTION OF DEVICES IN THE VICINITY OF THE MAGNET. THESE DEVICES MUST BE OUTSIDE CERTAIN MAGNETIC FIELDS. THE DISTANCES LISTED ARE FROM THE MAGNET ISOCENTER AND DO NOT CONSIDER ANY MAGNETIC ROOM SHIELDING.

X/Y AND Z AXIS	DEVICES
6'–11" / 10'–6" 3.0mT	SMALL MOTORS, WATCHES, CAMERAS, CREDIT CARDS, MAGNETIC DATA CARRIERS (SHORT–TERM EXPOSURE)
7'–7" / 13'–2" 1.0mT	COMPUTERS, MAGNETIC DISK DRIVES, OSCILLOSCOPES, PROCESSORS
8–7" / 15'–2 0.5mT	CARDIAC PACEMAKERS, X–RAY TUBES, INSULIN PUMPS, B/W MONITORS, MAGNETIC DATA CARRIERS (LONG–TERM STORAGE)
11–2" / 20'–1" 0.15mT	COLOR MONITORS, SIEMENS CT SCANNERS
12'–6" / 22'–4" 0.1mT	SIEMENS LINEAR ACCELERATORS
16'–1" / 26'–11" 0.05mT	X–RAY IMAGE INTENSIFIERS, GAMMA CAMERAS, PET/CYCLOTRON, ELECTRON MICROSCOPES, LINEAR ACCELERATORS

THE OWNER/USER IS TO VERIFY THE LOCATION OF THE 0.5mT FIELD AND ENSURE THAT IT IS MAINTAINED AS A RESTRICTED AREA.

MAGNET SITING REQUIREMENTS

IT MUST BE ENSURED THAT THE MAGNET IS LOCATED SO THAT THE STABILITY AND HOMOGENEITY OF THE MAGNETIC FIELD ARE NOT ADVERSELY AFFECTED BY EXTRANEOUS FIELDS AND STATIC OR DYNAMIC FERROMAGNETIC OBJECTS.

X/Y AND Z AXIS	SOURCE OF INTERFERENCE
4'–0"	FLOOR STEEL REINFORCEMENT<20 LBS./ FT^2 IRON BEAMS < 66 LBS./FT.
18'–0" / 21'–3"	STRETCHERS UP TO 110 LBS.
13'–1"	A/C CHILLERS
19'–8" / 22'–11"	TRANSPORT DEVICES UP TO 440 LBS.
21'–3 / 26'–2"	VEHICLES UP TO 2,000 LBS.
22'–11" / 31'–2"	ELEVATORS, TRUCKS UP TO 10,000 LBS.
39'–4"/26'–2"	AC TRANSFORMERS LESS THAN 100 KVA
41'–0"/32'–9"	AC TRANSFORMERS LESS THAN 250 KVA
42'–7"/39'–4"	AC TRANSFORMERS LESS THAN 650 KVA
45'–11"/49'–2"	AC TRANSFORMERS LESS THAN 1600 KVA
9'–10"/6'–6"	AC CABLES, MOTORS LESS THAN 100 AMPS
22'–11"/9'–10"	AC CABLES, MOTORS LESS THAN 250 AMPS
131'–2"	ELECTRIC RAILWAY SYSTEMS

FOR IRON OBJECTS LOCATED UP TO 45° FROM THE Z AXIS, THE DISTANCES FOR THE Z AXIS MUST BE USED.
REDUCTION IS POSSIBLE WITH STEEL SHIELDING.

MAXIMUM CABLE LENGTH

THERE ARE 6 DIFFERENT CABLE SETS THAT ARE AVAILABLE FOR THE MRI SYSTEM DIFFERENTIATED BY MAXIMUM LENGTHS FROM THE MAGNET TO THE FILTER PANEL (INSIDE) AND FROM THE FILTER PANEL TO THE ELECTRONICS (OUTSIDE).

	INSIDE	OUTSIDE
SET 1	20'	4'
SET 2	20'	32'
SET 3	20'	39'
SET 4	30'	4'
SET 5	30'	29'
SET 6	46'	13'

THE VERTICAL DISTANCE FOR CABLE TRAVEL FROM THE FILTER PANEL TO THE CABLE TRAY, AND FROM THE CABLE TRAY TO THE MAGNET MUST BE CONSIDERED.

THE MAXIMUM DISTANCE FROM THE ACC CABINET TO THE CONTROL CONSOLE IS 75 FEET.

RF SHIELDING

THE EXAMINATION AREA MUST BE SHIELDED TO PROVIDE A REDUCTION OF RADIO FREQUENCY WAVES EMANATING FROM EXTERNAL TRANSMITTERS. THE REQUIRED ATTENUATION IS 90dB IN THE FREQUENCY RANGE OF 15–128 MHz. THE RF SHIELD MUST BE TESTED BEFORE AND AFTER MAGNET PLACEMENT IN THE RF ROOM AND AFTER THE SIEMENS RF FILTER PANEL IS INSTALLED.

THE RF–SHIELDING MUST BE INSULATED FROM ALL GROUNDS SUCH THAT THE ONLY GROUND IS THE SINGLE POINT GROUND ON THE OUTSIDE OF THE RF–ROOM WALL. RESISTANCE ≥ 100 OHMS.

ALL ELECTRICAL LINES INTO THE RF ROOM MUST BE ROUTED THROUGH RF FILTERS (PROVIDED BY RF SHIELDING SUPPLIER).
ALL ELECTRICALLY NON–CONDUCTIVE SUPPLY LINES (E.G. OXYGEN) INTO THE RF ROOM MUST BE ROUTED THROUGH RF SEALED WAVE GUIDES (PROVIDED BY RF SHIELDING SUPPLIER).

FOR PRESSURE EQUALIZATION PURPOSES THE RF DOOR SHOULD OPEN TO THE OUTSIDE OF THE RF ROOM. AS AN ALTERNATIVE A 24"X24" OPENING IN THE RF ROOM FOR PRESSURE EQUALIZATION IS REQUIRED.

Attachment M

Financial Attachments

Financial Attachment I

Lawrence & Memorial Hospital

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

Total Facility: Description	FY 2010 Actual Results	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE										
Non-Government	$165,372,627	$165,372,627	$234,298	$165,606,925	$165,372,627	$275,123	$165,647,750	$165,372,627	$487,213	$165,859,840
Medicare	$97,994,557	$97,994,557	$170,177	$98,164,734	$97,994,557	$200,227	$98,194,784	$97,994,557	$354,581	$98,349,138
Medicaid and Other Medical Assistance	$30,160,421	$30,160,421	$10,875	$30,171,296	$30,160,421	$12,780	$30,173,201	$30,160,421	$22,632	$30,183,053
Other Government	$13,035,372	$13,035,372	$72,225	$13,107,597	$13,035,372	$84,420	$13,119,792	$13,035,372	$149,499	$13,184,871
Total Net Patient Patient Revenue	$306,562,977	$306,562,977	$487,575	$307,050,552	$306,562,977	$572,550	$307,135,527	$306,562,977	$1,013,925	$307,576,902
Other Operating Revenue	$14,292,897	$14,292,897		$14,292,897	$14,292,897		$14,292,897	$14,292,897		$14,292,897
Revenue from Operations	$320,855,874	$320,855,874	$487,575	$321,343,449	$320,855,874	$572,550	$321,428,424	$320,855,874	$1,013,925	$321,869,799
OPERATING EXPENSES										
Salaries and Fringe Benefits	$174,502,282	$174,502,282		$174,502,282	$174,502,282	$80,047	$174,582,329	$174,502,282	$160,092	$174,662,374
Professional / Contracted Services	$20,028,640	$20,028,640		$20,028,640	$20,028,640		$20,028,640	$20,028,640	$137,866	$20,166,506
Supplies and Drugs	$33,399,993	$33,399,993	$9,911	$33,409,904	$33,399,993	$11,638	$33,411,631	$33,399,993	$20,610	$33,420,603
Bad Debts	$14,381,176	$14,381,176		$14,381,176	$14,381,176		$14,381,176	$14,381,176		$14,381,176
Other Operating Expense	$35,065,186	$35,065,186	$2,973	$35,068,159	$35,065,186	$22,400	$35,087,586	$35,065,186	$85,360	$35,150,546
Subtotal	$277,377,277	$277,377,277	$12,884	$277,390,161	$277,377,277	$114,085	$277,491,362	$277,377,277	$403,928	$277,781,205
Depreciation/Amortization	$16,728,407	$16,728,407		$16,728,407	$16,728,407	$285,021	$17,013,428	$16,728,407	$570,042	$17,298,449
Interest Expense	$2,332,245	$2,332,245		$2,332,245	$2,332,245		$2,332,245	$2,332,245		$2,332,245
Lease Expense	$2,798,067	$2,798,067		$2,798,067	$2,798,067		$2,798,067	$2,798,067		$2,798,067
Total Operating Expense	$299,235,996	$299,235,996	$12,884	$299,248,880	$299,235,996	$399,106	$299,635,102	$299,235,996	$973,970	$300,209,966
Gain/(Loss) from Operations	$21,619,878	$21,619,878	$474,691	$22,094,569	$21,619,878	$173,444	$21,793,322	$21,619,878	$39,955	$21,659,833
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$21,619,878	$21,619,878	$474,691	$22,094,569	$21,619,878	$173,444	$21,793,322	$21,619,878	$39,955	$21,659,833
FTEs	1892.85	1892.85	0	1892.85	1892.85	0.9	1893.75	1892.85	1.7	1894.55
*Volume Statistics:	11,101	11,101	591	11,692	11,101	694	11,795	11,101	1,229	12,330

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.

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Total Facility: Description	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE						
Non-Government	$165,372,627	$710,007	$166,082,634	$165,372,627	$947,469	$166,320,096
Medicare	$97,994,557	$516,725	$98,511,282	$97,994,557	$689,544	$98,684,101
Medicaid and Other Medical Assistance	$30,160,421	$32,981	$30,193,402	$30,160,421	$44,012	$30,204,433
Other Government	$13,035,372	$217,862	$13,253,234	$13,035,372	$290,726	$13,326,098
Total Net Patient Patient Revenue	$306,562,977	$1,477,575	$308,040,552	$306,562,977	$1,971,751	$308,534,728
Other Operating Revenue	$14,292,897		$14,292,897	$14,292,897		$14,292,897
Revenue from Operations	$320,855,874	$1,477,575	$322,333,449	$320,855,874	$1,971,751	$322,827,625
OPERATING EXPENSES						
Salaries and Fringe Benefits	$174,502,282	$234,064	$174,736,346	$174,502,282	$308,035	$174,810,317
Professional / Contracted Services	$20,028,640	$137,866	$20,166,506	$20,028,640	$137,866	$20,166,506
Supplies and Drugs	$33,399,993	$30,035	$33,430,028	$33,399,993	$40,080	$33,440,073
Bad Debts	$14,381,176		$14,381,176	$14,381,176		$14,381,176
Other Operating Expense	$35,065,186	$105,661	$35,170,847	$35,065,186	$126,148	$35,191,334
Subtotal	$277,377,277	$507,626	$277,884,903	$277,377,277	$612,129	$277,989,406
Depreciation/Amortization	$16,728,407	$570,042	$17,298,449	$16,728,407	$570,042	$17,298,449
Interest Expense	$2,332,245		$2,332,245	$2,332,245		$2,332,245
Lease Expense	$2,798,067		$2,798,067	$2,798,067		$2,798,067
Total Operating Expense	$299,235,996	$1,077,668	$300,313,664	$299,235,996	$1,182,171	$300,418,167
Gain/(Loss) from Operations	$21,619,878	$399,907	$22,019,785	$21,619,878	$789,580	$22,409,458
Plus: Non-Operating Revenue			$0			$0
Revenue Over/(Under) Expense	$21,619,878	$399,907	$22,019,785	$21,619,878	$789,580	$22,409,458
FTEs	1892.85	2.5	1895.35	1892.85	3.2	1896.05
*Volume Statistics: Provide projected inpatient and/or outpatie	11,101	1,791	12,892	11,101	2,390	13,491

Financial Attachment II

Lawrence & Memorial Hospital

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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2011	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**591**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$12,884**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	151	$335,673	$165,496			$170,177	$3,292	$166,885
Medicaid		$2,223	75	$166,725	$155,850			$10,875	$1,635	$9,240
CHAMPUS/TriCare		$2,223	57	$126,711	$54,486			$72,225	$1,243	$70,983
Total Governmental			283	$629,109	$375,832	$0	$0	$253,277	$6,169	$247,108
Commericial Insurers		$2,223	304	$675,792	$441,408		$87	$234,297	$6,627	$227,670
Uninsured		$2,223	4	$8,892		$8,892		$0	$87	($87)
Total NonGovernment		$2,223	308	$684,684	$441,408	$8,892	$87	$234,297	$6,715	$227,583
Total All Payers		$2,223	591	$1,313,793	$817,240	$8,892	$87	$487,575	$12,884	$474,691

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2012	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**694**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$399,106**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	178	$394,947	$194,720			$200,227	$102,171	$98,056
Medicaid		$2,223	88	$195,931	$183,151			$12,780	$50,686	($37,906)
CHAMPUS/TriCare		$2,223	67	$148,105	$63,685			$84,420	$38,314	$46,106
Total Governmental			332	$738,983	$441,556	$0	$0	$297,427	$191,172	$106,256
Commericial Insurers		$2,223	357	$792,980	$517,755		$102	$275,122	$205,140	$69,982
Uninsured		$2,223	5	$10,799		$10,799		$0	$2,794	($2,794)
Total NonGovernment		$2,223	362	$803,779	$517,755	$10,799	$102	$275,122	$207,934	$67,188
Total All Payers		$2,223	694	$1,542,762	$959,311	$10,799	$102	$572,550	$399,106	$173,444

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2013	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**1229**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$973,971**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Total Facility by										
Payer Category:										
Medicare		$2,223	315	$699,409	$344,828			$354,581	$249,337	$105,245
Medicaid		$2,223	156	$346,973	$324,340			$22,632	$123,694	($101,062)
CHAMPUS/TriCare		$2,223	118	$262,278	$112,780			$149,499	$93,501	$55,997
Total Governmental			589	$1,308,660	$781,948	$0	$0	$526,712	$466,532	$60,180
Commericial Insurers		$2,223	632	$1,404,282	$916,889		$180	$487,213	$500,621	($13,408)
Uninsured		$2,223	9	$19,124		$19,124		$0	$6,818	($6,818)
Total NonGovernment		$2,223	640	$1,423,407	$916,889	$19,124	$180	$487,213	$507,439	($20,225)
Total All Payers		$2,223	1,229	$2,732,067	$1,698,837	$19,124	$180	$1,013,925	$973,971	$39,954

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**1791**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$1,077,667**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	458	$1,019,237	$502,512			$516,725	$275,883	$240,842
Medicaid		$2,223	227	$505,637	$472,656			$32,981	$136,864	($103,882)
CHAMPUS/TriCare		$2,223	172	$382,214	$164,352			$217,862	$103,456	$114,406
Total Governmental			858	$1,907,087	$1,139,519	$0	$0	$767,568	$516,202	$251,366
Commericial Insurers		$2,223	921	$2,046,436	$1,336,166		$263	$710,007	$553,921	$156,086
Uninsured		$2,223	13	$27,870		$27,870		$0	$7,544	($7,544)
Total NonGovernment		$2,223	933	$2,074,306	$1,336,166	$27,870	$263	$710,007	$561,465	$148,543
Total All Payers		$2,223	1,791	$3,981,393	$2,475,685	$27,870	$263	$1,477,575	$1,077,667	$399,908

Lawrence & Memorial Hospital

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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**2390**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$1,182,170**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	612	$1,360,120	$670,577			$689,544	$302,636	$386,908
Medicaid		$2,223	304	$674,747	$630,735			$44,012	$150,136	($106,124)
CHAMPUS/TriCare		$2,223	229	$510,045	$219,319			$290,726	$113,488	$177,237
Total Governmental			1,145	$2,544,913	$1,520,631	$0	$0	$1,024,281	$566,259	$458,022
Commericial Insurers		$2,223	1,228	$2,730,867	$1,783,047		$351	$947,469	$607,635	$339,833
Uninsured		$2,223	17	$37,191		$37,191		$0	$8,275	($8,275)
Total NonGovernment		$2,223	1,245	$2,768,057	$1,783,047	$37,191	$351	$947,469	$615,911	$331,558
Total All Payers		$2,223	2,390	$5,312,970	$3,303,679	$37,191	$351	$1,971,750	$1,182,170	$789,580

Attachment N

Financial Attachment Assumptions

Lawrence & Memorial Hospital
Project: MRI
Forecasted Profit and Loss Statement

	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR	5th YEAR		Rate Per Procedure	
	2011	2012	2013	2014	2015			
VOLUME								
MRI Scans	591	694	1,229	1,791	2,390		#######	
	591	694	1,229	1,791	2,390			
REVENUES								
MRI	$487,575	$572,550	$1,013,925	$1,477,575	$1,971,750			
Net Revenues	$487,575	$572,550	$1,013,925	$1,477,575	$1,971,750			
OPERATING EXPENSES								
Direct Expenses								
Salaries & Wages	-	63,029	126,057	184,302	242,547			
Nonsalary	9,911	11,638	158,476	167,901	177,946			
Total Direct Expenses	9,911	74,667	284,534	352,203	420,493			
Depreciation	-	285,021	570,042	570,042	570,042			
Indirect Expenses								
Fringe Benefits	-	17,018	34,035	49,762	65,488		27.00%	percent of total salaries Historical Average
Other indirect	2,973	22,400	85,360	105,661	126,148		30.00%	percent of total expenses Historical Average
Total Indirect Expense	2,973	39,418	119,396	155,422	191,635			
Total Operating Expenses	12,884	399,106	973,971	1,077,667	1,182,170			
OPERATING INCOME(LOSS)	474,691	173,444	39,954	399,908	789,580			
CUMULATIVE INCOME(LOSS)	474,691	648,135	688,089	1,087,996	1,877,576			

													relief	
Salary Detail:								FTE's	FTE's	FTE's	FTE's	FTE's		W/Diff.
MRI/CT Technician	0	46,285	92,569	138,854	185,139	80,495	per FTE	0	0.5	1	1.5	2	Y*	
Clerical	0	16,744	33,488	45,448	57,408	41,600	per FTE	0.00	0.35	0.70	0.95	1.20	Y*	
								---	---	---	---	---		
								0.0	0.9	1.7	2.5	3.2		
							Includes	15.00%	15.00%	15.00%	15.00%	15.00%	relief	
	0	63,029	126,057	184,302	242,547									
Non Salary Detail:														
Contrast Costs	7,027	8,252	14,613	21,295	28,417	11.89	per scan							
Med./Surg.Supplies	1,714	2,013	3,564	5,194	6,931	2.90	per scan							
Printed Forms/Supplies	798	937	1,659	2,418	3,227	1.35	per scan							
Film	372	437	774	1,128	1,506	0.63	per scan							
Repairs Outside Equipment	0	0	137,866	137,866	137,866									
* Denotes Start\Up Costs	---	---	---	---	---									
	9,911	11,638	158,476	167,901	177,946									
Depreciation:							Years of Service							
Building renovations		20,000	40,000	40,000	40,000	600,000	15							
Movable Equipment		265,021	530,042	530,042	530,042	2,650,210	5							
Total	-	285,021	570,042	570,042	570,042	3,250,210								

Lawrence & Memorial Hospital
Project: MRI
Forecasted Profit and Loss Statement

	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR	5th YEAR	Purchase								
	2011	2012	2013	2014	2015	Price								
Depreciation:							Years of Service							
Building renovations		20,000	40,000	40,000	40,000	600,000	15							
Movable Equipment		265,021	530,042	530,042	530,042	2,650,210	5							
Total	-	285,021	570,042	570,042	570,042	3,250,210								

Attachment O

Rate Schedule

Lawrence & Memorial Hospital
Pricemaster Listing

MRI

MNEMONIC	DESCRIPTION	PRICE
1605019	INJ GAD CONTRAST PER ML (20CC)	103
1605020	INJ GAD CONTRAST PER ML (40CC)	207
1717001	HAND PIECE	868
1717002	INTRODUCER SET	519
1717003	CLIPS	222
4301003	LOWER EXTW/O JT W/O&W/CONTRAS	2879
4301005	UPPER EXT W/O JT W/O&W/CONTRAS	1432
4301010	DORSAL SPINE W/O CONTRAST	1627
4301012	CERVICAL SPINE W/O CONTR	1956
4301015	BRAIN W/O CONTRAST	2143
4301015	BRAIN W/O CONTRAST	1016
4301015	BRAIN W/O CONTRAST	1016
4301015	BRAIN W/O CONTRAST	1016
4301015	BRAIN W/O CONTRAST	1016
4301015	BRAIN W/O CONTRAST	1016
4301015	BRAIN W/O CONTRAST	1016
4301016	ORBIT, FACE, NECK W/O CONTRAST	2048
4301017	TEMOROMANDIBULAR JOINT	1974
4301018	TMJ W/O CONTRAST	1974
4301019	LSPINE W/WO CONTRAST FULL	3278
4301020	ABDOMEN FULL W/O CONTRAST	1378
4301021	LOWER EXTREM JOINTW/O CONTRAST	1818
4301023	UPPER EXT.JOINT W/O CONTRAST	1850
4301027	LUMBAR SPINE W/O CONTRAST	2014
4301032	CHEST W/O CONTRAST	2047
4301034	BRAIN W/O CONTRAST FULL	2143
4301035	ORBIT,FACE,NECK W/O CONTRAST	2048
4301037	MRA-SPINAL CANAL W/O CONT	2001
4301038	MRA-UPPER EXTREMITY W/OUT CONT	1995
4301039	MRA-LOWER EXTREMITY	2240
4301040	MRA-CHEST	2296
4301041	MRA-ABDOMEN	1498
4301043	DORSAL SPINE W/WO CONTRAST	3410
4301044	CERVICAL SPINE W/WO CONTRAST	3473
4301046	BRAIN SCAN W/WO CONTRAST	3169
4301046	BRAIN SCAN W/WO CONTRAST	1601
4301046	BRAIN SCAN W/WO CONTRAST	1601
4301046	BRAIN SCAN W/WO CONTRAST	1601
4301046	BRAIN SCAN W/WO CONTRAST	1601
4301046	BRAIN SCAN W/WO CONTRAST	1601

4301046	BRAIN SCAN W/WO CONTRAST	1601
4301052	SPECTROSCOPY	1627
4301052	SPECTROSCOPY	784
4301056	ORBIT FACE NECK W/O&W/CONTRAST	2989
4301058	MRA HEAD W/O CONTRAST	1664
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301058	MRA HEAD W/O CONTRAST	806
4301060	MRA HEAD W/CONTRAST	3429
4301062	MRA HEAD W/O & W/CONTRAST	3812
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301062	MRA HEAD W/O & W/CONTRAST	1601
4301064	MRA NECK W/O CONTRAST	3322
4301064	MRA NECK W/O CONTRAST	806
4301064	MRA NECK W/O CONTRAST	806
4301064	MRA NECK W/O CONTRAST	806
4301064	MRA NECK W/O CONTRAST	806
4301066	MRA NECK W/CONTRAST	1432
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301066	MRA NECK W/CONTRAST	915
4301068	MRA NECK W/O & W/CONTRAST	2566
4301068	MRA NECK W/O & W/CONTRAST	1601
4301072	CHEST W/O & W/CONTRAST	2762
4301074	PELVIS W/O CONTRAST	1879
4301076	PELVIS W/O & W/CONTRAST	2700
4301078	UPPER EX W/O JOINT W/O CONTRAS	2020
4301082	UPPER EX JOINT W/CONTRAST	1513
4301084	UPPER EX JOINT W/O& W/CONTRAST	1740
4301086	LOWER EX W/O JOINT W/O CONTRAS	2001
4301088	LOWER EX W/CONTRAST	1146
4301090	LOWER EX JOINT W/CONTRAST	1708
4301092	LOWER EX JOINT W/O& W/CONTRAST	2446
4301096	ABDOMEN W/O & W/ CONTRAST	2424
4301101	BRST BILAT W AND/OR W/O CONT	2417

4301101	BRST BILAT W AND/OR W/O CONT	1100
4301101	BRST BILAT W AND/OR W/O CONT	1100
4301103	BRST UNI W AND/OR W/O CONTRAST	1835
4301104	CS SAME MD>=5YR 1ST 30 MIN	289
4301217	MRI NEEDLE PLACEMENT	530
4301218	MRI BREAST BIOPSY	1086
4301219	MRI BREAST BIOPSY (P)	0
4301220	BREAST CLIP PLCMT PST BX	331
4301221	DIAG CAD COMPUT LESION DETECT	76
4301223	SCRN CAD COMPUT LESION DETECT	76
4301226	NO CHARGE MRI (STATISTICAL)	0
1605019A	INJ GAD CONTRAST PER ML (19CC)	98
1605019B	INJ GAD CONTRAST PER ML (18CC)	93
1605019C	INJ GAD CONTRAST PER ML (17CC)	88
1605019D	INJ GAD CONTRAST PER ML (16CC)	83
1605019E	INJ GAD CONTRAST PER ML (15CC)	77
1605019F	INJ GAD CONTRAST PER ML (14CC)	72
1605019G	INJ GAD CONTRAST PER ML (13CC)	67
1605019H	INJ GAD CONTRAST PER ML (12CC)	62
1605019I	INJ GAD CONTRAST PER ML (11CC)	57
1605019J	INJ GAD CONTRAST PER ML (10CC)	51
1605019K	INJ GAD CONTRAST PER ML (9CC)	46
1605019L	INJ GAD CONTRAST PER ML (8CC)	41
1605020A	INJ GAD CONTRAST PER ML (30CC)	155
1605020B	INJ GAD CONTRAST PER ML (45CC)	233
4301037A	MRA-SPINAL CANAL W/CONT	2200
4301038A	MRA-UPPER EXTREMITY W/CONT	2100
4301104A	CONSCIOUS SEDATION ADDT'L 15	38

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 4, 2011

Via Fax & Email Only

Ms. Shraddha Patel
Director of Business Development & Planning
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

RE: Certificate of Need Completeness Letter; Docket Number: 11-31682-CON
Proposal to Acquire and Operate a 3.0 Tesla MRI Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT, at a Total Capital Expenditure of $3,250,210.

Dear Ms. Patel:

On February 4, 2011, the Office of Health Care Access ("OHCA") received the initial Certificate of Need ("CON") submission of Lawrence & Memorial Hospital ("Hospital"), proposing the acquisition and operation of a 3.0 tesla magnetic resonance imaging ("MRI") scanner to be located at the L&M Diagnostic Imaging at Crossroads in Waterford, CT. The total capital expenditure associated with the proposal is $3,250,210.

OHCA has reviewed the CON application pursuant to Section 19a-639a(c) and requests the following additional information as outlined below:

1. The application points out that the proposed MRI scanner is expected to become operational in FY 2012. Financial Attachment I, page 161 of the CON application, indicates that the Hospital's FY 2011 financials will be affected by the proposal. Please explain why Financial Attachment I reflects expenses in FY 2011 when the scanner is scheduled to become operational in FY 2012. If necessary submit a revised Financial Attachment I that shows no financial activity for FY 2011 and expands the table to include the project activity for FY 2014.

2. Identify the street address where the proposed imaging center will be located at the Crossroads in Waterford, CT.

3. When compared to Census 2000 data, it appears that the primary service area population listed in Table E of the CON application is overstated by approximately 7%. Please revise Table E utilizing Census 2000 data as the baseline or provide supporting assumptions for the figures currently presented in Table E.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Begin the pagination with Page 174. Please reference "Docket Number: 11-31682-CON" and submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, including all attachments, on CD using MS Word format and Adobe Acrobat. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7069.

Sincerely,

Jack A. Huber
Health Care Analyst

****
*** TX REPORT ***
****

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

FAX SHEET

TO: MS. SHRADDHA PATEL

FAX: (860) 444-3716

AGENCY: LAWRENCE & MEMORIAL HOSPITAL

FROM: JACK HUBER

DATE: 3/4/2011 **Time:** ~ 1:40 p.m.

NUMBER OF PAGES: 3
(including transmittal sheet)

Comments: Transmitted: CON Completeness Letter
Lawrence & Memorial Hospital
MRJ Scanner in Waterford
Docket Number: 11-31682-CON

PLEASE PHONE Jack A. Huber at (860) 418-7069
IF THERE ARE ANY TRANSMISSION PROBLEMS

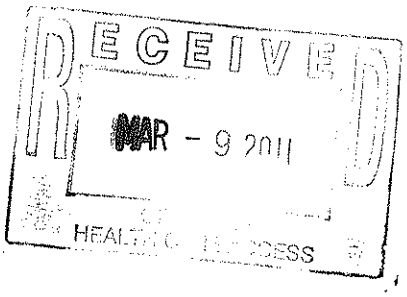
Huber, Jack

From: Huber, Jack
Sent: Friday, March 04, 2011 1:48 PM
To: 'spatel@lmhosp.org'
Subject: Completeness Letter for DN: 11-31682-CON
Attachments: 11-31682-CON_LM_COMP_LETTER1.doc

Dear Ms. Patel – Please find attached an electronic version of the completeness letter regarding the Hospital's proposal to add a third MRI scanner to be located in Waterford, CT. A faxed version of the letter is also being transmitted to you. Should you have any questions concerning the letter, please feel free to contact me by email or at 860-418-7069. Thank you. Regards, Jack

Jack A. Huber
OHCA Health Care Analyst

LAWRENCE & MEMORIAL HOSPITAL



March 8, 2011

Jack A. Huber
Health Care Analyst
State of Connecticut
Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Completeness Letter; Docket Number: 11-31682-CON
Proposal to Acquire and Operate a 3.0 Tesla MRI Scanner at L&M Diagnostic Imaging at Crossroads in Waterford, CT, at a Total Capital Expenditure of $3,250,210.

Dear Mr. Huber:

Enclosed are the original and six copies of the Responses to the OHCA Completeness Letter dated March 4, 2011 for Docket Number: 11-31682-CON.

Please do not hesitate to contact me at (860) 442-0711, extension 2073, if you have any questions.

Sincerely,

Crista Durand, Vice President
Strategic Planning, Marketing and Business Development

Responses to OHCA Completeness Letter Dated March 4, 2010
for Docket Number: 11-31682-CON

1. The application points out that the proposed MRI scanner is expected to become operational in FY 2012. Financial Attachment I, page 161 of the CON application, indicates that the Hospital's FY 2011 financials will be affected by the proposal. Please explain why Financial Attachment I reflects expenses in FY 2011 when the scanner is scheduled to become operational in FY 2012. If necessary submit a revised Financial Attachment I that shows no financial activity for FY 2011 and expands the table to include the project activity for FY 2014.

Response:
Revised Financial Attachments I and II are enclosed in Exhibit A of this Response Document. The proposed scanner will become operational in FY 2012. Financial Attachments I and II include financials for FY 2012 through FY 2015. Revised financial assumptions utilized in developing both Financial Attachments I and II are also included in Exhibit B of this Response Document.

2. Identify the street address where the proposed imaging center will be located at the Crossroads in Waterford, CT.

Response:
The proposed 3.0 Tesla MRI will be located at 196 Parkway South, Suite 102, Waterford, CT 06385.

3. When compared to Census 2000 data, it appears that the primary service area population listed in Table E of the CON application is overstated by approximately 7%. Please revise Table E utilizing Census 2000 data as the baseline or provide supporting assumptions for the figures currently presented in Table E.

Response:
Lawrence & Memorial Hospital's (L&M Hospital) primary service area (PSA), as shown in Table E of the original CON application, is comprised of the following towns in Connecticut: East Lyme, Groton, Ledyard, Montville, New London, Stonington, Old Lyme, Lyme, Stonington, and Waterford (refer to Exhibit C of this Response Document for a map of towns in Connecticut from OHCA's website http://www.ct.gov/ohca/lib/ohca/hospitalstudy/cthospitallocationbytown.pdf).

Towns in Connecticut, including those in L&M Hospital's PSA, are comprised of several zip codes. Zip codes often have their own zip code name or city name. The towns in L&M Hospital's PSA are comprised of 17 zip codes as shown below:

Town of East Lyme is comprised of zip codes 06333 and 06357
Town of Groton is comprised of zip codes 06340, 06349 (P.O. Box), and 06355

Town of Ledyard is comprised of zip codes 06335 and 06339
Town of Montville is comprised of zip codes 06353 (P.O. Box), 06370, and 06382
Town of Lyme and Old Lyme is comprised of zip code 06371
Town of New London is comprised of zip code 06320
Town of Stonington is comprised of zip code 06359
Town of Stonington is comprised of zip codes 06379 and 06378
Town of Waterford is comprised of zip codes 06375 and 06385

According to data from the U.S. Census Bureau, the zip codes in the PSA had a population of 168,345 in 2000 as shown in Table 1 below (the zip codes that are P.O. Boxes do not have any population per the U.S. Census Bureau). Refer to Exhibit D of this Response Document for year 2000 population data by zip code from the U.S. Census Bureau's website supporting the data in Table 1.

Table 1: Population by Zip Code and Town, U.S. Census Bureau Data vs. Claritas Data for Year 2000

Zip Code	Zip Code or City Name	Town Name	U.S. Census Bureau Data for Year 2000	Claritas Data for Year 2000
06333	East Lyme	East Lyme	5,966	7,101
06357	Niantic	East Lyme	12,152	11,006
06340	Groton	Groton	31,679	31,655
06349	Groton	Groton	-	1
06355	Mystic	Groton	12,090	12,085
06335	Gales Ferry	Ledyard	6,799	6,536
06339	Ledyard	Ledyard	7,911	8,107
06371	Lyme/Old Lyme	Lyme/Old Lyme	9,354	9,422
06353	Montville	Montville	-	84
06370	Oakdale	Montville	6,544	6,689
06382	Uncasville	Montville	12,001	11,541
06320	New London	New London	25,671	25,687
06359	North Stonington	North Stonington	4,981	4,993
06379	Pawcatuck	Stonington	8,696	8,617
06378	Stonington	Stonington	5,348	5,501
06375	Quaker Hill	Waterford	3,342	4,317
06385	Waterford	Waterford	15,811	14,820
TOTAL			**168,345**	**168,162**

Source data provided by U.S. Census Bureau and Claritas.

Table E in the original CON application included data from Claritas, an online source for U.S. demographics (Claritas data purchased from and supplied by M Rosadini Consultants LLC in March 2010). According to data from Claritas listed in Table 1, the population of the zip codes in the PSA had a population of 168,162 in 2000 (the zip codes that are P.O. Boxes do have population per Claritas). Refer to Exhibit E of this Response Document for year 2000 population data by zip code from Claritas obtained from M Rosadini Consultants LLC supporting the data in Table 1.

Aggregating the data by Town Name, the population statistics obtained from the U.S. Census Bureau are very similar to those obtained from Claritas as shown in Table 2. In fact, data for the PSA from the U.S. Census Bureau exceeds the data from Claritas by 183 people as shown in both Tables 1 and 2 (168,345 – 168,162 = 183).

Table 2: Population by Town, U.S. Census Bureau Data vs. Claritas Data for Year 2000

Town Name	U.S. Census Bureau Data for Year 2000	Claritas Data for Year 2000
East Lyme	18,118	18,107
Groton	43,769	43,741
Ledyard	14,710	14,643
Montville	18,545	18,314
Lyme/Old Lyme	9,354	9,422
New London	25,671	25,687
North Stonington	4,981	4,993
Stonington	14,044	14,118
Waterford	19,153	19,137
TOTAL	**168,345**	**168,162**

Source data provided by U.S. Census Bureau and Claritas.

The Claritas data from Table 2 matches year 2000 data reported in Table E from the CON application. Claritas data was utilized in the CON application (Docket Number: 11-31682-CON) and in Table E of the application because Claritas provides current (year 2009) and five year population projections (year 2014) needed for the CON application analyses.

Docket Number: 11-31682-CON

Exhibit A

Revised Financial Attachments I and II

Docket Number: 11-31682-CON

Revised Financial Attachment I

Lawrence & Memorial Hospital

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

Total Facility: Description	FY 2010 Actual Results	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE										
Non-Government	$165,372,627	$165,372,627	$0	$165,372,627	$165,372,627	$275,123	$165,647,750	$165,372,627	$487,213	$165,859,840
Medicare	$97,994,557	$97,994,557	$0	$97,994,557	$97,994,557	$200,227	$98,194,784	$97,994,557	$354,581	$98,349,138
Medicaid and Other Medical Assistance	$30,160,421	$30,160,421	$0	$30,160,421	$30,160,421	$12,780	$30,173,201	$30,160,421	$22,632	$30,183,053
Other Government	$13,035,372	$13,035,372	$0	$13,035,372	$13,035,372	$84,420	$13,119,792	$13,035,372	$149,499	$13,184,871
Total Net Patient Patient Revenue	$306,562,977	$306,562,977	$0	$306,562,977	$306,562,977	$572,550	$307,135,527	$306,562,977	$1,013,925	$307,576,902
Other Operating Revenue	$14,292,897	$14,292,897		$14,292,897	$14,292,897		$14,292,897	$14,292,897		$14,292,897
Revenue from Operations	$320,855,874	$320,855,874	$0	$320,855,874	$320,855,874	$572,550	$321,428,424	$320,855,874	$1,013,925	$321,869,799
OPERATING EXPENSES										
Salaries and Fringe Benefits	$174,502,282	$174,502,282		$174,502,282	$174,502,282	$80,047	$174,582,329	$174,502,282	$160,092	$174,662,374
Professional / Contracted Services	$20,028,640	$20,028,640		$20,028,640	$20,028,640		$20,028,640	$20,028,640	$137,866	$20,166,506
Supplies and Drugs	$33,399,993	$33,399,993	$0	$33,399,993	$33,399,993	$11,638	$33,411,631	$33,399,993	$20,610	$33,420,603
Bad Debts	$14,381,176	$14,381,176		$14,381,176	$14,381,176		$14,381,176	$14,381,176		$14,381,176
Other Operating Expense	$35,065,186	$35,065,186	$0	$35,065,186	$35,065,186	$22,400	$35,087,586	$35,065,186	$85,360	$35,150,546
Subtotal	$277,377,277	$277,377,277	$0	$277,377,277	$277,377,277	$114,085	$277,491,362	$277,377,277	$403,928	$277,781,205
Depreciation/Amortization	$16,728,407	$16,728,407		$16,728,407	$16,728,407	$285,021	$17,013,428	$16,728,407	$570,042	$17,298,449
Interest Expense	$2,332,245	$2,332,245		$2,332,245	$2,332,245		$2,332,245	$2,332,245		$2,332,245
Lease Expense	$2,798,067	$2,798,067		$2,798,067	$2,798,067		$2,798,067	$2,798,067		$2,798,067
Total Operating Expense	$299,235,996	$299,235,996	$0	$299,235,996	$299,235,996	$399,106	$299,635,102	$299,235,996	$973,970	$300,209,966
Gain/(Loss) from Operations	$21,619,878	$21,619,878	$0	$21,619,878	$21,619,878	$173,444	$21,793,322	$21,619,878	$39,955	$21,659,833
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$21,619,878	$21,619,878	$0	$21,619,878	$21,619,878	$173,444	$21,793,322	$21,619,878	$39,955	$21,659,833
FTEs	1892.85	1892.85	0	1892.85	1892.85	0.9	1893.75	1892.85	1.7	1894.55
*Volume Statistics:	11,101	11,101	0	11,101	11,101	694	11,795	11,101	1,229	12,330

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.

11. C (i). Please provide one ye
without, incremental

Total Facility: Description	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE						
Non-Government	$165,372,627	$710,007	$166,082,634	$165,372,627	$947,469	$166,320,096
Medicare	$97,994,557	$516,725	$98,511,282	$97,994,557	$689,544	$98,684,101
Medicaid and Other Medical Assistance	$30,160,421	$32,981	$30,193,402	$30,160,421	$44,012	$30,204,433
Other Government	$13,035,372	$217,862	$13,253,234	$13,035,372	$290,726	$13,326,098
Total Net Patient Patient Revenue	$306,562,977	$1,477,575	$308,040,552	$306,562,977	$1,971,751	$308,534,728
Other Operating Revenue	$14,292,897		$14,292,897	$14,292,897		$14,292,897
Revenue from Operations	$320,855,874	$1,477,575	$322,333,449	$320,855,874	$1,971,751	$322,827,625
OPERATING EXPENSES						
Salaries and Fringe Benefits	$174,502,282	$234,064	$174,736,346	$174,502,282	$308,035	$174,810,317
Professional / Contracted Services	$20,028,640	$137,866	$20,166,506	$20,028,640	$137,866	$20,166,506
Supplies and Drugs	$33,399,993	$30,035	$33,430,028	$33,399,993	$40,080	$33,440,073
Bad Debts	$14,381,176		$14,381,176	$14,381,176		$14,381,176
Other Operating Expense	$35,065,186	$105,661	$35,170,847	$35,065,186	$126,148	$35,191,334
Subtotal	$277,377,277	$507,626	$277,884,903	$277,377,277	$612,129	$277,989,406
Depreciation/Amortization	$16,728,407	$570,042	$17,298,449	$16,728,407	$570,042	$17,298,449
Interest Expense	$2,332,245		$2,332,245	$2,332,245		$2,332,245
Lease Expense	$2,798,067		$2,798,067	$2,798,067		$2,798,067
Total Operating Expense	$299,235,996	$1,077,668	$300,313,664	$299,235,996	$1,182,171	$300,418,167
Gain/(Loss) from Operations	$21,619,878	$399,907	$22,019,785	$21,619,878	$789,580	$22,409,458
Plus: Non-Operating Revenue			$0			$0
Revenue Over/(Under) Expense	$21,619,878	$399,907	$22,019,785	$21,619,878	$789,580	$22,409,458
FTEs	1892.85	2.5	1895.35	1892.85	3.2	1896.05
*Volume Statistics: Provide projected inpatient and/or outpatie	11,101	1,791	12,892	11,101	2,390	13,491

Docket Number: 11-31682-CON

Revised Financial Attachment II

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2012	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**694**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$399,106**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	178	$394,947	$194,720			$200,227	$102,171	$98,056
Medicaid		$2,223	88	$195,931	$183,151			$12,780	$50,686	($37,906)
CHAMPUS/TriCare		$2,223	67	$148,105	$63,685			$84,420	$38,314	$46,106
Total Governmental			332	$738,983	$441,556	$0	$0	$297,427	$191,172	$106,256
Commericial Insurers		$2,223	357	$792,980	$517,755		$102	$275,122	$205,140	$69,982
Uninsured		$2,223	5	$10,799		$10,799		$0	$2,794	($2,794)
Total NonGovernment		$2,223	362	$803,779	$517,755	$10,799	$102	$275,122	$207,934	$67,188
Total All Payers		$2,223	694	$1,542,762	$959,311	$10,799	$102	$572,550	$399,106	$173,444

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2013	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**1229**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$973,971**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	315	$699,409	$344,828			$354,581	$249,337	$105,245
Medicaid		$2,223	156	$346,973	$324,340			$22,632	$123,694	($101,062)
CHAMPUS/TriCare		$2,223	118	$262,278	$112,780			$149,499	$93,501	$55,997
Total Governmental			589	$1,308,660	$781,948	$0	$0	$526,712	$466,532	$60,180
Commericial Insurers		$2,223	632	$1,404,282	$916,889		$180	$487,213	$500,621	($13,408)
Uninsured		$2,223	9	$19,124		$19,124		$0	$6,818	($6,818)
Total NonGovernment		$2,223	640	$1,423,407	$916,889	$19,124	$180	$487,213	$507,439	($20,225)
Total All Payers		$2,223	1,229	$2,732,067	$1,698,837	$19,124	$180	$1,013,925	$973,971	$39,954

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**1791**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$1,077,667**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	458	$1,019,237	$502,512			$516,725	$275,883	$240,842
Medicaid		$2,223	227	$505,637	$472,656			$32,981	$136,864	($103,882)
CHAMPUS/TriCare		$2,223	172	$382,214	$164,352			$217,862	$103,456	$114,406
Total Governmental			858	$1,907,087	$1,139,519	$0	$0	$767,568	$516,202	$251,366
Commericial Insurers		$2,223	921	$2,046,436	$1,336,166		$263	$710,007	$553,921	$156,086
Uninsured		$2,223	13	$27,870		$27,870		$0	$7,544	($7,544)
Total NonGovernment		$2,223	933	$2,074,306	$1,336,166	$27,870	$263	$710,007	$561,465	$148,543
Total All Payers		$2,223	1,791	$3,981,393	$2,475,685	$27,870	$263	$1,477,575	$1,077,667	$399,908

	Lawrence & Memorial Hospital									
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	MRI									
Type of Unit Description:	Scans									
# of Months in Operation	12									
FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental	**2390**	Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$1,182,170**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare		$2,223	612	$1,360,120	$670,577			$689,544	$302,636	$386,908
Medicaid		$2,223	304	$674,747	$630,735			$44,012	$150,136	($106,124)
CHAMPUS/TriCare		$2,223	229	$510,045	$219,319			$290,726	$113,488	$177,237
Total Governmental			1,145	$2,544,913	$1,520,631	$0	$0	$1,024,281	$566,259	$458,022
Commericial Insurers		$2,223	1,228	$2,730,867	$1,783,047		$351	$947,469	$607,635	$339,833
Uninsured		$2,223	17	$37,191		$37,191		$0	$8,275	($8,275)
Total NonGovernment		$2,223	1,245	$2,768,057	$1,783,047	$37,191	$351	$947,469	$615,911	$331,558
Total All Payers		$2,223	2,390	$5,312,970	$3,303,679	$37,191	$351	$1,971,750	$1,182,170	$789,580

Docket Number: 11-31682-CON

Exhibit B

Revised Financial Assumptions

Lawrence & Memorial Hospital
Project: MRI
Forecasted Profit and Loss Statement

	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR		Rate Per	
	2012	**2013**	**2014**	**2015**		Procedure	
VOLUME							
MRI Scans	**694**	**1,229**	**1,791**	**2,390**		$825.00	
	694	**1,229**	**1,791**	**2,390**			
REVENUES							
MRI	$572,550	$1,013,925	$1,477,575	$1,971,750			
Net Revenues	$572,550	$1,013,925	$1,477,575	$1,971,750			
OPERATING EXPENSES							
Direct Expenses							
Salaries & Wages	63,029	126,057	184,302	242,547			
Nonsalary	11,638	158,476	167,901	177,946			
Total Direct Expenses	74,667	284,534	352,203	420,493			
Depreciation	285,021	570,042	570,042	570,042			
Indirect Expenses							
Fringe Benefits	17,018	34,035	49,762	65,488		27.00%	percent of total salaries Historical Average
Other indirect	22,400	85,360	105,661	126,148		30.00%	percent of total expenses Historical Average
Total Indirect Expense	39,418	119,396	155,422	191,635			
Total Operating							
Expenses	399,106	973,971	1,077,667	1,182,170			
OPERATING INCOME(LOSS)	173,444	39,954	399,908	789,580			
CUMULATIVE							
INCOME(LOSS)	648,135	688,089	1,087,996	1,877,576			

												relief	
Salary Detail:							FTE's	FTE's	FTE's	FTE's	FTE's		W/Diff.
MRI/CT Technician	46,285	92,569	138,854	185,139	80,495	per FTE	0	0.5	1	1.5	2	Y*	
Clerical	16,744	33,488	45,448	57,408	41,600	per FTE	0.00	0.35	0.70	0.95	1.20	Y*	
							---	---	---	---	---		
							0.0	0.9	1.7	2.5	3.2		
						Includes	15.00%	15.00%	15.00%	15.00%	15.00%	relief	
	63,029	126,057	184,302	242,547									
Non Salary Detail:													
Contrast Costs	8,252	14,613	21,295	28,417	11.89	per scan							
Med./Surg Supplies	2,013	3,564	5,194	6,931	2.90	per scan							
Printed Forms/Supplies	937	1,659	2,418	3,227	1.35	per scan							
Film	437	774	1,128	1,506	0.63	per scan							
Repairs Outside Equipment	0	137,866	137,866	137,866									
* Denotes Start\Up Costs	---	---	---	---									
	11,638	158,476	167,901	177,946									
Depreciation:						Years of Service							
Building renovations	20,000	40,000	40,000	40,000	600,000	15							
Movable Equipment	265,021	530,042	530,042	530,042	2,650,210	5							
Total	285,021	570,042	570,042	570,042	3,250,210								

Lawrence & Memorial Hospital
Project: MRI
Forecasted Profit and Loss Statement

	1st YEAR	2nd YEAR	3rd YEAR	4th YEAR	5th YEAR	Purchase								
	2011	**2012**	**2013**	**2014**	**2015**	**Price**								
Depreciation:							Years of Service							
Building renovations		20,000	40,000	40,000	40,000	600,000	15							
Movable Equipment		265,021	530,042	530,042	530,042	2,650,210	5							
Total	-	285,021	570,042	570,042	570,042	3,250,210								

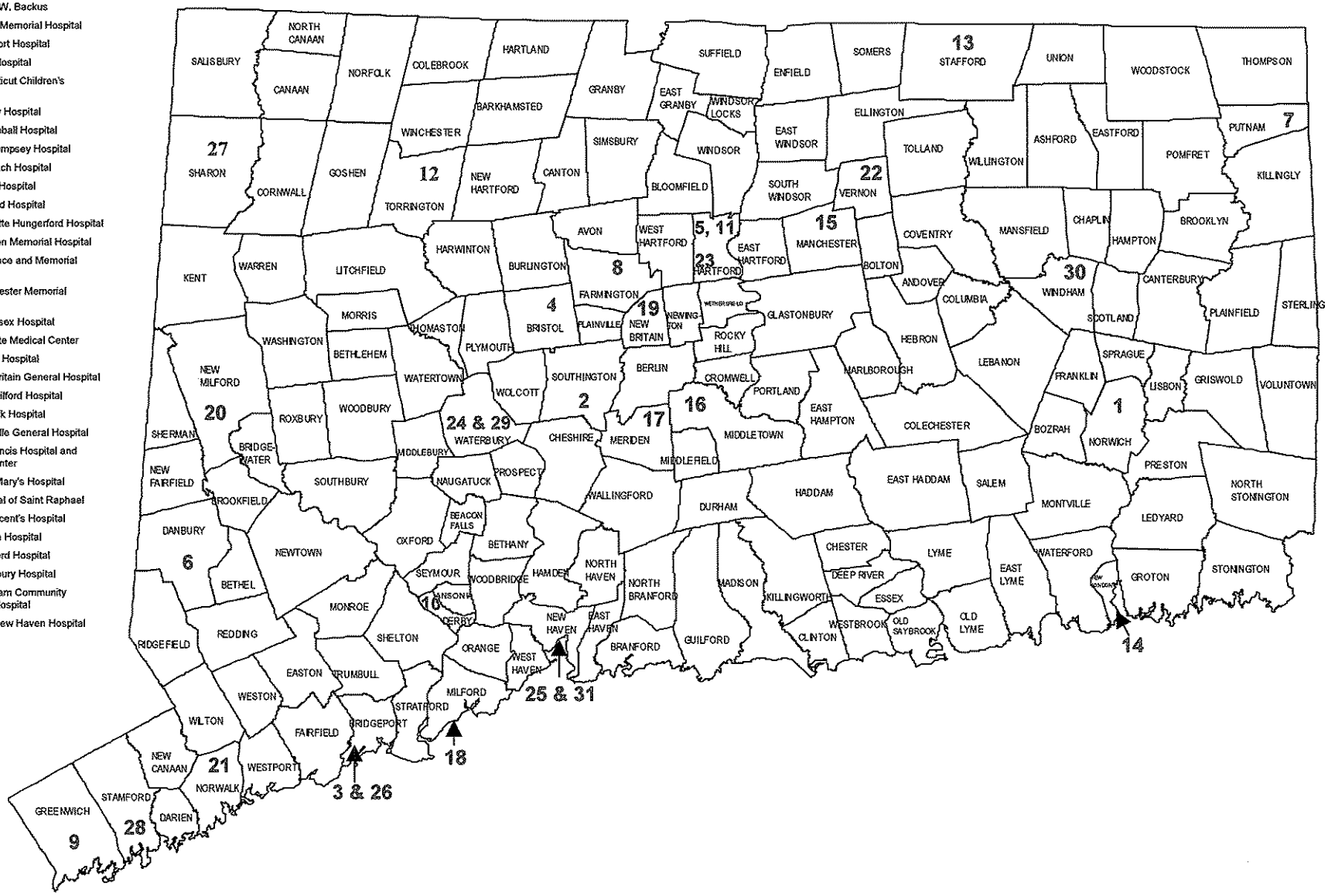
Docket Number: 11-31682-CON

Exhibit C

Map of Connecticut Towns

Connecticut Acute Care Hospitals & Medical Centers

1 - William W. Backus
2 - Bradley Memorial Hospital
3 - Bridgeport Hospital
4 - Bristol Hospital
5 - Connecticut Children's Hospital
6 - Danbury Hospital
7 - Day Kimball Hospital
8 - John Dempsey Hospital
9 - Greenwich Hospital
10 - Griffin Hospital
11 - Hartford Hospital
12 - Charlotte Hungerford Hospital
13 - Johnson Memorial Hospital
14 - Lawrence and Memorial Hospital
15 - Manchester Memorial Hospital
16 - Middlesex Hospital
17 - Midstate Medical Center
18 - Milford Hospital
19 - New Britain General Hospital
20 - New Milford Hospital
21 - Norwalk Hospital
22 - Rockville General Hospital
23 - St. Francis Hospital and Medical Center
24 - Saint Mary's Hospital
25 - Hospital of Saint Raphael
26 - St. Vincent's Hospital
27 - Sharon Hospital
28 - Stamford Hospital
29 - Waterbury Hospital
30 - Windham Community Memorial Hospital
31 - Yale-New Haven Hospital



Docket Number: 11-31682-CON

Exhibit D

U.S. Census Bureau Population Statistics for Year 2000 by Zip Code

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06333

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	5,966			map	brief
Male	2,973	49.8	49.1%	map	brief
Female	2,993	50.2	50.9%	map	brief
Median age (years)	39.1	(X)	35.3	map	brief
Under 5 years	369	6.2	6.8%	map	
18 years and over	4,160	69.7	74.3%		
65 years and over	549	9.2	12.4%	map	brief
One race	5,885	98.6	97.6%		
White	5,425	90.9	75.1%	map	brief
Black or African American	60	1.0	12.3%	map	brief
American Indian and Alaska Native	21	0.4	0.9%	map	brief
Asian	353	5.9	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	0	0.0	0.1%	map	brief
Some other race	26	0.4	5.5%	map	
Two or more races	81	1.4	2.4%	map	brief
Hispanic or Latino (of any race)	105	1.8	12.5%	map	brief
Household population	5,966	100.0	97.2%	map	brief
Group quarters population	0	0.0	2.8%	map	
Average household size	2.88	(X)	2.59	map	brief
Average family size	3.17	(X)	3.14	map	
Total housing units	2,122			map	
Occupied housing units	2,069	97.5	91.0%		brief
Owner-occupied housing units	1,838	88.8	66.2%	map	
Renter-occupied housing units	231	11.2	33.8%	map	brief
Vacant housing units	53	2.5	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	3,937				
High school graduate or higher	3,696	93.9	80.4%	map	brief
Bachelor's degree or higher	1,891	48.0	24.4%	map	
Civilian veterans (civilian population 18 years and over)	837	20.3	12.7%	map	brief
Disability status (population 5 years and over)	617	11.1	19.3%	map	brief
Foreign born	402	6.7	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,513	68.6	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,565	69.5	52.1%		brief
Speak a language other than English at home (population 5 years and over)	402	7.2	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	3,104	71.7	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	24.5	(X)	25.5	map	brief
Median household income in 1999 (dollars)	83,462	(X)	41,994	map	
Median family income in 1999 (dollars)	91,438	(X)	50,046	map	
Per capita income in 1999 (dollars)	34,256	(X)	21,587	map	
Families below poverty level	16	0.9	9.2%	map	brief
Individuals below poverty level	110	1.8	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	1,662				brief
Median value (dollars)	195,500	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,487	(X)	1,088	map	
Not mortgaged (dollars)	475	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

The letters PDF or symbol indicate a document is in the Portable Document Format (PDF). To view the file you will need the Adobe® Acrobat® Reader, which is available for **free** from the Adobe web site.

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06357

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	12,152			map	brief
Male	5,743	47.3	49.1%	map	brief
Female	6,409	52.7	50.9%	map	brief
Median age (years)	39.0	(X)	35.3	map	brief
Under 5 years	518	4.3	6.8%	map	
18 years and over	9,989	82.2	74.3%		
65 years and over	1,735	14.3	12.4%	map	brief
One race	11,902	97.9	97.6%		
White	10,390	85.5	75.1%	map	brief
Black or African American	1,094	9.0	12.3%	map	brief
American Indian and Alaska Native	58	0.5	0.9%	map	brief
Asian	158	1.3	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	8	0.1	0.1%	map	brief
Some other race	194	1.6	5.5%	map	
Two or more races	250	2.1	2.4%	map	brief
Hispanic or Latino (of any race)	727	6.0	12.5%	map	brief
Household population	9,811	80.7	97.2%	map	brief
Group quarters population	2,341	19.3	2.8%	map	
Average household size	2.31	(X)	2.59	map	brief
Average family size	2.83	(X)	3.14	map	
Total housing units	5,337			map	
Occupied housing units	4,239	79.4	91.0%		brief
Owner-occupied housing units	3,116	73.5	66.2%	map	
Renter-occupied housing units	1,123	26.5	33.8%	map	brief
Vacant housing units	1,098	20.6	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	9,054				
High school graduate or higher	7,935	87.6	80.4%	map	brief
Bachelor's degree or higher	2,714	30.0	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,527	15.4	12.7%	map	brief
Disability status (population 5 years and over)	1,426	15.5	19.3%	map	brief
Foreign born	558	4.6	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	2,914	60.3	56.7%		brief
Female, Now married, except separated (population 15 years and over)	2,888	52.7	52.1%		brief
Speak a language other than English at home (population 5 years and over)	1,466	12.7	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	5,459	53.6	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	24.6	(X)	25.5	map	brief
Median household income in 1999 (dollars)	60,575	(X)	41,994	map	
Median family income in 1999 (dollars)	66,925	(X)	50,046	map	
Per capita income in 1999 (dollars)	26,063	(X)	21,587	map	
Families below poverty level	61	2.2	9.2%	map	brief
Individuals below poverty level	341	3.5	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,805				brief
Median value (dollars)	151,700	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,236	(X)	1,088	map	
Not mortgaged (dollars)	426	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06340

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	31,679			map	brief
Male	16,393	51.7	49.1%	map	brief
Female	15,286	48.3	50.9%	map	brief
Median age (years)	30.5	(X)	35.3	map	brief
Under 5 years	2,771	8.7	6.8%	map	
18 years and over	23,684	74.8	74.3%		
65 years and over	3,727	11.8	12.4%	map	brief
One race	30,464	96.2	97.6%		
White	25,723	81.2	75.1%	map	brief
Black or African American	2,632	8.3	12.3%	map	brief
American Indian and Alaska Native	282	0.9	0.9%	map	brief
Asian	1,130	3.6	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	61	0.2	0.1%	map	brief
Some other race	636	2.0	5.5%	map	
Two or more races	1,215	3.8	2.4%	map	brief
Hispanic or Latino (of any race)	1,866	5.9	12.5%	map	brief
Household population	29,189	92.1	97.2%	map	brief
Group quarters population	2,490	7.9	2.8%	map	
Average household size	2.39	(X)	2.59	map	brief
Average family size	3.00	(X)	3.14	map	
Total housing units	13,379			map	
Occupied housing units	12,203	91.2	91.0%		brief
Owner-occupied housing units	5,169	42.4	66.2%	map	
Renter-occupied housing units	7,034	57.6	33.8%	map	brief
Vacant housing units	1,176	8.8	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	19,562				
High school graduate or higher	16,908	86.4	80.4%	map	brief
Bachelor's degree or higher	4,134	21.1	24.4%	map	
Civilian veterans (civilian population 18 years and over)	3,651	18.8	12.7%	map	brief
Disability status (population 5 years and over)	4,800	19.9	19.3%	map	brief
Foreign born	1,846	5.8	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	6,676	52.2	56.7%		brief
Female, Now married, except separated (population 15 years and over)	6,345	53.7	52.1%		brief
Speak a language other than English at home (population 5 years and over)	2,810	9.7	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	17,417	71.5	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	16.7	(X)	25.5	map	brief
Median household income in 1999 (dollars)	41,666	(X)	41,994	map	
Median family income in 1999 (dollars)	46,256	(X)	50,046	map	
Per capita income in 1999 (dollars)	22,002	(X)	21,587	map	
Families below poverty level	449	5.8	9.2%	map	brief
Individuals below poverty level	2,019	6.9	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	3,949				brief
Median value (dollars)	130,300	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,146	(X)	1,088	map	
Not mortgaged (dollars)	390	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06355

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	12,090			map	brief
Male	5,856	48.4	49.1%	map	brief
Female	6,234	51.6	50.9%	map	brief
Median age (years)	41.7	(X)	35.3	map	brief
Under 5 years	618	5.1	6.8%	map	
18 years and over	9,507	78.6	74.3%		
65 years and over	1,958	16.2	12.4%	map	brief
One race	11,878	98.2	97.6%		
White	11,347	93.9	75.1%	map	brief
Black or African American	164	1.4	12.3%	map	brief
American Indian and Alaska Native	60	0.5	0.9%	map	brief
Asian	255	2.1	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	5	0.0	0.1%	map	brief
Some other race	47	0.4	5.5%	map	
Two or more races	212	1.8	2.4%	map	brief
Hispanic or Latino (of any race)	188	1.6	12.5%	map	brief
Household population	11,746	97.2	97.2%	map	brief
Group quarters population	344	2.8	2.8%	map	
Average household size	2.38	(X)	2.59	map	brief
Average family size	2.89	(X)	3.14	map	
Total housing units	5,318			map	
Occupied housing units	4,938	92.9	91.0%		brief
Owner-occupied housing units	3,883	78.6	66.2%	map	
Renter-occupied housing units	1,055	21.4	33.8%	map	brief
Vacant housing units	380	7.1	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	8,885				
High school graduate or higher	8,246	92.8	80.4%	map	brief
Bachelor's degree or higher	3,766	42.4	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,592	17.0	12.7%	map	brief
Disability status (population 5 years and over)	1,592	14.4	19.3%	map	brief
Foreign born	560	4.7	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	3,030	64.6	56.7%		brief
Female, Now married, except separated (population 15 years and over)	3,006	58.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	662	5.8	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	6,564	67.4	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	19.6	(X)	25.5	map	brief
Median household income in 1999 (dollars)	65,645	(X)	41,994	map	
Median family income in 1999 (dollars)	73,683	(X)	50,046	map	
Per capita income in 1999 (dollars)	33,057	(X)	21,587	map	
Families below poverty level	58	1.7	9.2%	map	brief
Individuals below poverty level	334	2.8	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	3,456				brief
Median value (dollars)	165,700	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,397	(X)	1,088	map	
Not mortgaged (dollars)	433	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

FACT SHEET

Zip Code Tabulation Area 06335

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	6,799			map	brief
Male	3,338	49.1	49.1%	map	brief
Female	3,461	50.9	50.9%	map	brief
Median age (years)	38.1	(X)	35.3	map	brief
Under 5 years	365	5.4	6.8%	map	
18 years and over	4,888	71.9	74.3%		
65 years and over	659	9.7	12.4%	map	brief
One race	6,651	97.8	97.6%		
White	6,266	92.2	75.1%	map	brief
Black or African American	132	1.9	12.3%	map	brief
American Indian and Alaska Native	55	0.8	0.9%	map	brief
Asian	153	2.3	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	5	0.1	0.1%	map	brief
Some other race	40	0.6	5.5%	map	
Two or more races	148	2.2	2.4%	map	brief
Hispanic or Latino (of any race)	165	2.4	12.5%	map	brief
Household population	6,794	99.9	97.2%	map	brief
Group quarters population	5	0.1	2.8%	map	
Average household size	2.73	(X)	2.59	map	brief
Average family size	3.10	(X)	3.14	map	
Total housing units	2,577			map	
Occupied housing units	2,490	96.6	91.0%		brief
Owner-occupied housing units	2,061	82.8	66.2%	map	
Renter-occupied housing units	429	17.2	33.8%	map	brief
Vacant housing units	87	3.4	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	4,520				
High school graduate or higher	4,284	94.8	80.4%	map	brief
Bachelor's degree or higher	1,725	38.2	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,133	24.1	12.7%	map	brief
Disability status (population 5 years and over)	775	12.3	19.3%	map	brief
Foreign born	269	3.9	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,672	64.3	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,715	63.4	52.1%		brief
Speak a language other than English at home (population 5 years and over)	297	4.6	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	3,747	72.4	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	19.9	(X)	25.5	map	brief
Median household income in 1999 (dollars)	65,050	(X)	41,994	map	
Median family income in 1999 (dollars)	71,509	(X)	50,046	map	
Per capita income in 1999 (dollars)	25,147	(X)	21,587	map	
Families below poverty level	71	3.6	9.2%	map	brief
Individuals below poverty level	257	3.8	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	1,835				brief
Median value (dollars)	148,000	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,340	(X)	1,088	map	
Not mortgaged (dollars)	438	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

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U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06339

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	7,911			map	brief
Male	3,920	49.6	49.1%	map	brief
Female	3,991	50.4	50.9%	map	brief
Median age (years)	36.1	(X)	35.3	map	brief
Under 5 years	553	7.0	6.8%	map	
18 years and over	5,662	71.6	74.3%		
65 years and over	664	8.4	12.4%	map	brief
One race	7,668	96.9	97.6%		
White	6,716	84.9	75.1%	map	brief
Black or African American	235	3.0	12.3%	map	brief
American Indian and Alaska Native	460	5.8	0.9%	map	brief
Asian	168	2.1	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	5	0.1	0.1%	map	brief
Some other race	84	1.1	5.5%	map	
Two or more races	243	3.1	2.4%	map	brief
Hispanic or Latino (of any race)	236	3.0	12.5%	map	brief
Household population	7,906	99.9	97.2%	map	brief
Group quarters population	5	0.1	2.8%	map	
Average household size	2.82	(X)	2.59	map	brief
Average family size	3.14	(X)	3.14	map	
Total housing units	2,920			map	
Occupied housing units	2,804	96.0	91.0%		brief
Owner-occupied housing units	2,300	82.0	66.2%	map	
Renter-occupied housing units	504	18.0	33.8%	map	brief
Vacant housing units	116	4.0	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	5,003				
High school graduate or higher	4,613	92.2	80.4%	map	brief
Bachelor's degree or higher	1,409	28.2	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,114	20.3	12.7%	map	brief
Disability status (population 5 years and over)	1,156	16.1	19.3%	map	brief
Foreign born	382	4.9	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,816	61.3	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,886	61.7	52.1%		brief
Speak a language other than English at home (population 5 years and over)	561	7.7	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	4,115	69.8	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	22.1	(X)	25.5	map	brief
Median household income in 1999 (dollars)	61,019	(X)	41,994	map	
Median family income in 1999 (dollars)	66,393	(X)	50,046	map	
Per capita income in 1999 (dollars)	24,827	(X)	21,587	map	
Families below poverty level	50	2.3	9.2%	map	brief
Individuals below poverty level	334	4.3	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,073				brief
Median value (dollars)	138,600	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,240	(X)	1,088	map	
Not mortgaged (dollars)	388	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06371

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	9,354			map	brief
Male	4,622	49.4	49.1%	map	brief
Female	4,732	50.6	50.9%	map	brief
Median age (years)	43.7	(X)	35.3	map	brief
Under 5 years	526	5.6	6.8%	map	
18 years and over	7,178	76.7	74.3%		
65 years and over	1,626	17.4	12.4%	map	brief
One race	9,300	99.4	97.6%		
White	9,119	97.5	75.1%	map	brief
Black or African American	20	0.2	12.3%	map	brief
American Indian and Alaska Native	22	0.2	0.9%	map	brief
Asian	113	1.2	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	1	0.0	0.1%	map	brief
Some other race	25	0.3	5.5%	map	
Two or more races	54	0.6	2.4%	map	brief
Hispanic or Latino (of any race)	93	1.0	12.5%	map	brief
Household population	9,338	99.8	97.2%	map	brief
Group quarters population	16	0.2	2.8%	map	
Average household size	2.47	(X)	2.59	map	brief
Average family size	2.89	(X)	3.14	map	
Total housing units	5,277			map	
Occupied housing units	3,785	71.7	91.0%		brief
Owner-occupied housing units	3,201	84.6	66.2%	map	
Renter-occupied housing units	584	15.4	33.8%	map	brief
Vacant housing units	1,492	28.3	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	6,920				
High school graduate or higher	6,485	93.7	80.4%	map	brief
Bachelor's degree or higher	3,289	47.5	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,359	18.9	12.7%	map	brief
Disability status (population 5 years and over)	1,177	13.3	19.3%	map	brief
Foreign born	365	3.9	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	2,541	68.3	56.7%		brief
Female, Now married, except separated (population 15 years and over)	2,518	65.8	52.1%		brief
Speak a language other than English at home (population 5 years and over)	526	5.9	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	4,800	64.7	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	25.4	(X)	25.5	map	brief
Median household income in 1999 (dollars)	69,957	(X)	41,994	map	
Median family income in 1999 (dollars)	78,204	(X)	50,046	map	
Per capita income in 1999 (dollars)	41,882	(X)	21,587	map	
Families below poverty level	49	1.8	9.2%	map	brief
Individuals below poverty level	274	2.9	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,855				brief
Median value (dollars)	252,700	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,493	(X)	1,088	map	
Not mortgaged (dollars)	447	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06370

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	6,544			map	brief
Male	3,272	50.0	49.1%	map	brief
Female	3,272	50.0	50.9%	map	brief
Median age (years)	37.4	(X)	35.3	map	brief
Under 5 years	385	5.9	6.8%	map	
18 years and over	4,797	73.3	74.3%		
65 years and over	541	8.3	12.4%	map	brief
One race	6,413	98.0	97.6%		
White	6,095	93.1	75.1%	map	brief
Black or African American	123	1.9	12.3%	map	brief
American Indian and Alaska Native	45	0.7	0.9%	map	brief
Asian	93	1.4	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	4	0.1	0.1%	map	brief
Some other race	53	0.8	5.5%	map	
Two or more races	131	2.0	2.4%	map	brief
Hispanic or Latino (of any race)	174	2.7	12.5%	map	brief
Household population	6,542	100.0	97.2%	map	brief
Group quarters population	2	0.0	2.8%	map	
Average household size	2.79	(X)	2.59	map	brief
Average family size	3.11	(X)	3.14	map	
Total housing units	2,485			map	
Occupied housing units	2,348	94.5	91.0%		brief
Owner-occupied housing units	1,981	84.4	66.2%	map	
Renter-occupied housing units	367	15.6	33.8%	map	brief
Vacant housing units	137	5.5	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	4,429				
High school graduate or higher	3,963	89.5	80.4%	map	brief
Bachelor's degree or higher	897	20.3	24.4%	map	
Civilian veterans (civilian population 18 years and over)	919	19.1	12.7%	map	brief
Disability status (population 5 years and over)	1,196	19.2	19.3%	map	brief
Foreign born	293	4.4	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,643	64.6	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,595	60.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	374	5.9	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	3,712	73.2	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	26.6	(X)	25.5	map	brief
Median household income in 1999 (dollars)	60,269	(X)	41,994	map	
Median family income in 1999 (dollars)	66,033	(X)	50,046	map	
Per capita income in 1999 (dollars)	23,085	(X)	21,587	map	
Families below poverty level	27	1.5	9.2%	map	brief
Individuals below poverty level	131	2.0	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	1,720				brief
Median value (dollars)	126,300	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,203	(X)	1,088	map	
Not mortgaged (dollars)	379	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06382

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	12,001			map	brief
Male	6,735	56.1	49.1%	map	brief
Female	5,266	43.9	50.9%	map	brief
Median age (years)	36.1	(X)	35.3	map	brief
Under 5 years	631	5.3	6.8%	map	
18 years and over	9,364	78.0	74.3%		
65 years and over	1,473	12.3	12.4%	map	brief
One race	11,602	96.7	97.6%		
White	9,860	82.2	75.1%	map	brief
Black or African American	896	7.5	12.3%	map	brief
American Indian and Alaska Native	225	1.9	0.9%	map	brief
Asian	257	2.1	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	3	0.0	0.1%	map	brief
Some other race	361	3.0	5.5%	map	
Two or more races	399	3.3	2.4%	map	brief
Hispanic or Latino (of any race)	836	7.0	12.5%	map	brief
Household population	10,356	86.3	97.2%	map	brief
Group quarters population	1,645	13.7	2.8%	map	
Average household size	2.54	(X)	2.59	map	brief
Average family size	3.01	(X)	3.14	map	
Total housing units	4,319			map	
Occupied housing units	4,078	94.4	91.0%		brief
Owner-occupied housing units	2,992	73.4	66.2%	map	
Renter-occupied housing units	1,086	26.6	33.8%	map	brief
Vacant housing units	241	5.6	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	8,151				
High school graduate or higher	6,588	80.8	80.4%	map	brief
Bachelor's degree or higher	1,314	16.1	24.4%	map	
Civilian veterans (civilian population 18 years and over)	1,607	17.4	12.7%	map	brief
Disability status (population 5 years and over)	1,581	16.5	19.3%	map	brief
Foreign born	587	5.0	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	3,065	54.7	56.7%		brief
Female, Now married, except separated (population 15 years and over)	2,339	55.9	52.1%		brief
Speak a language other than English at home (population 5 years and over)	1,260	11.2	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	5,669	58.8	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	21.4	(X)	25.5	map	brief
Median household income in 1999 (dollars)	51,642	(X)	41,994	map	
Median family income in 1999 (dollars)	60,047	(X)	50,046	map	
Per capita income in 1999 (dollars)	21,951	(X)	21,587	map	
Families below poverty level	119	4.2	9.2%	map	brief
Individuals below poverty level	565	5.5	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,510				brief
Median value (dollars)	125,200	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,148	(X)	1,088	map	
Not mortgaged (dollars)	364	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06320

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	25,671			map	brief
Male	12,543	48.9	49.1%	map	brief
Female	13,128	51.1	50.9%	map	brief
Median age (years)	31.2	(X)	35.3	map	brief
Under 5 years	1,709	6.7	6.8%	map	
18 years and over	19,814	77.2	74.3%		
65 years and over	3,107	12.1	12.4%	map	brief
One race	24,216	94.3	97.6%		
White	16,299	63.5	75.1%	map	brief
Black or African American	4,784	18.6	12.3%	map	brief
American Indian and Alaska Native	225	0.9	0.9%	map	brief
Asian	544	2.1	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	21	0.1	0.1%	map	brief
Some other race	2,343	9.1	5.5%	map	
Two or more races	1,455	5.7	2.4%	map	brief
Hispanic or Latino (of any race)	5,061	19.7	12.5%	map	brief
Household population	22,965	89.5	97.2%	map	brief
Group quarters population	2,706	10.5	2.8%	map	
Average household size	2.26	(X)	2.59	map	brief
Average family size	3.00	(X)	3.14	map	
Total housing units	11,560			map	
Occupied housing units	10,181	88.1	91.0%		brief
Owner-occupied housing units	3,861	37.9	66.2%	map	
Renter-occupied housing units	6,320	62.1	33.8%	map	brief
Vacant housing units	1,379	11.9	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	15,348				
High school graduate or higher	12,030	78.4	80.4%	map	brief
Bachelor's degree or higher	3,008	19.6	24.4%	map	
Civilian veterans (civilian population 18 years and over)	2,647	14.1	12.7%	map	brief
Disability status (population 5 years and over)	5,488	24.2	19.3%	map	brief
Foreign born	2,498	9.7	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	3,964	40.2	56.7%		brief
Female, Now married, except separated (population 15 years and over)	3,888	36.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	5,663	23.6	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	13,438	65.8	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	17.2	(X)	25.5	map	brief
Median household income in 1999 (dollars)	33,809	(X)	41,994	map	
Median family income in 1999 (dollars)	38,942	(X)	50,046	map	
Per capita income in 1999 (dollars)	18,437	(X)	21,587	map	
Families below poverty level	725	13.4	9.2%	map	brief
Individuals below poverty level	3,643	15.8	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,814				brief
Median value (dollars)	107,900	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,154	(X)	1,088	map	
Not mortgaged (dollars)	427	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06359

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	4,981			map	brief
Male	2,503	50.3	49.1%	map	brief
Female	2,478	49.7	50.9%	map	brief
Median age (years)	39.6	(X)	35.3	map	brief
Under 5 years	287	5.8	6.8%	map	
18 years and over	3,728	74.8	74.3%		
65 years and over	518	10.4	12.4%	map	brief
One race	4,894	98.3	97.6%		
White	4,697	94.3	75.1%	map	brief
Black or African American	30	0.6	12.3%	map	brief
American Indian and Alaska Native	103	2.1	0.9%	map	brief
Asian	53	1.1	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	0	0.0	0.1%	map	brief
Some other race	11	0.2	5.5%	map	
Two or more races	87	1.7	2.4%	map	brief
Hispanic or Latino (of any race)	72	1.4	12.5%	map	brief
Household population	4,955	99.5	97.2%	map	brief
Group quarters population	26	0.5	2.8%	map	
Average household size	2.71	(X)	2.59	map	brief
Average family size	3.03	(X)	3.14	map	
Total housing units	2,047			map	
Occupied housing units	1,830	89.4	91.0%		brief
Owner-occupied housing units	1,622	88.6	66.2%	map	
Renter-occupied housing units	208	11.4	33.8%	map	brief
Vacant housing units	217	10.6	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	3,425				
High school graduate or higher	3,118	91.0	80.4%	map	brief
Bachelor's degree or higher	1,002	29.3	24.4%	map	
Civilian veterans (civilian population 18 years and over)	627	16.9	12.7%	map	brief
Disability status (population 5 years and over)	809	17.5	19.3%	map	brief
Foreign born	107	2.1	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,237	61.8	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,248	62.7	52.1%		brief
Speak a language other than English at home (population 5 years and over)	185	4.0	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	2,880	73.5	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	27.2	(X)	25.5	map	brief
Median household income in 1999 (dollars)	57,887	(X)	41,994	map	
Median family income in 1999 (dollars)	61,733	(X)	50,046	map	
Per capita income in 1999 (dollars)	25,815	(X)	21,587	map	
Families below poverty level	47	3.3	9.2%	map	brief
Individuals below poverty level	236	4.8	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	1,289				brief
Median value (dollars)	151,400	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,265	(X)	1,088	map	
Not mortgaged (dollars)	414	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06379

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	8,696			map	brief
Male	4,222	48.6	49.1%	map	brief
Female	4,474	51.4	50.9%	map	brief
Median age (years)	38.9	(X)	35.3	map	brief
Under 5 years	555	6.4	6.8%	map	
18 years and over	6,581	75.7	74.3%		
65 years and over	1,329	15.3	12.4%	map	brief
One race	8,540	98.2	97.6%		
White	8,241	94.8	75.1%	map	brief
Black or African American	70	0.8	12.3%	map	brief
American Indian and Alaska Native	47	0.5	0.9%	map	brief
Asian	129	1.5	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	5	0.1	0.1%	map	brief
Some other race	48	0.6	5.5%	map	
Two or more races	156	1.8	2.4%	map	brief
Hispanic or Latino (of any race)	110	1.3	12.5%	map	brief
Household population	8,691	99.9	97.2%	map	brief
Group quarters population	5	0.1	2.8%	map	
Average household size	2.39	(X)	2.59	map	brief
Average family size	2.98	(X)	3.14	map	
Total housing units	3,900			map	
Occupied housing units	3,641	93.4	91.0%		brief
Owner-occupied housing units	2,387	65.6	66.2%	map	
Renter-occupied housing units	1,254	34.4	33.8%	map	brief
Vacant housing units	259	6.6	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	6,011				
High school graduate or higher	5,036	83.8	80.4%	map	brief
Bachelor's degree or higher	1,483	24.7	24.4%	map	
Civilian veterans (civilian population 18 years and over)	985	15.1	12.7%	map	brief
Disability status (population 5 years and over)	1,222	15.2	19.3%	map	brief
Foreign born	500	5.8	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,921	57.9	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,946	54.2	52.1%		brief
Speak a language other than English at home (population 5 years and over)	696	8.6	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	4,380	64.5	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	22.0	(X)	25.5	map	brief
Median household income in 1999 (dollars)	45,548	(X)	41,994	map	
Median family income in 1999 (dollars)	55,560	(X)	50,046	map	
Per capita income in 1999 (dollars)	22,916	(X)	21,587	map	
Families below poverty level	104	4.4	9.2%	map	brief
Individuals below poverty level	560	6.5	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	2,102				brief
Median value (dollars)	141,900	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,251	(X)	1,088	map	
Not mortgaged (dollars)	352	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06378

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	5,348			map	brief
Male	2,644	49.4	49.1%	map	brief
Female	2,704	50.6	50.9%	map	brief
Median age (years)	44.0	(X)	35.3	map	brief
Under 5 years	269	5.0	6.8%	map	
18 years and over	4,243	79.3	74.3%		
65 years and over	940	17.6	12.4%	map	brief
One race	5,299	99.1	97.6%		
White	5,213	97.5	75.1%	map	brief
Black or African American	20	0.4	12.3%	map	brief
American Indian and Alaska Native	8	0.1	0.9%	map	brief
Asian	41	0.8	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	4	0.1	0.1%	map	brief
Some other race	13	0.2	5.5%	map	
Two or more races	49	0.9	2.4%	map	brief
Hispanic or Latino (of any race)	70	1.3	12.5%	map	brief
Household population	5,328	99.6	97.2%	map	brief
Group quarters population	20	0.4	2.8%	map	
Average household size	2.26	(X)	2.59	map	brief
Average family size	2.83	(X)	3.14	map	
Total housing units	2,811			map	
Occupied housing units	2,356	83.8	91.0%		brief
Owner-occupied housing units	1,794	76.1	66.2%	map	
Renter-occupied housing units	562	23.9	33.8%	map	brief
Vacant housing units	455	16.2	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	4,147				
High school graduate or higher	3,807	91.8	80.4%	map	brief
Bachelor's degree or higher	1,770	42.7	24.4%	map	
Civilian veterans (civilian population 18 years and over)	758	17.5	12.7%	map	brief
Disability status (population 5 years and over)	719	13.9	19.3%	map	brief
Foreign born	236	4.3	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	1,410	63.9	56.7%		brief
Female, Now married, except separated (population 15 years and over)	1,347	57.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	416	8.0	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	2,971	66.0	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	20.7	(X)	25.5	map	brief
Median household income in 1999 (dollars)	59,167	(X)	41,994	map	
Median family income in 1999 (dollars)	74,083	(X)	50,046	map	
Per capita income in 1999 (dollars)	35,777	(X)	21,587	map	
Families below poverty level	27	1.7	9.2%	map	brief
Individuals below poverty level	244	4.4	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	1,342				brief
Median value (dollars)	229,200	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,499	(X)	1,088	map	
Not mortgaged (dollars)	528	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06375

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	3,342			map	brief
Male	1,633	48.9	49.1%	map	brief
Female	1,709	51.1	50.9%	map	brief
Median age (years)	36.1	(X)	35.3	map	brief
Under 5 years	159	4.8	6.8%	map	
18 years and over	2,657	79.5	74.3%		
65 years and over	521	15.6	12.4%	map	brief
One race	3,265	97.7	97.6%		
White	3,038	90.9	75.1%	map	brief
Black or African American	96	2.9	12.3%	map	brief
American Indian and Alaska Native	26	0.8	0.9%	map	brief
Asian	78	2.3	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	1	0.0	0.1%	map	brief
Some other race	26	0.8	5.5%	map	
Two or more races	77	2.3	2.4%	map	brief
Hispanic or Latino (of any race)	77	2.3	12.5%	map	brief
Household population	2,760	82.6	97.2%	map	brief
Group quarters population	582	17.4	2.8%	map	
Average household size	2.42	(X)	2.59	map	brief
Average family size	2.89	(X)	3.14	map	
Total housing units	1,200			map	
Occupied housing units	1,141	95.1	91.0%		brief
Owner-occupied housing units	981	86.0	66.2%	map	
Renter-occupied housing units	160	14.0	33.8%	map	brief
Vacant housing units	59	4.9	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	2,034				
High school graduate or higher	1,725	84.8	80.4%	map	brief
Bachelor's degree or higher	499	24.5	24.4%	map	
Civilian veterans (civilian population 18 years and over)	446	16.7	12.7%	map	brief
Disability status (population 5 years and over)	512	16.2	19.3%	map	brief
Foreign born	110	3.3	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	750	57.4	56.7%		brief
Female, Now married, except separated (population 15 years and over)	866	58.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	201	6.3	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	1,748	63.1	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	20.7	(X)	25.5	map	brief
Median household income in 1999 (dollars)	56,524	(X)	41,994	map	
Median family income in 1999 (dollars)	65,671	(X)	50,046	map	
Per capita income in 1999 (dollars)	21,482	(X)	21,587	map	
Families below poverty level	5	0.6	9.2%	map	brief
Individuals below poverty level	108	3.9	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	950				brief
Median value (dollars)	140,600	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,159	(X)	1,088	map	
Not mortgaged (dollars)	287	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

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U.S. Census Bureau
American FactFinder

FACT SHEET

Zip Code Tabulation Area 06385

View a Fact Sheet for a **race, ethnic, or ancestry group**

Census 2000 Demographic Profile Highlights:

General Characteristics - show more >>	Number	Percent	U.S.		
Total population	15,811			map	brief
Male	7,549	47.7	49.1%	map	brief
Female	8,262	52.3	50.9%	map	brief
Median age (years)	42.8	(X)	35.3	map	brief
Under 5 years	779	4.9	6.8%	map	
18 years and over	12,309	77.9	74.3%		
65 years and over	3,121	19.7	12.4%	map	brief
One race	15,578	98.5	97.6%		
White	14,662	92.7	75.1%	map	brief
Black or African American	330	2.1	12.3%	map	brief
American Indian and Alaska Native	65	0.4	0.9%	map	brief
Asian	403	2.5	3.6%	map	brief
Native Hawaiian and Other Pacific Islander	2	0.0	0.1%	map	brief
Some other race	116	0.7	5.5%	map	
Two or more races	233	1.5	2.4%	map	brief
Hispanic or Latino (of any race)	382	2.4	12.5%	map	brief
Household population	15,425	97.6	97.2%	map	brief
Group quarters population	386	2.4	2.8%	map	
Average household size	2.41	(X)	2.59	map	brief
Average family size	2.91	(X)	3.14	map	
Total housing units	6,787			map	
Occupied housing units	6,401	94.3	91.0%		brief
Owner-occupied housing units	5,390	84.2	66.2%	map	
Renter-occupied housing units	1,011	15.8	33.8%	map	brief
Vacant housing units	386	5.7	9.0%	map	

Social Characteristics - show more >>	Number	Percent	U.S.		
Population 25 years and over	11,600				
High school graduate or higher	10,104	87.1	80.4%	map	brief
Bachelor's degree or higher	3,338	28.8	24.4%	map	
Civilian veterans (civilian population 18 years and over)	2,121	17.4	12.7%	map	brief
Disability status (population 5 years and over)	2,436	16.7	19.3%	map	brief
Foreign born	1,088	6.9	11.1%	map	brief
Male, Now married, except separated (population 15 years and over)	3,720	61.6	56.7%		brief
Female, Now married, except separated (population 15 years and over)	3,807	55.3	52.1%		brief
Speak a language other than English at home (population 5 years and over)	1,420	9.4	17.9%	map	brief

Economic Characteristics - show more >>	Number	Percent	U.S.		
In labor force (population 16 years and over)	7,962	62.9	63.9%		brief
Mean travel time to work in minutes (workers 16 years and older)	18.9	(X)	25.5	map	brief
Median household income in 1999 (dollars)	55,984	(X)	41,994	map	
Median family income in 1999 (dollars)	65,714	(X)	50,046	map	
Per capita income in 1999 (dollars)	27,915	(X)	21,587	map	
Families below poverty level	104	2.4	9.2%	map	brief
Individuals below poverty level	681	4.4	12.4%	map	

Housing Characteristics - show more >>	Number	Percent	U.S.		
Single-family owner-occupied homes	4,789				brief
Median value (dollars)	156,300	(X)	119,600	map	brief
Median of selected monthly owner costs	(X)	(X)			brief
With a mortgage (dollars)	1,185	(X)	1,088	map	
Not mortgaged (dollars)	329	(X)	295		

(X) Not applicable.
Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

Docket Number: 11-31682-CON

Exhibit E

Claritas Population Statistics for Year 2000 by Zip Code

M Rosadini Consultants LLC
Population/Demographics Analysis
Population Summary

Pop Facts: Population Quick Facts	06320 New London		06333 East Lyme		06335 Gales Ferry		06339 Ledyard		06340 Groton		06349 Groton		06353 Montville		06355 Mystic		06357 Niantic		06359 North Stonington		06370 Oakdale		06371 Old Lyme		06375 Quaker Hill		06378 Stonington		06379 Pawcatuck		06382 Uncasville		06385 Waterford		Subtotal PSA	
Population																																		
2014 Projection	25,667		7,943		6,482		8,547		34,609		1		97		14,240		11,818		5,271		7,709		9,258		4,498		5,421		8,797		12,518		14,806		177,682	
2009 Estimate	25,665		7,679		6,490		8,395		33,675		1		93		13,528		11,485		5,172		7,375		9,305		4,420		5,457		8,717		12,187		14,783		174,427	
2000 Census	25,687		7,101		6,536		8,107		31,655		1		84		12,085		11,006		4,993		6,689		9,422		4,317		5,501		8,617		11,541		14,820		168,162	
1990 Census	28,547		6,240		6,797		7,818		37,729		4		72		11,215		9,089		4,884		6,509		8,484		3,812		5,186		8,231		9,889		14,107		168,613	
Growth 2009-2014	0.01%		3.44%		-0.12%		1.81%		2.77%		0.00%		4.30%		5.26%		2.90%		1.91%		4.53%		-0.51%		1.76%		-0.66%		0.92%		2.72%		0.16%		1.87%	
Growth 2000-2009	-0.09%		8.14%		-0.70%		3.55%		6.38%		0.00%		10.71%		11.94%		4.35%		3.59%		10.26%		-1.24%		2.39%		-0.80%		1.16%		5.60%		-0.25%		3.73%	
Growth 1990-2000	-10.02%		13.80%		-3.84%		3.70%		-16.10%		-75.00%		16.67%		7.76%		21.09%		2.23%		2.77%		11.06%		13.25%		6.07%		4.69%		16.71%		5.05%		-0.27%	
2009 Estimated Total Population by Age	**25,665**		**7,679**		**6,490**		**8,395**		**33,675**		**1**		**93**		**13,528**		**11,485**		**5,172**		**7,375**		**9,305**		**4,420**		**5,457**		**8,717**		**12,187**		**14,783**		**174,427**	
Age 0 to 4	1,584	6.17%	432	5.63%	339	5.22%	535	6.37%	2,521	7.49%	0	0.00%	5	5.38%	651	4.81%	444	3.87%	270	5.22%	402	5.45%	488	5.24%	198	4.48%	236	4.32%	524	6.01%	578	4.74%	684	4.63%	9,891	5.67%
Age 5 to 9	1,545	6.02%	459	5.98%	359	5.53%	570	6.79%	2,178	6.47%	0	0.00%	7	7.53%	703	5.20%	481	4.19%	297	5.74%	432	5.86%	535	5.75%	210	4.75%	262	4.80%	562	6.45%	615	5.05%	744	5.03%	9,959	5.71%
Age 10 to 14	1,613	6.28%	546	7.11%	428	6.59%	605	7.21%	2,073	6.16%	0	0.00%	7	7.53%	787	5.82%	518	4.51%	338	6.54%	487	6.60%	595	6.39%	260	5.88%	298	5.46%	593	6.80%	673	5.52%	870	5.89%	10,691	6.13%
Age 15 to 17	922	3.59%	477	6.21%	383	5.90%	425	5.06%	1,162	3.45%	0	0.00%	5	5.38%	561	4.15%	397	3.46%	236	4.56%	363	4.92%	445	4.78%	204	4.62%	228	4.18%	371	4.26%	493	4.05%	665	4.50%	7,337	4.21%
Age 18 to 20	2,464	9.60%	286	3.72%	229	3.53%	263	3.13%	2,099	6.23%	0	0.00%	2	2.15%	381	2.82%	408	3.55%	167	3.23%	273	3.70%	259	2.78%	482	10.90%	125	2.29%	263	3.02%	547	4.49%	465	3.15%	8,713	5.00%
Age 21 to 24	1,947	7.59%	469	6.11%	338	5.21%	443	5.28%	2,225	6.61%	1	******%	4	4.30%	579	4.28%	701	6.10%	233	4.51%	362	4.91%	419	4.50%	356	8.05%	224	4.10%	381	4.37%	890	7.30%	622	4.21%	10,194	5.84%
Age 25 to 34	3,550	13.83%	765	9.96%	711	10.96%	1,048	12.48%	5,509	16.36%	0	0.00%	9	9.68%	1,290	9.54%	1,735	15.11%	602	11.64%	840	11.39%	690	7.42%	321	7.26%	487	8.92%	995	11.41%	1,829	15.01%	1,350	9.13%	21,731	12.46%
Age 35 to 44	3,812	14.85%	904	11.77%	901	13.88%	1,192	14.20%	5,158	15.32%	0	0.00%	16	17.20%	1,967	14.54%	1,958	17.05%	675	13.05%	1,178	15.97%	988	10.62%	493	11.15%	683	12.52%	1,309	15.02%	1,929	15.83%	1,882	12.73%	25,045	14.36%
Age 45 to 49	1,683	6.56%	748	9.74%	643	9.91%	734	8.74%	2,287	6.73%	0	0.00%	8	8.60%	1,198	8.86%	888	7.73%	578	11.18%	715	9.69%	839	9.02%	324	7.33%	476	8.72%	790	9.37%	958	7.86%	1,274	8.62%	14,063	8.06%
Age 50 to 54	1,549	6.04%	698	9.09%	573	8.83%	682	8.12%	1,877	5.57%	0	0.00%	7	7.53%	1,217	9.00%	876	7.63%	460	8.89%	616	8.35%	908	9.76%	307	6.95%	537	9.84%	665	7.63%	848	6.96%	1,262	8.54%	13,082	7.50%
Age 55 to 59	1,163	4.53%	581	7.57%	469	7.23%	559	6.66%	1,458	4.33%	0	0.00%	6	6.45%	1,019	7.53%	766	6.67%	386	7.46%	483	6.55%	834	8.96%	277	6.27%	497	9.11%	541	6.21%	640	5.25%	1,079	7.30%	10,758	6.17%
Age 60 to 64	950	3.70%	426	5.55%	355	5.47%	450	5.36%	1,193	3.54%	0	0.00%	3	3.23%	821	6.07%	576	5.02%	293	5.67%	399	5.41%	622	6.68%	248	5.50%	387	7.09%	465	5.33%	587	4.82%	862	5.83%	8,632	4.95%
Age 65 to 74	1,286	5.01%	530	6.90%	465	7.16%	550	6.55%	1,770	5.26%	0	0.00%	8	8.60%	1,129	8.35%	859	7.48%	372	7.19%	520	7.05%	920	9.89%	334	7.56%	548	10.04%	627	7.19%	728	5.97%	1,419	9.60%	12,125	6.95%
Age 75 to 84	1,034	4.03%	277	3.61%	232	3.57%	266	3.17%	1,440	4.28%	0	0.00%	4	4.30%	807	5.97%	621	5.41%	208	4.02%	243	3.29%	556	5.98%	297	6.72%	343	6.29%	508	5.83%	528	4.33%	1,121	7.58%	8,485	4.86%
Age 85 and over	563	2.19%	81	1.05%	65	1.00%	73	0.87%	745	2.21%	0	0.00%	2	2.15%	418	3.09%	257	2.24%	57	1.10%	62	0.84%	207	2.22%	114	2.58%	126	2.31%	183	2.10%	284	2.33%	484	3.27%	3,721	2.13%
Age 16 and over	20,630	80.38%	6,072	79.07%	5,249	80.88%	6,545	77.96%	26,505	78.71%	1	******%	71	76.34%	11,100	82.72%	9,926	86.43%	4,185	80.92%	5,914	80.19%	7,526	80.88%	3,676	83.17%	4,588	84.08%	6,914	79.32%	10,157	83.30%	12,239	82.79%	141,383	81.06%
Age 18 and over	20,001	77.93%	5,765	75.07%	4,981	76.75%	6,260	74.57%	25,741	76.44%	1	******%	69	74.19%	10,826	80.03%	9,545	83.98%	4,031	77.94%	5,691	77.17%	7,242	77.83%	3,548	80.27%	4,433	81.24%	6,667	76.48%	9,828	80.64%	11,820	79.96%	136,549	78.28%
Age 21 and over	17,537	68.33%	5,479	71.35%	4,752	73.22%	5,997	71.44%	23,642	70.21%	1	******%	67	72.04%	10,445	77.21%	9,237	80.43%	3,864	74.71%	5,418	73.46%	6,983	75.05%	3,066	69.37%	4,308	78.94%	6,404	73.47%	9,281	76.15%	11,355	76.81%	127,836	73.29%
Age 65 and over	2,883	11.23%	888	11.56%	762	11.74%	889	10.59%	3,955	11.74%	0	0.00%	14	15.05%	2,354	17.40%	1,737	15.12%	637	12.32%	825	11.19%	1,683	18.09%	745	16.86%	1,017	18.64%	1,318	15.12%	1,600	13.13%	3,024	20.46%	24,331	13.95%
2009 Estimated Median Age	**33.07**		**40.48**		**40.84**		**37.81**		**33.45**		**23.5**		**40.28**		**44.27**		**40.34**		**42.03**		**40.22**		**46.39**		**39.26**		**46.95**		**40.45**		**37.57**		**45.43**		**38.65**	
2009 Estimated Average Age	**35.57**		**38.2**		**38.75**		**37.13**		**35.67**		**23.5**		**38.93**		**42.55**		**41.18**		**39.53**		**38.32**		**42.58**		**39.73**		**44**		**39.69**		**38.72**		**43.51**		**38.89**	
2009 Estimated Population by Single Race Classification	**25,665**		**7,679**		**6,490**		**8,395**		**33,675**		**1**		**93**		**13,528**		**11,485**		**5,172**		**7,375**		**9,305**		**4,420**		**5,457**		**8,717**		**12,187**		**14,783**		**174,427**	
White Alone	15,339	59.77%	6,295	81.98%	5,803	89.41%	6,783	80.80%	25,600	76.02%	1	******%	85	91.40%	12,423	91.83%	9,382	81.69%	4,813	93.06%	6,818	92.45%	8,984	96.55%	3,834	86.74%	5,259	96.37%	8,010	91.89%	9,130	74.92%	13,355	90.34%	141,914	81.36%
Black or African American Alone	4,953	19.30%	328	4.27%	159	2.45%	301	3.59%	3,060	9.09%	0	0.00%	3	3.23%	199	1.47%	1,268	11.04%	34	0.66%	114	1.55%	15	0.16%	145	3.28%	13	0.24%	81	0.93%	1,311	10.76%	907	2.08%	12,291	7.05%
American Indian and Alaska Native Alone	187	0.73%	35	0.46%	53	0.82%	515	6.13%	245	0.73%	0	0.00%	1	1.08%	45	0.33%	46	0.40%	109	2.11%	48	0.65%	14	0.15%	28	0.63%	9	0.16%	41	0.47%	198	1.62%	49	0.33%	1,623	0.93%
Asian Alone	889	3.46%	805	10.48%	241	3.71%	332	3.95%	2,370	7.04%	0	0.00%	1	1.08%	480	3.55%	236	2.05%	89	1.72%	152	2.06%	194	2.08%	234	5.29%	86	1.58%	292	3.35%	472	3.87%	679	4.59%	7,552	4.33%
Native Hawaiian and Other Pacific Islander Alone	23	0.09%	3	0.04%	2	0.03%	12	0.14%	85	0.25%	0	0.00%	0	0.00%	16	0.12%	10	0.09%	0	0.00%	3	0.04%	0	0.00%	3	0.07%	5	0.09%	9	0.10%	5	0.04%	2	0.01%	178	0.10%
Some Other Race Alone	2,648	10.32%	57	0.74%	60	0.92%	115	1.37%	867	2.57%	0	0.00%	1	1.08%	75	0.55%	269	2.34%	18	0.35%	60	0.81%	33	0.35%	65	1.47%	23	0.42%	69	0.79%	580	4.76%	141	0.95%	5,081	2.91%
Two or More Races	1,626	6.34%	156	2.03%	172	2.65%	337	4.01%	1,448	4.30%	0	0.00%	2	2.15%	290	2.14%	274	2.39%	109	2.11%	180	2.44%	65	0.70%	111	2.51%	62	1.14%	215	2.47%	491	4.03%	250	1.69%	5,788	3.32%
2009 Estimated Population Hispanic or Latino	**25,665**		**7,679**		**6,490**		**8,395**		**33,675**		**1**		**93**		**13,528**		**11,485**		**5,172**		**7,375**		**9,305**		**4,420**		**5,457**		**8,717**		**12,187**		**14,783**		**174,427**	
Hispanic or Latino	6,310	24.59%	297	3.87%	215	3.31%	333	3.97%	2,442	7.25%	0	0.00%	5	5.38%	287	2.12%	875	7.62%	98	1.89%	215	2.92%	122	1.31%	135	3.05%	78	1.43%	124	1.42%	1,217	9.99%	428	2.90%	13,181	7.56%
Not Hispanic or Latino	19,355	75.41%	7,382	96.13%	6,275	96.69%	8,062	96.03%	31,233	92.75%	1	******%	88	94.62%	13,241	97.88%	10,610	92.38%	5,074	98.11%	7,160	97.08%	9,183	98.69%	4,285	96.95%	5,379	98.57%	8,593	98.58%	10,970	90.01%	14,355	97.10%	161,246	92.44%
2009 Estimated Population by Sex	**25,665**		**7,679**		**6,490**		**8,395**		**33,675**		**1**		**93**		**13,528**		**11,485**		**5,172**		**7,375**		**9,305**		**4,420**		**5,457**		**8,717**		**12,187**		**14,783**		**174,427**	
Male	12,625	49.19%	4,029	52.47%	3,191	49.17%	4,122	49.10%	17,687	52.52%	1	******%	49	52.69%	6,540	48.34%	5,198	45.26%	2,576	49.81%	3,695	50.10%	4,612	49.56%	2,131	48.21%	2,683	49.17%	4,259	48.86%	6,926	56.83%	7,075	47.86%	87,399	50.11%
Female	13,040	50.81%	3,650	47.53%	3,299	50.83%	4,273	50.90%	15,988	47.48%	0	0.00%	44	47.31%	6,988	51.66%	6,287	54.74%	2,596	50.19%	3,680	49.90%	4,693	50.44%	2,289	51.79%	2,774	50.83%	4,458	51.14%	5,261	43.17%	7,708	52.14%	87,028	49.89%
Male/Female Ratio	0.97		1.1		0.97		0.96		1.11				1.11		0.94		0.83		0.99		1		0.98		0.93		0.97		0.96		1.32		0.92		1	