

2006 SEP 1  
CONNECTICUT  
GENERAL  
HOSPITAL

## CyberKnife Project Description

The Stamford Hospital (TSH) is proposing to purchase a CyberKnife radiosurgery system to be placed on the main campus hospital site. The CyberKnife is the first and only radiosurgery system designed to treat tumors anywhere in the body with sub-millimeter accuracy. This technology would add robotic radiosurgery to treat central nervous system lesions as well as extra cranial sites with extraordinary accuracy therefore minimizing the side effects to normal tissue. In addition, the use of the CyberKnife would allow for fewer treatments and a shorter treatment time for the patient. This technology would also complement the current linear accelerator and IMRT treatments available at TSH while expanding the scope of conditions treated with Radiation Therapy at the Bennett Cancer Center.

The total capital costs for this equipment are \$5,595,000 which includes \$3,895,000 in equipment and \$1,700,000 in construction/renovation costs. This technology does not exist anywhere else in Fairfield County. The only provider of this service in the state of Connecticut is St. Francis Hospital and Medical Center in Hartford.

Advantages of the CyberKnife System include the following:

- Treats tumors anywhere in the body
- Continuously tracks, detects and corrects for tumor and patient movement throughout the treatment
- Utilizes the skeletal structure of the body and sometimes fiducial markers as a reference, eliminating the need for invasive frames typically used with traditional radiosurgery systems
- An option for inoperable or surgically complex tumors
- Successfully treats patients in single or multiple fractions (usually five or less)
- Provides unsurpassed linac maneuverability and complete access and coverage for any tumor volume
- Has patient-centric design providing a relaxed treatment experience
- Enables superior flexibility in treatment planning:
  - Forward or inverse treatment planning
  - Isocentric or non-isocentric treatment plans
  - Simultaneous treatment of multiple tumors

The population to be served is the same as the current TSH Primary, Secondary and Extended service areas which are as follows: Primary – Stamford and Darien, Secondary – New Canaan, Greenwich, Old Greenwich, Riverside, Cos Cob, Norwalk, Wilton, and Westport and Extended – Fairfield, Southport, Ridgefield, Weston, Bedford, NY, Bedford Hills, NY, Katonah, NY, Mt. Kisco, NY, Port Chester, NY, Pound Ridge, NY, Rye, NY and South Salem, NY.

There are numerous benefits to establishing the CyberKnife in Southwestern Fairfield County. Patients within the health care delivery system will be treated with state-of-the-art equipment, improving their chances for excellent outcomes, without their having to travel to distant hospitals to seek this type of world-class care. In addition, introduction of Cyberknife technology will expand the scope of conditions that can be successfully treated by TSH's physicians, radiation therapy physicists and therapists. In addition, the accelerated treatment course available with Cyberknife will result in less travel, inconvenience and stress for patients and their families.

This service will be provided under TSH's existing hospital license and will not affect the Hospital's payer mix or sources when the project becomes operational.



# State of Connecticut

## Office of Health Care Access

### Letter of Intent Form

### Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

#### SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	The Stamford Hospital	
Doing Business As	The Stamford Hospital	
Name of Parent Corporation	Stamford Health System	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	30 Shelburne Road, P.O. Box 9317, Stamford CT, 06904	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Kathleen A. Silard, Senior Vice President, Operations	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	30 Shelburne Road, P.O. Box 9317, Stamford CT, 06904	

Contact Person's Telephone Number	203-276-7505	
Contact Person's Fax Number	203-276-5529	
Contact Person's e-mail Address	<a href="mailto:ksilard@stamhealth.org">ksilard@stamhealth.org</a>	

## SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Acquisition of CyberKnife Stereotactic Radiosurgery System Technology

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

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

<input type="checkbox"/> New (F, S, Fnc)	<input type="checkbox"/> Replacement	<input checked="" type="checkbox"/> Additional (F, S, Fnc)
<input checked="" type="checkbox"/> Expansion (F, S, Fnc)	<input type="checkbox"/> Relocation	<input type="checkbox"/> Service Termination
<input type="checkbox"/> Bed Addition	<input type="checkbox"/> Bed Reduction	<input type="checkbox"/> Change in Ownership/Control

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

<input checked="" type="checkbox"/> Project expenditure/cost greater than \$ 3,000,000	<input checked="" type="checkbox"/> Equipment Acquisition	<input type="checkbox"/> Major Medical (> \$3,000,000)
<input type="checkbox"/> New	<input type="checkbox"/> Replacement	<input checked="" type="checkbox"/> Major Medical (> \$3,000,000)
<input type="checkbox"/> Imaging	<input type="checkbox"/> Linear Accelerator	

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

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

30 Shelburne Road, Stamford, CT 06904

d. List each town this project is intended to serve: This proposal would serve the current TSH Primary, Secondary and Extended service area towns as follows: Primary - Stamford and Darien, Secondary – New Canaan, Greenwich, Old Greenwich, Riverside, Cos Cob, Norwalk, Wilton, and Westport and Extended – Fairfield, Southport, Ridgefield, Weston, Bedford NY, Bedford Hills NY, Katonah NY, Mt. Kisco NY, Port Chester NY, Pound Ridge NY, Rye NY and South Salem, NY.

e. Estimated starting date for the project: Installation begins January 2008, Operational by April 2008

f. Type of project: 13, 25, 27  
 (Fill in the appropriate number(s) from page 7 of this Form)

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

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
N/A	N/A	N/A	N/A	N/A

**SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION**

a. Estimated Total Project Cost: \$ 5,595,000

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	\$3,895,000
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	\$1,700,000
Other (Non-Construction) Specify: _____	
<b>Total Capital Expenditure</b>	<b>\$5,595,000</b>
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
<b>Total Capital Cost</b>	<b>\$5,595,000</b>

<b>Total Project Cost</b>	<b>\$5,595,000</b>
<b>Capitalized Financing Costs</b> (Informational Purpose Only)	

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

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

No       Yes

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

Energy  Fire Safety Code  Non Substantive

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

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

**Major Medical and/or Imaging Equipment Acquisition:**

Equipment Type	Name	Model	Number of Units	Cost per unit
Cyberknife	Accuray Cyberknife System	Cyberknife G4 Base System	1	\$3,850,000
Workstation	CyRis InView Workstation	CyRis InView	1	\$ 45,000

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

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

<input checked="" type="checkbox"/> Applicant's Equity	<input type="checkbox"/> Capital Lease	<input type="checkbox"/> Conventional Loan
<input type="checkbox"/> Charitable Contributions	<input type="checkbox"/> Operating Lease	<input type="checkbox"/> CHEFA Financing
<input type="checkbox"/> Funded Depreciation	<input type="checkbox"/> Grant Funding	<input type="checkbox"/> Other (specify): _____

**SECTION IV. PROJECT DESCRIPTION**

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

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.
2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and who is the target population to be served.
4. Identify any unmet need and describe how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
7. Who will be responsible for providing the service?
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

## AFFIDAVIT

To be completed by each Applicant

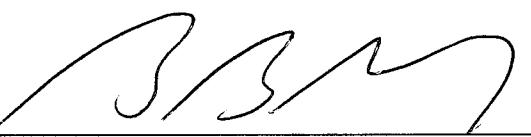
Applicant: The Stamford Hospital

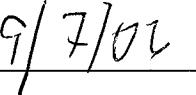
Project Title: Acquisition of Cyberknife Stereotactic Radiosurgery System Technology

I, Brian G. Grissler, Chief Executive Officer  
(Name) (Position – CEO or CFO)

of The Stamford Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that The Stamford Hospital complies with the appropriate and (Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

  
Signature

  
Date

Subscribed and sworn to before me on SEPTEMBER 7 2006

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

**LAUREN MALLOZZI**  
**NOTARY PUBLIC**  
MY COMMISSION EXPIRES FEB. 28, 2008

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

## Project Type Listing

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

### Inpatient

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

### Outpatient

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

### Non-Clinical

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