STANLEY J. FOSTER, MD., P.C.

PLASTIC RECONSTRUCTIVE SURGERY
HAND SURGERY
COSMETIC SURGERY

TEL: 203-757-0583
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EMAIL: SFOSTERMD@AOL.COM

1389 WEST MAIN STREET
SUITE 306 • TOWER 1
WATERBURY, CT 06708

Healing Hands • Excellence in Surgery •

June 29, 2004

OCHA
Susan Cole
410 Capitol Ave
MS#13HCA
P. O. BOX 340308
Hartford, CT 06134-0308

Re: CON

CERTIFIED MAIL

Dear Susan:

Dr. Foster first applied for a CON on February 10, 2000.(enclosures) He has been trying to purchase a location for this venture. He has unsuccessfully tried to purchase the following locations that all fell through:

1. Watertown Ave, Waterbury
2. Route 188 Lot in Middlebury
3. Bronson Road in Middlebury
4. The old Post office in Middlebury
5. Data Comp Building in Middlebury

He has now been successful in acquiring Middlebury Edge in Middlebury for the new surgical suite. Therefore Dr. Foster can now go forward with the process to obtain a CON.

Dr. Foster started performing outpatient surgery in August 1995 with general anesthesia sedation. In July 1997 he also performed hundreds of outpatient surgery with general anesthesia given by a certified nurse anesthetists at an outpatient office based surgical facility owned by another surgeon. Dr. Foster performs about 1000 outpatient surgeries per year.

Please advise me on the next steps so I can go forward with the CON. Thanks in advance for all your help in this matter. I can be reached at 203-757-0583.

Sincerely,

Sally George
Manager

STANLEY J. FOSTER, MD., P.C.

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February 10, 2000

State of Connecticut
The Commissioner
Office of Health Care Access
410 Capitol Avenue
MS # 13HCA
P. O. BOX 340308
Hartford, CT 06134-0308

Dear Commissioner:

I am a Plastic and Hand Surgeon practicing medicine in the town of Waterbury Connecticut. This Letter of Intent is for the request of a Certificate of Need for my new Surgical Center. The proposed Surgical Center is located on 513 Watertown Avenue, Waterbury, Connecticut and is approximately 3500 square feet. To ensure high standards I will comply with requirements to obtain certification and licensure with State, Federal, HCFA, JACHO and AAAHC. These will aide me in allowing to provide the Community quality healthcare.

My objective is to create a healthcare delivery system that will provide the Community high quality medical care that is cost effective, accessible and confidential. The continuous complaints from patients regarding accommodating surgery dates, time, high cost and long waits, and lack of confidentiality will be eliminated with this facility, especially cosmetic patients. The smaller size of this facility compared to other facilities will provide a more personal approach. It will also reduce the fees substantially, creating cost-effective healthcare to the insured, non-insured and self-paying cosmetic patients. Also, accommodating their requested surgery dates and times for their busy schedules promotes shorter medical absences. This creates healthcare access that really demonstrates we care about their daily life needs, a benefit that has not been recognized in the community.

Geographically in Waterbury there are two hospitals, a hospital owned surgical center, and Opti-Care Surgical Center (eye surgery only). These facilities have not been able to provide services to my patients without all the problems listed above. This facility which is specific to the specialty of Cosmetic and Hand Surgery will be able to meet the needs of the people of the community. Additionally, Waterbury will benefit from attracting people from surrounding towns.

I strongly feel this project should be approved not only for the many reasons listed throughout this letter, but because it allows the people various choices of care in an era of growing medical restrictions, denial of care, and elevated cost to provide medical treatment.

Thank you in advance for all your help with this matter. If you have any questions, please contact Office Manager Sally George, or myself at 203-757-0583.

Sincerely,

Stanley J. Foster MD

Stanley Foster, MD

SECTION IV. PROJECT DESCRIPTION

The proposed project of this ~~fee~~ free standing ambulatory surgical center is to provide the community an accessible, quality, cost affective, confidential, and advantageous system to obtain healthcare. To create a healthcare delivery system that is cost effective, high quality, accessible, and confidential. This 3500 square foot facility will enable Dr. Foster to provide cost effective healthcare to his self-pay and insured patients.

The continuous complaints from patients regarding accommodating surgery dates, times, high cost and long waits can be eliminated through this facility. The smaller size of this facility compared to other facilities would reduce the fees substantially and this would benefit the community greatly. With less overhead this allows Dr. Foster to keep the fees low and therefore allowing him to negotiate cheaper rates with insurance companies, third party payers, and self-paying patients, this also is a great benefit to the community. The smaller size offers easier access to their requested surgery dates and times.

There are many reasons why there is a need for this type of facility. A big problem in hospitals and large surgical centers is confidentiality. Cosmetic patients cannot achieve this because of the large amount of employees that have access to the surgery schedule make it impossible to perform any procedure and maintain confidentiality and a competitive price. This has been attempted with no success. Another problem is availability, seldom are we able to schedule a case that accommodates the patients wishes in other facilities.

I feel the effect of this small surgical center will improve the quality of care, availability, give the patients a choice of day and time for their procedure. This will also eliminate the long waiting between cases, making everyone happy. This will help draw people from the outer surrounding towns of Waterbury Connecticut by providing this personal one-on-one type of care creating a positive attitude about this town. Finally the cost-effective delivery of healthcare which is an increasing problem in the delivery of healthcare.

Geographically in Waterbury there are two other surgical centers. One is owned by Saint Mary's Hospital and cannot provide the needs of my patients. The other is Opti-Care and this is for eye surgery only. Not the same service that my facility will provide, which is specific to cosmetic and hand surgery. Dr. Foster and his staff will provide these services. This will also allow Dr. Fosters colleges of the same specialty to utilize these services.

Quality of care is the same as the hospital provides at ~~half the price~~ less fee. All State, Federal, HCFA, JACHO, AAAHC requirements will be followed to obtain certification and licensure.

State of Connecticut
Office of Health Care Access
Letter of Intent/ Waiver Form

All applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of OHCA's Regulations. Applicants should submit this form 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 more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below

	Applicant One	Applicant Two
Full legal name	Stanley J. Foster, MD P.C.	
DBA	same	
Name of Parent Corporation	same	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	1389 West Main Street Suite 306 Waterbury, CT 06708	
Applicant type (e.g., profit/ non-profit)	Profit	
Contact person, including title or position	Stanley Foster, MD, President Sally George, Manager	
Contact person's street mailing address	1389 West Main St. suite 306 Waterbury, CT 06708	
Contact person's phone #, fax # and e-mail address.	203-757-0583 203-757-0626-Fax SFOSTERMD@AOL.COM	

SECTION II. GENERAL APPLICATION INFORMATION

Proposal/Project Title: Surgical Center (cosmetic & Hand Surgery)

Type of Proposal, please check all that apply:

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

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

☐ Capital Expenditure pursuant to Section 19a-639, C.G.S.
☒ Project cost greater than $ 1,000,000
☐ Equipment Acquisition greater than $ 400,000
☒ New ☐ Replacement ☐ Major Medical
☐ Imaging ☐ Linear Accelerator
☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

Location of proposal (Town including street address): 513 Watertown Ave, Waterbury, CT

List all the municipalities this project is intended to serve: Local, city wide, Public, Greater Wtby. areas

Estimated starting date for the project: March 2000

Type of Facility: (Please check E for Existing and P for Proposed in all boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☒	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Other (specify): (E)_____			(P)_____			

If the project includes an additional function of an existing service or a reduction/elimination of service, provide the following:

Type of project: _____ **(Fill in the appropriate number(s) from page 4 of this form)**

Number of Beds

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Capital Expenditure: $ 1,000,000

Please provide the following breakdown as appropriate:

Renovations	$ 200,000.
New Construction	$ ✓ 500,000.
Fixed Equipment	$ 100,000.
Movable Equipment	$ ✓ 175,000
Fair Market Value of Leased Space	$
Fair Market Value of Leased Equipment	$
Other	$ ✓ 50,000.

Note: The aggregate of all categories should equal the estimated total capital expenditure.
"Other" includes any category not listed above, (e.g., land acquisition, service agreement, fees, etc.)

Major Medical equipment acquisition:

Unit Type	Model	Name	Number of Units	Cost

Computer acquisition: ☒ Yes ☐ No

Type of financing or funding source: (more than one can be checked)	☒	Applicant's Equity	☐	Lease Financing
	☒	Conventional Loan	☐	Charitable Contributions
	☐	CHEFA	☐	Grant Funding
	☐	Other (specify): _____		

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following:

1. What are the anticipated payer sources?
2. Identify any unmet need and how this project will fulfill that need?
3. What is the effect of this project on the health care delivery system in the State of Connecticut?
4. Are there any similar existing providers in the proposed geographic area?
5. Why should this project be approved?
6. Who will be responsible for providing the service?
7. Who is the target population?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER INFORMATION

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is related to a Year 2000 project that involves the purchase of:
- ☐ Physical Plant/ Non Medical equipment, total cost not to exceed $3,000,000
- ☐ Computer Diagnostic or Medical equipment Components, total cost not to exceed $2,000,000
- ☐ Computer Hardware and/ or Software, total cost not exceeding $3,000,000

☐ This request is for Replacement Equipment
- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____
- ☐ The cost of the equipment is not to exceed $2,000,000
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit.

For Office Use Only:

Action taken:

☐ Waiver Approved	☐ Waiver Denied
☐ Appropriate Forms Sent	List of the forms sent: _____

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 From.

Inpatient

1. Cardiac Services
2. Critical Care Unit
3. Hospice
4. Maternity
5. Med/ Surg.
6. Pediatrics
7. Rehabilitation Services
8. Transplants - Bone Marrow
9. Transplants - Organ
10. Trauma Centers
19. Other Inpatient

Outpatient

20. Ambulatory Surgery Center
21. Birthing Centers
22. Imaging Services
23. Lithotripsy
24. Mobile Services
25. Oncology Services
26. Outpatient Rehabilitation Services
27. Paramedics Services
28. Primary Care Clinics
29. Urgent Care Units
39. Other Outpatient

Behavioral Health

40. Detox - Inpatient
41. Detox - Outpatient
42. Psych. Only - Inpatient
43. Psych Only - Outpatient
44. Psych Only - Partial Hospital Program
45. Substance Abuse Only - Inpatient
46. Substance Abuse Only - Outpatient
47. Psych. and Substance Abuse - Inpatient
48. Psych. and Substance Abuse - Outpatient
49. Psych. and Substance Abuse - Partial Hospital Program
59. Other Behavioral Health

Non-Clinical

60. Facility Development
61. Non-Medical Equipment
62. Organizational Structure
71. Other Non-Clinical