CORAM

January 15, 2007

Ms. Karen Roberts, Compliance Officer
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
PO Box 340308
Hartford, CT 06134-0308

RE: Coram Alternate Site Services, Inc.
2 Barnes Industrial Park Road, Suite A
Wallingford, CT 06492

Dear Ms. Roberts:

Pursuant to your request dated December 28, 2006, enclosed please find a completed Connecticut Office of Health Care Access; *Form 2030, Letter of Intent* for the above referenced facility.

As discussed in our telephone conversations, Coram Alternate Site Services, Inc. ("Coram") is proposing to open an Ambulatory Infusion Suite at our Wallingford, CT location.

Should any further action be required on our part, please contact me at 800.267.2642. Thank you, in advance, for your assistance in this matter.

Sincerely,

Erik J. Heikkenen
Manager, Licensure & Certification

cc: Julie Williams, Director, Ambulatory Infusion Suites
Peggy Clinton, Area Clinical Director, East

State of Connecticut
Office of Health Care Access

Form 2030 Instructions:
Letter of Intent

Letter of Intent

All Applicants must complete the Letter of Intent (LOI) form prior to submitting a Certificate of Need (CON) application. The LOI, coupled with the CON application form specific to a given proposal, constitutes the CON request. The LOI consists of four sections that should provide sufficient information to allow the Office of Health Care Access (OHCA) to prepare the CON application form. These sections are:

- Section I APPLICANT INFORMATION
- Section II GENERAL APPLICATION INFORMATION
- Section III EXPENDITURE INFORMATION
- Section IV PROJECT DESCRIPTION.

All portions of Section I – IV **must be completed.** If any portion is incomplete, the LOI will be returned to you for completion. An incomplete LOI will not be used for meeting statutory deadline purposes. OHCA recognizes that some of the information requested might not be pertinent to your proposal. If this is the case, please indicate that the question is "Not Applicable".

OHCA recognizes that at the LOI phase of the application process, some of the information may be preliminary in nature and subject to modification prior to or at the time of the submission of the CON application form. Please notify OHCA immediately of any *significant* change or changes to information filed in the LOI. These modifications may constitute the filing of a new LOI.

Section III

All Applicants must complete the item identified as "Estimated Total Capital Cost."

OHCA requires an original and three copies of your completed Form 2030. All pages must be consecutively numbered. Please submit the completed Form 2030, Letter of Intent to:

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

If you have any questions concerning this form, please contact Kimberly Martone at (860) 418-7001.

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	Coram Alternate Site Services, Inc.	
Doing Business As	Coram Alternate Site Services, Inc.	
Name of Parent Corporation	Coram Specialty Infusion Services, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	2 Barnes Industrial Park Road, Suite A Wallingford, CT 06492	
What is the Applicant's Status: P for Profit or NP for Nonprofit	Profit	
Does the Applicant have Tax Exempt Status?	No	
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Susan Radolf, Branch Manager	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	2 Barnes Industrial Park Road, Suite A Wallingford, CT 06492	

Contact Person's Telephone Number	(203) 697-4100	
Contact Person's Fax Number	(203) 697-4101	
Contact Person's e-mail Address	radolfs@coramhc.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Coram Alternate Site Services, Inc. non-affiliated Ambulatory Infusion Suite

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.:

X New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

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

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

☐ Equipment Acquisition

☐ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

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

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

2 Barnes Industrial Park Road, Suite A, Wallingford, CT 06492

d. List each town this project is intended to serve: Entire state of Connecticut

e. Estimated starting date for the project: 2/2/2007

f. Type of project: #27, Other Outpatient
(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				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $30,467

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

Medical Equipment Purchases	
Medical Equipment Purchases	$5,960
Non-Medical Equipment Purchases*	$5,007
Land/Building Purchases	
Construction/Renovation	$19,500
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$30,467**
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	
Total Capital Cost	**$30,467**
Total Project Cost	**$30,467**
Capitalized Financing Costs (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
N/A				

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):

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

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: Coram Alternate Site Services, Inc.

Project Title: Coram Alternate Site Services, Inc. non-affiliated Ambulatory Infusion Suite

I, Vito Ponzio, Jr. (Name), Senior Vice President, Administration (Position)

of Coram Alternate Site Services, Inc. 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 Coram Alternate Site Services, Inc. (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486

and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 1/14/07

Subscribed and sworn to before me on January 14, 2007

Notary Public/~~Commissioner of Superior Court~~ _____

My commission expires: 10-5-10

RONDALYNE BILBY NOTARY PUBLIC STATE OF COLORADO MY COMMISSION EXPIRES 10-5-10

Project Type Listing

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

Inpatient

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

Outpatient

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

Non-Clinical

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

Coram Alternate Site Services, Inc., Wallingford, CT: Attachment: Section III(b)

Item	Description	Units	Cost	Total
Construction/Renovation	N/A	1	19,500	19,500
Infusion Chair	Medical Equipment	4	1,350	5,400
Medical Supplies	Medical Equipment	1	560	560
Steelcase Reception Room Table	Non-Medical Equipment	2	225	450
Steelcase Reception Room Chair	Non-Medical Equipment	4	513	2,052
Privacy Curtain	Non-Medical Equipment	4	375	1,500
Sanyo Mini Bar Refrigerator	Non-Medical Equipment	1	225	225
Magnavox Portable DVD Player	Non-Medical Equipment	4	100	400
Sony Head Phones	Non-Medical Equipment	4	20	80
Kuerig Coffee Maker	Non-Medical Equipment	1	300	300
				30,467

SECTION IV. PROJECT DESCRIPTION

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.

Coram Alternate Site Services, Inc. ("CASS") currently provides a variety of infusion therapy services to patients in a home setting. Therapies currently offered include, but are not limited to, parenteral and/or enteral nutrition, hemophilia, anti-infective and immune (IVIG), which includes Autoimmune Disorders, Primary Immune Deficiency and post transplant services.

The above services are provided under the applicable pharmacy licensure issued by the Department of Consumer Protection, Commission of Pharmacy.

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

Coram is a national provider of home infusion services and specialty pharmacy distribution with more than 70 branch locations across the country. Coram has begun to expand our infusion and specialty pharmacy services by providing patients, through their referring primary physicians, the opportunity to receive their infusion therapy in an Ambulatory Infusion Suite ("AIS") setting (see attached brochure).

Examples of therapies offered in Coram's AIS' include: Remicade or Tysabri. In the case of Tysabri, the FDA has mandated this medication can only be administered in Tysabri Outreach: Unified Commitment to Health ("TOUCH") certified infusion suites and cannot be provided in the home. In addition to the very specialized therapies of Remicade and Tysbri, Coram will continue to offer and provide parenteral and/or enteral nutrition, hemophilia, anti-infective, IVIG and the many other therapies we provide in a home setting.

The proposed AIS services will offer seamless integration with Coram's on-site specialty pharmacy and home care services as well as provide economic advantages to our patients as treatments in an AIS setting are often less expensive.

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

The current population for Coram are those patients who require TPN, Antibiotic therapy, Pain Management, IVIG, enteral feedings, or Aralast therapies. The target population are those patients whose injectible drug therapy should be administered in a controlled setting due to the risk of adverse infusion reactions such as Tysabri. Biological medications should be administered in an Ambulatory Infusion Suite. In addition, another target are those patients who do not feel comfortable or are unable to self-administer their prescribed therapy at home such as IVIG or Aralast therapy. Vivatrol therapy, as prescribes by psychiatrists for the treatment of alcoholism is another medication which must be administered in a controlled setting. As this physician population does not customarily perform infusion therapy in their office setting, the Coram AIS will serve this patient population for the Hartford, New Haven, and Fairfield counties, although patients throughout the state can be serviced. Currently there is no other suitable alternative for this patient population to receive this therapy in the Wallingford area as there are no other AIS'.

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

As mentioned above, the Coram AIS in Wallingford would serve those patients who either have no other convenient alternative to receive their therapy is a controlled setting other than a hospital ER such as patients prescribed for Tysabri therapy. The AIS would provide an alternative for those patients requiring an injectible therapy who do not feel comfortable performing the infusion independently at home, an alternative to safe and convenient care without having to visit the local hospital emergency department.

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

Although there are other Ambulatory Infusion Suites in the State of CT, to our knowledge, there are none in the Wallingford, CT area. In addition, for those patients on Coram service who request to be seen in an Ambulatory infusion Suite setting, it is unacceptable for the patient to be referred to a competitor ambulatory infusion suite because of payer issues, i.e. Coram is in network with the insurance company and the competitor may not be. Coram is currently an in network alternative for the following insurance companies: Cigna, Healthnet, Oxford Healthplan, United Healthcare and HCAP, Aetna, Anthem Blue Cross and Blue Shield of CT as well as several other plans.

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

As more biological pharmaceuticals are introduced in the market place, many, such as **Tysabri by Elan** Pharmaceuticals, will require administration in a controlled setting. Since it is not cost effective nor desirable for the patients nor the physicians for this proposed patient population to receive these drugs in the hospital Emergency departments, the Coram AIS is a cost effective, safe, clinically sound alternative. In addition, as Coram is in network with all major insurance companies, patients requiring this service will have an in network, cost effective alternative to receiving their injectible therapies.

7. Who will be responsible for providing the service?

Our proposed AIS will be located in a designated area of our facility where patients will receive their therapies, in a safe clinical environment. All ordered and prescribed medications with be prepared and dispensed from our on-site pharmacy by licensed Registered Pharmacist. Such infusion services shall be administrated and monitored by Coram's licensed Registered Nurses, within the scope of their licenses. Coram's Registered Nurses and Pharmacist will also continually consult with the patient's prescribing physician regarding such services and the patient's plan of care.

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

Coram has worked closely with our contracted commercial payors and healthcare plans to insure the contemplated AIS services will fulfill their patients' infusion therapy needs. The responses received have been very positive and we anticipate the AIS will be utilized by all contracted payors and commercial healthcare plans we currently conduct business with.

Coram will continue to review the Medicare and Medicaid reimbursement rules and regulations as they relate to the proposed AIS services and hope Medicare and Medicaid will approve such reimbursement incurred through providing services for their recipients.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 28, 2006

Ms. Marge Brown
Senior Vice President, Quality and Compliance
Corporate Compliance Officer
CORAM Corporate Headquarters
1675 Broadway, Suite 900
Denver, CO 80202

RE: Wallingford Connecticut Branch of CORAM Specialty Infusion Services

Dear Ms. Brown:

It has come to the attention of the Connecticut Office of Health Care Access ("OHCA") that CORAM Specialty Infusion Services ("CORAM") may be planning open an Infusion Suite in its Wallingford Connecticut branch location. Please note that OHCA is the Connecticut state regulatory agency which oversees the mandates of Section 19a-638 and 19a-639 of the Connecticut General Statutes which sets forth the Connecticut Certificate of Need process. Please view the OHCA website at www.ct.gov/ohca for more information regarding OHCA's mandates and the Certificate of Need process, statutes and regulations. OHCA's process requires that providers of freestanding ambulatory infusion suites seek and receive Certificate of Need authorization prior to commencement of operation. Please see attached, for comparison purposes, a copy of a September 20, 2005 Certificate of Need Determination issued by OHCA to Collins I.V. Care, Inc. regarding the establishment of a freestanding ambulatory infusion suite (currently a Certificate of Need application pending under Docket Number 05-30555-CON) and a copy of a Letter of Intent filed by Professional Home Care Services, Inc. for the establishment of an outpatient infusion therapy center (currently a Certificate of Need application pending under Docket Number 05-30609-CON).

If OHCA's understanding is accurate and CORAM Specialty Infusion Services does intend to commence operation of an outpatient infusion suite in Connecticut, CORAM should immediately file a completed Letter of Intent form with this agency in order to begin the Certificate of Need process. A copy of the OHCA Letter of Intent form is attached for your use and is also available on the OHCA website. If CORAM contends that the project does not fall within the Connecticut Certificate of Need laws, please file a full description of the intended project and how it specifically differs from the projects undertaken by Collins I.V. Care, Inc. and Professional Home Care Services, Inc. Please respond to this letter by **January 18, 2006**. Please contact me at (860) 418-7041 if you have any questions regarding this letter. Please contact Kimberly Martone, Supervisor of the Certificate of Need process at (860) 418-7029 if you have any questions regarding the Letter of Intent or the Certificate of Need process.

Sincerely,

Karen Roberts

Karen Roberts
Compliance Officer

Copy: Cristine A. Vogel, Commissioner, OHCA
Susan Cole, Director of Certification, OHCA
Kimberly Martone, Supervisor of CON, OHCA

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 20, 2005

John R. Collins
General Manager
Collins I.V. Care, Inc.
60 Watson Boulevard
Stratford, CT 06615

Re: Certificate of Need Determination, Report Number 05-30555-DTR
Collins I.V. Care, Inc. d/b/a Collins I.V. Care
Establish a Freestanding Ambulatory Infusion Suite

Dear Mr. Collins:

On July 22, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request for the estlabishment of a freestanding ambulatory infusion suite in Stratford, Connecitcut.

Please be advised that OHCA has reviewed your request and makes the following findings:

1. Collins I.V. Care, Inc. d/b/a Collins I.V. Care ("Collins I.V.") is a for-profit pharmacy located at 60 Watson Boulevard, Stratford, Connecticut that provides home infusion therapy throughout the State of Connecticut.

2. Collins I.V. is licensed by the State of Connecticut Department of Consumer Protection as a pharmacy and certified to provide infusion services.

3. Collins I.V. Care is accredited by the Joint Commission on Accreditation of Healthcare Organiations.

4. Collins I.V. Care proposes to establish an ambulatory infusion suite with its existing building at 60 Watson Boulevard in Stratford. The suite will allow patients to receive infusions administered by qualified infusion registered nurses. Currently, these patients are served at home or in a hospital.

5. A patient's infusion would be administered under the supervision of a qualified Registered Nurse. Supervison and direction will be provided by the Vice President of Operaitons who is a registered nurse certified in infusion therapy.

6. Care is provided to patients exclusively by an infusion therapy nurse. Collins I.V. is not licensed as a home health agency. It provides the service under its Pharmacy license.

7. Utilization of an ambulatory suite would be an option for patients that may be geographically and logistically convenient.

8. Commercial insurance companies would be billed for the services. There is no facility fee charged. The insurance companies privde reimbursement for medication, supplies, equipment, infusion pharmacy services and infusion nursing services.

9. The estimated capital cost associated with this proposal is $101,500.

10. Section 19a-630 of the Connecticut General Statutes states that a "Health care facility or institution" means any facility or institution engaged primarily in providing services for the prevention, diagnosis or treatment of human health conditions, including, but not limited to: Outpatient clinics; outpatient surgical facilities; imaging centers; home health agencies, as defined in section 19a-490; clinical laboratory or central service facilities serving one or more health care facilities, practitioners or institutions; hospitals; nursing homes; rest homes; nonprofit health centers; diagnostic and treatment facilities; rehabilitation facilities; and mental health facilities."

Based on the above findings, OHCA has determined that the addition of an ambulatory infusion suite at 60 Watson Boulevard, Stratford, Connecticut represents an additional service and will require Certificate of Need authorization pursuant to Section 19a-638 of the Connecticut General Statutes.

Please be advised that your letter dated September 9, 2005, and the CON Determination Form filed with OHCA on August 3, 2005, serve as your Letter of Intent. Your Certificate of Need Application form has been sent to you under separate cover. If you have any questions concerning this letter, please contact Laurie Greci at (860) 418-7001.

Sincerely,

Cristine A. Vogel
Commissioner

c: Sandra Bauer, Health Processing Technician, DPH, DCBR

CAV:lkg

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

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-643-79 of OHCA's Regulations. Please 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 there are 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	Professional Home Care Services, Inc.	
Doing Business As		
Name of Parent Corporation	Specialty Pharma, Inc.	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	104 Sebethe Drive Cromwell, CT 06416	
Applicant type (e.g., profit/non-profit)	Profit	
Contact person, including title or position	Lou Calamari President	
Contact person's street mailing address	104 Sebethe Drive Cromwell, CT 06416	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establishment of Outpatient Infusion Therapy Center

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.:

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

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

Project expenditure/cost cost greater than $ 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

c. Location of proposal (Town including street address):
400-2 Talcottville Road Vernon, CT

d. List all the municipalities this project is intended to serve: Vernon; Manchester; and East Hartford

e. Estimated starting date for the project:

f. Type of project: 25 (other outpatient) **(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 (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ 25,000

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$10,000
Medical Equipment (Purchase)	$ 5,000
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	$ 5,000
Sales Tax	
Delivery & Installation	$5,000
Total Capital Expenditure	**$ 25,000**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$ 25,000**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

X Applicant's Equity Lease Financing Conventional Loan

Charitable Contributions CHEFA Financing Grant Funding

Funded Depreciation Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) 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 (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

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

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

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

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

7. Who will be responsible for providing the service?

8. Who are the payers of this service?

Response to Section IV Questions Regarding Project Description:

Professional Home Care Services, Inc. ("PHCS") is a Connecticut corporation holding infusion therapy pharmacy licenses for the storage, dispensing and sale of parenteral, enteral and infusion therapies in connection with the provision of home infusion therapy services in Connecticut and has extensive experience regarding such therapies. PHCS proposes to introduce a new service in Connecticut that would offer infusion therapy at a central location for individuals that are not homebound. PHCS believes that there is a current, and a strong probability of an increasing future, demand for such services, and that it can provide these services in a more cost-effective manner than home infusion services for those who are not homebound. PHCS is in a position to establish and operate the proposed infusion therapy center in a manner that will assure that the proposed services will be effective, economic and of high quality. It is anticipated that, with the successful establishment of the proposed center, approval will be sought in the future for the establishment of similar centers in other Connecticut locations.

The propose infusion therapy center will be established at 400-2 Talcottville Road, in Vernon, Connecticut under an operating lease with the owner of the building. Initially four chairs for the delivery of infusion therapy will be installed at the center. Pharmaceuticals will be prepared at the JCAHO accredited PHCS pharmacy locations under sterile conditions by licensed pharmacists. Nursing services will be provided by nurses who are trained and experienced in providing infusion therapy services. It is not expected that all infusion therapy services will require physician supervision/presence. Infusion therapies for hydration and other common therapies may be infused without physician/APRN/physician assistant presence. However, infusion therapies involving biologicals or infusions where the possibility of an adverse reaction is high will be administered in the presence of a physician/APRN/physician assistant. The clinicians caring for the patients will have the appropriate and requisite credentials and training to provide the indicated level of supervision.

PHCS has consulted with a variety of commercial health insurers and other payers regarding the proposed new services and has met with encouragement from them to establish the proposed center. It is also anticipated that services with be provided pursuant to the Medicare and Medicaid programs.

Representatives of PHCS have consulted with representatives of the Connecticut Department of Public Health and the Office of the Attorney General regarding the licensure that would be required for the proposed services, and have been advised that the proposed center would be eligible for licensure as an outpatient clinic operated by a corporation pursuant to the provisions of Sections 19-13-D45 through 19-13-D53 of the Regulations of the Department of Public Health (Public Health Code).

Recently, new infusion therapies have been introduced for the treatment of certain chronic diseases, which for the longest time had no promising treatment options. These new therapies have been classified as "biologicals" and may represent the tip of the iceberg in terms of newly proven therapies. In addition to biologicals, there are many other therapies that are being shown to be most effective when administered intravenously (e.g., pain management, hydration, parenteral nutrition, anticoagulants to name just a few). Many of these therapies are appropriate for delivery outside the home, and, for many individuals, access and cost factors will make utilization of the proposed center preferable to the home services now provided.

PHCS believes that there are a number of physician offices in the service area identified in Section II.d that provide some infusion therapy services. Manchester and Rockville Hospital, which also provides infusion therapy services, is located in the contemplated service area. However, it is

PHCS' understanding that, for reasons that will be set forth in its application, as the demand for infusion therapy services outside the home increases, hospitals and physicians who currently deliver those services will be less inclined to provide them. This prospect underscores the importance of establishing centers like that proposed in order to assure continued access to infusion therapy services by those for whom home infusion is not appropriate.

404522 v1

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

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

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 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 Section V only.

State of Connecticut
Office of Health Care Access

Form 2030 Instructions:
Letter of Intent

Letter of Intent

All Applicants must complete the Letter of Intent (LOI) form prior to submitting a Certificate of Need (CON) application. The LOI, coupled with the CON application form specific to a given proposal, constitutes the CON request. The LOI consists of four sections that should provide sufficient information to allow the Office of Health Care Access (OHCA) to prepare the CON application form. These sections are:

- Section I APPLICANT INFORMATION
- Section II GENERAL APPLICATION INFORMATION
- Section III EXPENDITURE INFORMATION
- Section IV PROJECT DESCRIPTION.

All portions of Section I – IV **must be completed.** If any portion is incomplete, the LOI will be returned to you for completion. An incomplete LOI will not be used for meeting statutory deadline purposes. OHCA recognizes that some of the information requested might not be pertinent to your proposal. If this is the case, please indicate that the question is "Not Applicable".

OHCA recognizes that at the LOI phase of the application process, some of the information may be preliminary in nature and subject to modification prior to or at the time of the submission of the CON application form. Please notify OHCA immediately of any *significant* change or changes to information filed in the LOI. These modifications may constitute the filing of a new LOI.

Section III
All Applicants must complete the item identified as "Estimated Total Capital Cost."

OHCA requires an original and three copies of your completed Form 2030. All pages must be consecutively numbered. Please submit the completed Form 2030, Letter of Intent to:

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

If you have any questions concerning this form, please contact Kimberly Martone at (860) 418-7001.

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		
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail		
What is the Applicant's Status: P for Profit or NP for Nonprofit		
Does the Applicant have Tax Exempt Status?	Yes No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.		
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail		

Contact Person's Telephone Number		
Contact Person's Fax Number		
Contact Person's e-mail Address		

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

_____

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

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

☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

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

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

☐ Equipment Acquisition

☐ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

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

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

_____

d. List each town this project is intended to serve: _____

e. Estimated starting date for the project: _____

f. Type of project: _____
(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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $_____

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
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	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (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

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):

☐ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: _____

Project Title: _____

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

of _____ 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 _____ complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.
(Facility Name)

_____ _____
Signature Date

Subscribed and sworn to before me on _____

_____
Notary Public/Commissioner of Superior Court

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 Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 5, 2007

Susan Randolf
Branch Manager
Coram Alternate Site Services, Inc.
2 Barnes Industrial Park Rd. Suite A
Wallingford, CT 06492

Re: Letter of Intent, Docket Number 07-30906
Coram Alternate Site Services, Inc.
Establish an Ambulatory Infusion Suite in Wallingford
Notice of Letter of Intent

Dear Ms. Randolf:

On January 16, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Coram Alternate Site Services, Inc. ("Applicant") to establish an ambulatory infusion suite in Wallingford, at a total capital expenditure of $30,467.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Record Journal* pursuant to Sections 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:SL:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 5, 2007

Requisition # HCA07-116
FAX #: (203) 317-2233

Record Journal
11 Crown Street, Box 915
Meriden, CT 06450-0915

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, February 9, 2007.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Steven Lazarus** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:SL:bko

c: Sandy Salus, OHCA

Record Journal
Docket Number 07-30906

Letter of Intent
February 5, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Coram Alternate Site Services, Inc.
Town:	Wallingford
Docket Number:	07-30906-LOI
Proposal:	Establish an Ambulatory Infusion Suite in Wallingford
Total Capital Expenditure:	$30,467

The Applicant may file its Certificate of Need application between March 17, 2007 and May 16, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1729
RECIPIENT ADDRESS	912033172233
DESTINATION ID	
ST. TIME	02/05 11:50
TIME USE	00'45
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 5, 2007

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If there are any questions regarding this legal notice, please contact **Steven Lazarus** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

January 22, 2007

Susan Randolf
Branch Manager
Coram Alternate Site Services, Inc.
2 Barnes Industrial Park Road
Suite A
Wallingford, CT 06492

RE: Certificate of Need Application Forms, Docket Number 07-30906-CON
Coram Alternate Site Services, Inc.
Establish an Ambulatory Infusion Suite in Wallingford, Connecticut

Dear Ms. Randolf:

Enclosed are the application forms for Coram Alternate Site Services, Inc.'s Certificate of Need ("CON") proposal for to establish an ambulatory infusion suite in Wallingford, Connecticut with an associated capital expenditure of $30,467. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between March 17, 2007, and May 16, 2007.

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

The analyst assigned to the CON application is Steven W. Lazarus. Please feel free to contact him at (860) 418-7012, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than March 17, 2007, and may be submitted no later than May 16, 2007. The Analyst assigned to your application is Steven W. Lazarus and he may be reached at the Office of Health Care Access at (860) 418-7012.

Docket Number: 06-30906-CON

Applicant(s) Name: Coram Alternate Site Services, Inc.

Contact Person: Susan Randolf
Contact Title: Branch Manager
Coram Alternate Site Services, Inc.
Contact Address: 2 Barnes Industrial Park Road
Suite A
Wallingford, CT 06492

Project Location: Wallingford

Project Name: Establish an Ambulatory Infusion Suite in Wallingford, Connecticut

Type proposal: Section 19a-638 C.G.S.

Est. Capital Expenditure: $30,467

1. Expansion of Existing or New Service

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

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

A. Provide the primary and secondary service area towns for the proposed service area.

B. Provide the rationale for choosing the proposed primary and secondary service area towns.

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

D. If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town

E. Provide the population to be served, including the number of individuals to receive the proposed service. Include demographic Information, as appropriate.

F. Scheduling backlogs in service area

G. Travel distance from proposed site to service area towns

H. Hours of operation of existing & proposed service

I. Identify the existing providers of the proposed service in your service area.

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

K. Provide the units of service for the past three years of Coram Alternate Site Services, Inc.'s ("AIS") home infusion therapy operation in Connecticut, in the following table format:

Fiscal Year	Number of Patients Served	Number of Visits Performed	*Number of Patients Suitable for Ambulatory Infusion Suite Therapy
2004			
2005			
2006			
2007**			

*In the last column, indicate the number, or percentage of patients reported in Column 1 that would be suitable to receive their infusion therapy in an AIS.
**Provide year-to-date

L. Provide the units of service projected for the first three years of operation at the proposed AIS site , in the following table format. **Be sure to include calculation/derivation.**

Fiscal Year	Number of Patients	Number of Visits
*2007		
2008		
2009		
2010		

*Annualized

M. Provide the projected number of patients and the number of treatments for the following types of infusion therapy in the following table format:

Types of Infusion Therapy	2007*	2008	2009	2010
Hydration				
Parenteral nutrition				
Antibiotics				
Pain Medication				
Chemotherapy for treatment of cancer				
Other:				
Total				

*Annualized

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

Primary Service Area:

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

Secondary Service Area:

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

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

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

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

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

☐ Epidemiological studies ☐ Needs assessments
☐ Public information reports ☐ Market share analysis

☐ Other (Identify)
☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

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

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

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

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

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

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

☐ DPH
☐ Fire Marshall Report
☐ AAAHC
☐ Other:
☐ JCAHO
☐ Other States Health Dept. Reports
☐ (New Out-of-State Providers) AAAASF

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

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

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

G. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital (Applicant), Physician(s) working at the Hospital and/or any staff related to the proposal.

H. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

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

- ☐ Energy conservation
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

7. Miscellaneous

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

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

- ☐ Corporation (Inc.)
- ☐ Partnership
- ☐ Joint Venture
- ☐ Other (Specify):
- ☐ Limited Liability Company (LLC)
- ☐ Professional Corporation (PC)

B. Provide the following financial information:

i) Since the Applicant is not a hospital, please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

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

9. Major Cost Components/Total Capital Expenditure

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

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

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

10. Construction/Renovation Information

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

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

C. Explain how the proposed new construction or renovations will affect the delivery of patient care.

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

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

11. Capital Equipment Lease/ Purchase

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

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

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

12. Type of Financing

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

☐ Applicant's equity:

Source and amount:

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

☐ Grant:

Amount of grant	
Funding institution/ entity	

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

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

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

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

☐ Other financing alternatives:

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

B. Please provide copies of the following, if applicable:
i. Letter of interest from the lending institution,
ii. Letter of interest from CHEFA,
iii. Amortization schedule (if not level amortization payments),
iv. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

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

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

*Includes managed care activity.

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

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

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

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

ii) Please complete the enclosed, OHCA's **Financial Attachment II**.

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

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

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

vi) Describe how this proposal is cost effective.

14. Project Specific Questions:

A. As the proposal represents a new service for the State of Connecticut, as well as for the proposed service area, provide a discussion on the public need for the proposal. Include in the discussion an analysis of the factors that make an Ambulatory Infusion Suite ("AIS") a safe, efficient and cost-effective alternative to:

1. Home-based infusion therapy; and
2. Hospital-based infusion therapy.

B. Please provide a discussion on the patients that may be utilizing the proposed service, specifically on:

1. Demographics;
2. Treatments received; and
3. Primary diagnosis.

C. Where are the proposed patients currently receiving the proposed services and by whom?

D. Will the proposed services be offered/provided to children (under 18 years of age)?

E. What special accommodations will be made for the treatments to children?

F. Please detail the methods by which patients will receive their infusion therapy, i.e. intravenous, central line, etc.

G. How many patients does the Applicant propose to treat in a single day?

H. What is the average number of infusions by type of treatment? Provide source documentation to support minimum or maximum number of patients per day.

I. Will the Applicant's existing and/or new patients have a choice of AIS treatment or home-infusions? If a patient is suitable for either, will the patients be given their choice of treatment method?

J. Provide a staff organization chart for the proposed AIS. Please indicate which of the staff members will be on-site during hours of operation.

K. What procedures will be followed to assess a patient's ability to receive therapy? Who will be responsible for responsible for assessing a patient prior to treatment?

L. Describe the training that qualifies the person who will be providing the infusion treatment.

M. Please detail how the Applicant will conform with the Health Insurance Portability and Accountability Act ("HIPAA") Act of 1996.

Coram Alternate Site Service, Inc. (Connecticut)

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

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

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

Type of Service Description
Type of Unit Description:
# of Months in Operation

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