OPTIMUS HEALTH CARE

982 East Main Street
Bridgeport, CT 06608-2409
T (203) 696-3260
F (203) 339-7677
www.optimushealthcare.org

Other sites:
Bridgeport Community Health Center
471 Barnum Avenue
Bridgeport, CT 06608-2409
T (203) 333-6864
F (203) 332-0376

Chase Wellness Center
1071 East Main Street
Bridgeport, CT 06608
T (203) 330-2783

Ralphola Taylor Community Health Center
790 Central Avenue
Bridgeport, CT 06607-1796
T (203) 332-4564

Park City Primary Care Center
64 Black Rock Ave
Bridgeport, CT 06605
T (203) 579-5000

Hollow Community Health Center
82 George Street
Bridgeport, CT 06605
T (203) 576-3881

Stamford Community Health Center
137 Henry Street
Stamford, CT 06902
T (203) 327-5111

245 Selleck Street
Stamford, CT 06902
T (203) 359-6990

Stratford Community Health Center
727 Honeyspot Road
Stratford, CT 06415-7108
T (203) 375-7252

David S. Watson
Chairman of the Board

Ludwig M. Spinelli
Chief Executive Officer

Richard Torres
MD, MPH, FACP, CHES
Chief Medical Officer

Joint Commission
an Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

February 1, 2007

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

Re: Letter of Intent: Optimus Health Care, Inc.
Construction of New Facility at 2 Lipton Place
Stamford, Connecticut

Dear Commissioner Vogel:

Optimus Health Care, Inc. ("Optimus") is pleased to submit the enclosed Letter of Intent (LOI) for the construction of a new facility at 2 Lipton Place in Stamford, Connecticut.

Optimus seeks to consolidate three existing locations (Selleck, Henry and Atlantic Streets) into a single standalone building for the delivery of primary care and behavioral health. The proposed site at 2 Lipton Place will allow Optimus to construct a facility large enough to provide care to its existing population as well as many new patients. The proposed location will significantly improve the efficiency and delivery of patient care through its contemporary design and the reduction of duplicated services.

Optimus has previously secured the land and city approvals to construct a two-story, 13,300 square-foot building. In addition, Optimus has received approval from the Department of Health and Human Services (DHHS), Health Resources and Services Administration's (HRSA) for the proposed facility.

Please forward the Certificate of Need (CON) questions to my attention. I look forward to working with you and the Office of Health Care Access staff on this exciting project for Optimus.

Thank you for your time and attention.

Sincerely,

Ludwig M. Spinelli

Ludwig M. Spinelli
Chief Executive Officer

rm

enclosure

01

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	Optimus Health Care, Inc.	
Doing Business As	Stamford Community Health Center	
Name of Parent Corporation	Optimus Health Care, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	982 East Main Street Bridgeport, CT 06608	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
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.	Mr. Ludwig Spinelli Chief Executive Officer	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	982 East Main Street Bridgeport, CT 06608	

Contact Person's Telephone Number	(203) 696-3260 (x 3349)	
Contact Person's Fax Number	(203) 339-7677	
Contact Person's e-mail Address	lspinelli@opthc.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Construction of New Facility at 805 Atlantic Street, Stamford, CT

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:

805 Atlantic Street, Stamford, CT 06902

d. List each town this project is intended to serve:
Stamford (very small number of patients from Greenwich, Norwalk)

e. Estimated starting date for the project: June 2007 (begin construction), March 2008 (begin operations)

f. Type of project: 16,18, 27, 30
(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

Not applicable

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $4,431,840

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

Medical Equipment Purchases	$180,750
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	$419,250
Land/Building Purchases	
Construction/Renovation	$3,831,840
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$4,431,840**
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	**$4,431,840**
Capitalized Financing Costs (Informational Purpose Only)	$0

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

Listed below is a preliminary breakdown of the medical and non-medical equipment.

Major Medical Equipment	
Two ultrasound Machines	120,000
Two Fetal Monitors	20,000
Dopplers (5)	750
Other examroom Supplies (ob/gyn)	10,000
Internal Medicine & Pediatric Examrooms	30,000
Sub Total	180,750
Computers, servers, Office furniture, Copiers & other furnishings	419,250
Grand Total	**600,000**

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

Not applicable. The proposal does not have a total capital expenditure/cost of $20,000,000 or more.

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.

Not applicable. The project does not include any major medical equipment and/or imaging equipment. Medical equipment to be purchased has been identified in Section III (b) above.

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): **State bond funds**				

Background

Optimus Health Care Inc. ("Optimus"), formerly the Bridgeport Community Health Center, operates six full time health care facilities in Bridgeport, Stratford and Stamford and is a Federally Qualified Health Center (FQHC). Optimus serves a target area which is medically underserved and provides the full scope of outpatient care including Adult Medicine, OB/GYN, Pediatrics, Dental, Podiatry, Behavioral Health, Nutrition, Substance Abuse, HIV/AIDS, Social Services, and laboratory departments. Optimus has been accredited by the Joint Commission on Accreditation of Health Organizations, most recently in November 2004.

Optimus operates two full-time patient care locations in the city of Stamford; 245 Selleck Street and 137 Henry Street. In addition, it provides health care services at two locations (90 Fairfield Avenue and 597 Pacific Street) as part of its Stamford Homeless Program and maintains an administrative office for the homeless program at 616 Atlantic Street. Optimus is currently renovating space at 1351 Washington Boulevard for a dental program. This location is also the planned site for the delivery of primary care services to Stamford Hospital's clinic patients should Docket Number: 06-30764 (currently in completeness) receive OHCA approval.

Optimus seeks to consolidate three existing locations (Selleck, Henry and Atlantic streets) into a single standalone building for the delivery of primary care and behavioral health services to the existing and growing Optimus patient population. Care will continue to be provided at the two Homeless Program sites. The proposed site is less than two miles from either of the existing full service patient care sites and is centrally located in the South End of Stamford. The site is easily accessible by public transportation. Optimus is the recipient of a medical expansion grant from the Department of Health and Human Services (DHHS), Health Resources and Services Administration's (HRSA) Bureau of Primary Care. This grant is for the expansion of Optimus' medical capacity in Stamford. The conditions of the grant require Optimus to treat a large number of new patients by expanding its Stamford-based services. In order to expand its medical capacity in Stamford, Optimus must have additional exam and clinical support space. The existing locations are too small for the current patient population and do not offer expansion options. The proposed site at 805 Atlantic Street will allow Optimus

to construct a facility large enough to provide care to its existing population as well as new patients as required by the HRSA grant. The proposed location will significantly improve the efficiency and delivery of patient care.

Optimus has previously secured the land and city approvals to construct a two-story, 13,300 square foot building at 805 Atlantic Street, Stamford, CT. As an FQHC, Optimus must obtain and has received HRSA approval to proceed with the building's construction. Architectural plans have been developed and have gone out to bid. Optimus has just selected a construction management company based on the bids and has informed this company of their selection as well as the need for CON approval prior to the start of any construction activities.

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.

   Optimus Health Care Inc. provides the full spectrum of primary care services, including Adult Medicine, OB/GYN, Pediatrics, Dental, Podiatry, Behavioral Health, Nutrition, Substance Abuse, HIV/AIDS, Social Services, and laboratory departments.

   Optimus' DPH Licenses for its Stamford locations are included as Attachment I.

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

   All of the existing services noted above will be offered at the proposed 805 Atlantic Street site with the exception of dental services. Since a large dental service is being constructed at 1351 Washington Boulevard in Stamford, dental services are not currently being planned for the 805 Atlantic Street site. However, should expansion of dental services be required in the future, there will be shelled space available at 805 Atlantic Street for such expansion.

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

   The target population will remain the current population served which includes children and adults that reside in the South and West End of Stamford and those in the medically underserved/health professional shortage service area. This service area has a population of approximately 57,000 people, which represented approximately 40% of the total city of Stamford population in 2000. The target population is challenged by poverty, unemployment, low paying cash jobs, cultural isolation, and access barriers to primary care, dental and social services. Approximately 32% of the residents live below the 200% Federal Poverty Level and

more than 40% are immigrants, many without health insurance. It is anticipated that more than 10,000 individuals will receive care at the proposed site each year.

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

As noted above in the Background Section, Optimus will consolidate three existing sites into the proposed site at 805 Atlantic Street. The existing patient care sites have a number of deficiencies which limit Optimus' ability to adequately meet all current and projected patient demand. The 137 Henry Street site has an inadequate number of exam rooms, the rooms are too small and there is poor ventilation. Patient flow is negatively impacted and patient privacy is difficult to maintain due to the current layout and design. Additionally, there is almost no storage space. The location at 245 Selleck Street is even smaller than the Henry Street location and therefore has all of the same deficiencies, many of which are more significant.

Optimus operates the only full service FQHC in the city of Stamford. Demand for its services has grown substantially over the past few years. Optimus is also one of only two Immigrant Health Centers in the State of Connecticut and has seen a tremendous increase in the size and needs of the immigrant population in Stamford.

The proposed facility at 805 Atlantic Street will provide Optimus with sufficient exam room space, clinical support space, and administrative space to meet the growing demand for its services and will improve the delivery of patient care.

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

There are no other full-service FQHCs in the proposed geographic area, however there are a limited number of providers who provide some or all of the same services and they are listed below:

- **Stamford Dental Center (dental services only);**
- **Stamford Health Department has part-time clinics for well-child care, STDs, HIV prevention, counseling and testing, blood pressure screening and a traveler's clinic;**
- **St. Joseph's Family Life Center (Center will be closing in 2007 and patients will be transitioned to Optimus as per Docket Number: 06-30692);**
- **Stamford Hospital offers the full spectrum of inpatient and ambulatory care. (Transfer of its primary care clinics to Optimus has been proposed as per Docket Number: 06-30764);**
- **F.S. Dubois Center is the state regional mental health agency and provides behavioral health care; and**
- **A small number of private psychiatric practices that accept Medicaid or offer a sliding fee scale for behavioral health care.**

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

The effect of this project on the health care delivery system in Connecticut will be positive. Optimus' existing patients will be provided increased access to high

quality primary care services. The growing poor, immigrant and uninsured population in Stamford will have improved access to primary care services, which should decrease emergency room utilization and improve the overall health status of this population. Currently, Optimus leases its space at Henry and Selleck streets and the hours of operation are limited based on the working hours of those buildings. The proposed building will permit Optimus to expand its hours of operation since it will own and control the building. Services will be able to be provided into the evening or on weekends or holidays if needed. This will improve access to these needed services for the target population. Patient care will be delivered more efficiently and cost effectively by consolidating the existing two patient care locations into one single location.

7. Who will be responsible for providing the service?

   Optimus Health Care, Inc. 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?

   Optimus Health Care receives reimbursement from a variety of payers including:
   - **Medicare;**
   - **Medicaid (Title XIX and Husky);**
   - **Commercial Insurers; and**
   - **Self Pay (as per sliding fee scale).**

   Since Optimus serves a large uninsured patient population, it is also the recipient of state and federal grant funds and does provide a significant amount of charity care.

   The current payers will remain the same when the proposed project becomes operational.

AFFIDAVIT

To be completed by each Applicant

Applicant: Optimus Health Care, Inc.

Project Title: Construction of New Facility at 2 Lipton Place, Stamford, CT

I, Ludwig Spinelli, Chief Executive Officer
(Name) (Position – CEO or CFO)

of Optimus Health Care, 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 Optimus Health Care Inc. 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.

Ludwig Spinelli
Signature

2/1/07
Date

Subscribed and sworn to before me on 1st day February, 2007

Margarita S. Tocces
Notary Public/~~Commissioner of Superior Court~~ STATE OF Connecticut
MARGARITA S. TOCCES

My commission expires: May 31, 2008

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

ATTACHMENT I

DPH LICENSES

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0343

Outpatient Clinic

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

Optimus Health Care, Inc. of Bridgeport, CT, d/b/a Stamford Community Health Center is hereby licensed to maintain and operate an Outpatient Clinic.

Stamford Community Health Center is located at 137 Henry Street, Stamford, CT 06902.

This license expires **September 30, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2004.

Services:
Well Child Services
Family Planning Services
Primary Care Services

License revised to reflect:
11-14-06 *Licensee name changed eff: 6/22/06*

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0371

Outpatient Clinic

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

Optimus Health Care, Inc. of Bridgeport, CT, d/b/a Stamford Community Health Center is hereby licensed to maintain and operate an Outpatient Clinic.

Stamford Community Health Center is located at 245 Selleck Street, Stamford, CT 06902.

This license expires **December 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006.

Services:
Primary Care Services
Well Child Services

License revised to reflect:
11-14-06- *Licensee name changed eff: 6/22/06*

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0414

Outpatient Clinic

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

Optimus Health Care, Inc. of Bridgeport, CT, d/b/a Stamford Community Health Center Homeless Program is hereby licensed to maintain and operate an Outpatient Clinic.

Stamford Community Health Center Homeless Program is located at 90 Fairfield Avenue, Stamford, CT 06608.

This license expires **March 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 21, 2005.
Services:
Primary Care Services

License revised to reflect:
11-14-06 *Licensee name changed eff: 6/22/06*.

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0415

Outpatient Clinic

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

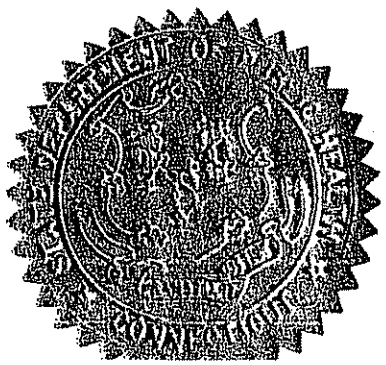
Optimus Health Care, Inc. of Bridgeport, CT, d/b/a Stamford Community Health Center Care for The Homeless is hereby licensed to maintain and operate an Outpatient Clinic.

Stamford Community Health Center Care for The Homeless is located at 597 Pacific Street, Stamford, CT 06902.

This license expires **March 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 21, 2005.
Services:
Primary Care Services

License revised to reflect:
11-14-06 *Licensee name changed eff: 6/22/06*.



J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Mr. Ludwig Spinelli
Chief Executive Officer
Optimus Health Care, Inc., d/b/a Stamford Community Health Center
982 East Main Street
Bridgeport, CT 06608

Re: Letter of Intent; Docket Number: 07-30914
Optimus Health Care, Inc., d/b/a Stamford Community Health Center
Construction of a Replacement FQHC Facility in Stamford
Notice of Letter of Intent

Dear Mr. Spinelli:

On February 2, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Optimus Health Care, Inc., d/b/a Stamford Community Health Center ("Applicant") for the construction of a replacement FQHC facility in Stamford at a total capital expenditure of $4, 431,840.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Advocate* pursuant to Section 19a-639 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:JH:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Requisition # HCA07-122
Email: obits@scni.com

The Advocate
75 Tresser Blvd.
Stamford, CT 06903

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 **Monday, February 12, 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 **Jack Huber** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

The Advocate
Docket Number 07-30914

Letter of Intent
February 8, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Optimus Health Care d/b/a Stamford Community Health Center
Town:	Stamford
Docket Number:	07-30914-LOI
Proposal:	Construction of a Replacement FQHC Facility in Stamford
Total Capital Expenditure:	$4,431,840

The Applicant may file its Certificate of Need application between April 3, 2007 and June 2, 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.

Greer, Leslie

From: Classified (SCNI) [classified@scni.com]
Sent: Thursday, February 08, 2007 3:38 PM
To: Greer, Leslie
Subject: RE: Legal Ad

Request Received.

Ashwin Mital
Legals Rep
203-316-2004
legal.notices@scni.com

> ----------
> From: Greer, Leslie
> Sent: Thursday, February 8, 2007 15:30
> To: SCNI Obits
> Subject: Legal Ad
>
> <<File: 07-30914 LOI Advocate.doc>>
> February 8, 2007
>
>
>
> Dear Legal Ad,
>
>
>
> Please post the attached legal ad in your paper by February 12, 2007.
> Please notify me that you have received this request.

>
> Thank you,
>
>
>
>
>
> Leslie M. Greer
>
> Office of Health Care Access
>
> (860) 418-7001
>
> Leslie.Greer@po.state.ct.us
>
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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Ludwig M. Spinelli
Chief Executive Officer
Optimus Health Care
982 East Main Street
Bridgeport, CT 06608

RE: Certificate of Need Application Forms; Docket Number: 07-30914-CON
Optimus Health Care, Inc. d/b/a Stamford Community Health Center
Construction of a Replacement FQHC Facility in Stamford

Dear Mr. Spinelli:

Enclosed are the application forms for Optimus Health Care's Certificate of Need ("CON") proposal for the Construction of a Replacement FQHC Facility in Stamford with an associated capital expenditure of $4,431,840. According to the parameters stated in Section 19a-639 of the Connecticut General Statutes, the CON application may be filed between April 3, 2007, and June 2, 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 CON 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 Attachments and other data as appropriate be in MS Excel format.

The OHCA analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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, an answer of "Not Applicable" may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than April 3, 2007, and may be submitted no later than June 2, 2007. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached directly at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number: 07-30914-CON

Applicant Name: Optimus Health Care, Inc.,
d/b/a Stamford Community Health Center

Contact Person: Ludwig Spinelli

Contact Title: Chief Executive Officer

Contact Address: Optimus Health Care, Inc.
982 East Main Street
Bridgeport, CT 06608

Project Location: Stamford

Project Name: Construction of a Replacement FQHC Facility

Proposal Type: Section 19a-639, C.G.S.

Estimated Total Capital Expenditure: $4,431,840

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE:_____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

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: _____

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. Explain how it was determined there was a need for the proposal in your service area. Provide the following information:

a) Service area towns.
b) The units of service (i.e. primary care, dental, mental health, substance abuse services, etc.) for the past three fiscal years.
c) The units of service projected for the first three years of operation after the completion of the new facility. **Include the derivation of the projections and any associated calculations.**
d) The population to be served by the replacement facility.
e) Hours of operation of existing/proposed services.

B. 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.

C. 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) _____

5. Quality Measures

A. 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 Committee for Quality Assurance ☐ Public Health Code & Federal Corollary

☐ National Association of Child Bearing Centers ☐ American College of Obstetricians & Gynecologists ☐ American College of Surgeons

☐ Report of the Inter-Society Council for Radiation Oncology ☐ American College of Radiology ☐ Substance Abuse and Mental Health Services Administration

☐ Other: Specify _____

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

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

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

☐	DPH	☐	JCAHO
☐	Fire Marshall Report	☐	Other States Health Dept. Reports (new out-of-state providers)
☐	AAAHC	☐	AAAASF
☐	Other: _____		

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

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

F. Provide a copy of any plan of action which has been formulated to address the above action against the Applicant, its physicians and/or any staff related to the proposal.

G. Provide a copy of the most recent Quality Assurance plan.

[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.

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

7. Miscellaneous

A. Will this proposal affect any of 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. Please provide the State of Connecticut Department of Public Health license currently held.

8. Financial Information

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

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

B. 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.

9. Major Cost Components/Total Capital Expenditure

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

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

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

10. Construction 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/proposed floor plans and site plan.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

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

E. 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:

1.	What is the anticipated residual value at the end of the lease or loan term?	$_____
2.	What is the useful life of the equipment?	___ Years
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	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.)	

13. Revenue, Expense and Volume Projections

A. 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 or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

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. **Please complete the enclosed, OHCA's 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) 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.).

iii) 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.

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

v) Describe how this proposal is cost effective.

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

12. 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				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Payer Category:										
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