STAMFORD HOSPITAL | The Regional Center for Health

Affiliate Columbia University-College of Physicians & Surgeons
Member NewYork-Presbyterian Healthcare System
A Planetree Hospital

30 Shelburne Road
P.O. Box 9317
Stamford, CT 06904-9317
203.276.1000
www.stamhealth.org

March 26, 2007

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

Re: The Stamford Hospital - Establishment of a Freestanding Endoscopy Center

Dear Commissioner Vogel:

Please find enclosed an original and five copies of the The Stamford Hospital's Letter of Intent regarding the Establishment of a Freestanding Endoscopy Center. The appropriate forms are attached and will provide the required information to allow your office to prepare the Certificate of Need application forms.

Please contact me at 203-276-7510 with any questions.

Respectfully submitted,

David L. Smith
Senior Vice President,
Strategy and Market Development

cc: Steve Cowherd
Jeffers & Ireland, P.C.

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	The Stamford Hospital	Stamford Endoscopy Center, LLC ("SEC, LLC")
Doing Business As	The Stamford Hospital	
Name of Parent Corporation	Stamford Health System, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	P.O. Box 9317 30 Shelburne Road Stamford, CT 06904	c/o Merritt Healthcare 195 Danbury Road, Whitlock Building Wilton, CT 06897
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	P
Does the Applicant have Tax Exempt Status?	Yes X No	Yes No X
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	David L. Smith SVP Strategy & Market Development	Matt Searles Developer/Manager

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Stamford Hospital P.O. Box 9317 30 Shelburne Road Stamford, CT 06904	c/o Merritt Healthcare 195 Danbury Road Whitlock Building Wilton, CT 06897
Contact Person's Telephone Number	(203) 276 - 7510	(203) 563 – 9470, 103
Contact Person's Fax Number	(203) 276 - 5529	(203) 563 – 9589
Contact Person's e-mail Address	dsmith@ stamhealth.org	msearles@ merritthealthcare.com

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establishment of a Freestanding Endoscopy Center ("SEC, LLC") in Stamford, Connecticut.

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:

1351 Washington Avenue, Stamford Connecticut, 06902.

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

Stamford, Greenwich, Cos Cob, Riverside, New Canaan, Darien & Norwalk.

e. Estimated starting date for the project:

April 2008.

f. Type of project:

11 - Ambulatory Surgery Center.

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: $2,500,000

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	700,000
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	1,800,000
Other (Non-Construction) Specify: Share of Leasehold Exp.	
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	2,500,000
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: The Stamford Hospital, SEC, LLC

Project Title: Establishment of a freestanding Endoscopy Center ("SEC, LLC") in Stamford Connecticut.

I, Brian Grissler, President and CEO of Stamford Hospital – a member of SEC, LLC, 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 Stamford Hospital and SEC, LLC 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

3/23/07.
Date

Subscribed and sworn to before me on 23rd day of march 2007.

Ilaine Perez
Notary Public/Commissioner of Superior Court

My commission expires: ILAINE PEREZ NOTARY PUBLIC MY COMMISSION EXPIRES APR. 30, 2011

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

Project Description

The Stamford Hospital ("Stamford" or the "Hospital") is a 315 bed regional health center servicing Southwestern, Connecticut. Together with its physicians, the mission of the Hospital is to provide a broad range of high-quality health and wellness services focused on the need of its communities. The Hospital maintains an educational partnership with Columbia University College of Physicians and Surgeons for its teaching programs in internal medicine, family practice, psychiatry, obstetrics/gynecology and surgery. Stamford Hospital is a subsidiary of the Stamford Health System, Inc.

Stamford Hospital proposes to establish the Stamford Endoscopy Center (the "SEC" or the "Center") in Stamford, Connecticut. The SEC will be freestanding and will be a joint venture between Stamford Hospital and utilizing physician members. The SEC will be 50% owned by Stamford Hospital and 50% owned by gastroenterology physicians practicing within the Hospital's service area. The Center will occupy space in offices currently under lease by Stamford at 1351 Washington Avenue. SEC will seek licensure with the Connecticut Department of Public Health, Medicare certification and third party accreditation.

The demand for endoscopy and colonoscopy procedures are increasing throughout the US and Connecticut due to an aging population and medical advances in the use of minimally invasive technology and preventative care. In addition, the US healthcare system has experienced a trend whereby endoscopy centers have been moving out of the hospital setting into the freestanding facilities. Many of these freestanding centers are physician owned or formed as joint ventures with hospitals or companies specializing in the development and management of endoscopy centers. Stamford's management has indicated a philosophical support for selected physician hospital joint ventures during the development of its Strategic Plan.

The project is expected to enhance the health care delivery system in Connecticut. Specifically, the project will provide an efficient and cost effective facility for the delivery of gastroenterology outpatient procedures and will assist the Stamford Health System in accommodating the growing demands of its expanding cardiovascular services, imaging services and other ambulatory initiatives services of the Hospital at the Tully Health Center.

The patient base the Hospital intends to migrate to the Center is located primarily in the towns of Stamford, New Canaan, Greenwich, Wilton, Darien & Norwalk. The procedures which will be performed at the Center are currently performed in Stamford Hospital and in the Tully Health Center on patients from the Stamford Health System service area. Because these procedures are migrating from Stamford Health System facilities, the Applicant anticipates no impact on existing providers in the service area. Notwithstanding, there are two other freestanding endoscopy centers in the service area; Diagnostic Endoscopy in Stamford and Greenwich Endoscopy.

The SEC will seek to participate with Medicare and Medicaid and will seek to enter into contracts with major commercial payors. The Center will treat all patients regardless of ability of the patient to pay for services.

The SEC will enter into a development and management contract with certain principals of Merritt Healthcare Solutions.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 28, 2007

Mr. David Smith
Senior Vice President Strategy and Market Development
The Stamford Hospital
P.O. Box 9317
Stamford, CT 06904

Re: Letter of Intent, Docket Number 07-30946
The Stamford Hospital
Establishment of the Stamford Endoscopy Center at 1351Washington Avenue, Stamford. The new center will be a joint venture between Stamford Hospital and utilizing physician members.
Notice of Letter of Intent

Dear Mr. Smith,

On March 27, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Stamford Hospital ("Applicant") for the establishment of the Stamford Endoscopy Center at 1351Washington Avenue, Stamford. The new center will be a joint venture between Stamford Hospital and utilizing physician members, at a total capital expenditure of $2,500,000.

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 28, 2007

Requisition # HCA07-151
Email: obits@scni.com

The Stamford 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 **Sunday, April 1, 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 Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LKG:lmg

c: Sandy Salus, OHCA

The Advocate
Docket Number 07-30946

Letter of Intent
March 28, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	The Stamford Hospital
Town:	Stamford
Docket Number:	07-30946-LOI
Proposal:	Establishment of the Stamford Endoscopy Center at 1351 Washington Avenue, Stamford. The new center will be a joint venture between Stamford Hospital and utilizing physician members
Total Capital Expenditure:	$2,500,000

The Applicant may file its Certificate of Need application between May 26, 2007 and July 25, 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.

Olejarz, Barbara

From: System Administrator [postmaster@tribune.com]
Sent: Wednesday, March 28, 2007 3:48 PM
To: Olejarz, Barbara
Subject: Delivered: Legal Ad

Legal Ad

<<Legal Ad>> Your message

To: SCNI Obits
Subject: Legal Ad
Sent: Wed, 28 Mar 2007 13:47:33 -0600

was delivered to the following recipient(s):

SCNI Obits on Wed, 28 Mar 2007 14:47:52 -0600
MSEXCH:MSExchangeMTA:Chicago-Tower:ERD-CHI-EXMB4

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 27, 2007

David Smith
Senior Vice President Strategy and Market Development
The Stamford Hospital
P.O. Box 9317
Stamford, CT 06904 9317

RE: Certificate of Need Application Forms, Docket Number 07-30946-CON
The Stamford Hospital
Establishment and Operation of a Freestanding Endoscopy Center

Dear Mr. Smith:

Enclosed are the application forms for The Stamford Hospital's Certificate of Need ("CON") proposal for the establishment and operation of a freestanding endoscopy center with an associated capital expenditure of $2,500,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between May 26, 2007, and July 25, 2007.

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

The analyst assigned to the CON application is Laurie K. Greci. Please feel free to contact her at (860) 418-7001, 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, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than May 26, 2007, and may be submitted no later than July 25, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30946-CON

Applicant's Name: The Stamford Hospital

Contact Person: David Smith
Contact Title: Senior Vice President Strategy and Market Development
The Stamford Hospital

Contact Address: P.O. Box 9317
Stamford, CT 06904-9317

Project Location: Stamford

Project Name: Establishment and Operation of a Freestanding Endoscopy Center

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

Est. Capital Expenditure: $2,500,000

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.

i) Provide the following information:
   a) List the primary service area towns (PSA). Provide the rationale for choosing these PSA towns.
   b) List the secondary service area towns (SSA). Provide the rationale for choosing these SSA towns.
   c) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   d) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   e) Scheduling backlogs in service area
   f) Travel distance from proposed site to service area towns
   g) Hours of operation of existing/proposed service

ii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

iii) Provide the information as outlined in the following table for the existing providers' in the Applicant's PSA & SSA:

Service Area (PSA or SSA)	Provider Name	Number of Operating Rooms				Estimated Capacity for Proposal		Current Utilization[7]
		Available[1]	Utilized[2]	Not Utilized[3]	Equipped for Proposal[4]	Minimum[5]	Maximum[6]	

[1] Include used, equipped, and shell space.
[2] Include those actually used to perform surgeries.
[3] Include those not used and those that are equipped or are only shell space.
[4] Include those rooms that are uniquely equipped to perform the type of surgeries included in the proposal.
[5] Minimum number of surgeries to be performed in a single operating room for one year. Provide an explanation of the criteria or basis used to estimate the number. Provide documentation to support the criteria or basis used.
[6] Maximum number of surgeries of the type included in the proposal that can optimally be performed in a single operating room(s) in one year. Provide an explanation of the criteria or basis used to estimate the number. Provide documentation to support the criteria or basis used.
[7] Report the most current 12 month period.

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

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)
☐ 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. Affiliations, Mergers, Acquisitions and Changes in Ownership

A. Provide a copy of the written agreement or memorandum of understanding between the Applicants related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

B. Identify the following items for each Applicant:

i) Geographical service area.
ii) Health care services provided.
iii) Physician referral patterns.
iv) Corporate or entity structural relationships.
v) Shared service arrangements (e.g., Group Purchasing, billing etc.).

C. Provide for each Applicant the following information related to the proposal:

i) Articles of Incorporation, Articles of Organization or Partnership Agreements (all that are appropriate).
ii) Legal chart of corporate or entity structure.
iii) Board of Directors or governing body resolutions approving the proposal.
iv) Current and proposed percentage of ownership.
v) Changes in legal status.
vi) Changes in membership of board of directors or governing body.
vii) Changes in independence of board of directors or governing body.
viii) Changes in facility licensed beds, health care services, service areas, locations and management.
ix) Medicare provider number.
x) Identify if a new cost center will be established or if an existing cost center will be utilized. Provide the units of service for all new cost centers.

9. 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. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA

copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) Provide the name and units of service for the new cost center to be established for the proposal.

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

10. 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.

11. 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 and proposed floor plans.

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	

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 for three years with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	FY____ Projected Payer Mix	FY_____ Projected Payer Mix	FY_____ 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 a copy of the charity care policy for the new Center. Include a list of sliding fees as available.

D. 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.** 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.). ***Note**: Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

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.

14. Project Specific Questions

A. Referring to the definitions[2] given below, check each level of anesthesia being used or proposed for use:

☐ Minimal Sedation ("Conscious Sedation") ☐ Moderate Sedation/Analgesia

☐ Deep Sedation/Analgesia ☐ General Anesthesia

Minimal Sedation is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesis ("Conscious Sedation") describes a medically controlled state of depressed consciousness that allows protective reflexes to be maintained. The patient retains the ability to independently maintain his or her airway and to respond purposefully to verbal commands and/or tactile stimulation. Moderate Sedation and Analgesia is a state that allows patients to tolerate unpleasant

[2] Source: American Society of Anesthesiologists, October 1999.

procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and tactile stimulation. Those patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree than encompassed by sedation/analgesia.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

B. List the anesthetic and/or sedating drugs currently used by the Facility. List the drug's common chemical name and/or brand name.

_____

_____

_____

C. List the monitoring equipment currently available at the Facility.

_____

_____

_____

D. List the emergency resuscitative equipment currently available at the Facility.

_____

_____

_____

E. Attach a copy of the Facility's Conscious Sedation Protocol and/or Anesthesia Protocol as amended to date.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

13. D (i). Please provide one year of actual results and three years of projections of **The Stamford Hospital** 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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs										

***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. D (i). Please provide one year of actual results and three years of projections of **Stamford Endoscopy Center's** 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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs										

***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. D(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		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue Col. 2 * Col. 3	Deductions	Care	Debt	Revenue Col.4 - Col.5	Expenses Col. 1 Total *	from Operations Col. 8 - Col. 9
Total Facility by Payer Category:								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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