St. Vincent's Medical Center

November 6, 2007

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

Re: St. Vincent's Medical Center
Establishment of Hyperbaric Oxygen Therapy Service and Relocation of Ambulatory Wound Care Services

Dear Commissioner Vogel:

I am pleased to submit the attached Letter of Intent for the establishment of Hyperbaric Oxygen Therapy and the relocation of ambulatory wound care services. St. Vincent's currently provides care to patients suffering from chronic wounds. Care includes the diagnosis, treatment, and prevention of future wounds. Patients currently receive such care at several locations throughout St. Vincent's including outpatient clinics, the emergency department and the inpatient units. There is a need to centralize ambulatory wound care services and add Hyperbaric Oxygen Therapy (HBOT) services. These efforts are being pursued based on patient needs and community physician requests.

Due to the absence of any available on-campus space, the major construction project currently underway, and the lack of adequate parking at St. Vincent's for the next several years, it is proposed that the consolidation of all existing ambulatory wound services and the addition of Hyperbaric Oxygen Therapy (HBOT) be located off-campus at 115 Technology Drive in Trumbull, CT. The proposed location offers patients a convenient and easily accessible location. The site can be accessed either by car or public bus transportation. There is ample surface parking adjacent to the building and the building can be easily accessed by patients who require a wheelchair or other ambulation assistance. The Hospital currently operates a surgical physician practice at the same location and the building is also occupied by many St. Vincent's affiliated physician practices.

Please send all applicable forms to my attention. St. Vincent's management staff and I look forward to the working with you and the Office of Health Care Access staff on this important project.

Sincerely,

John C. Gleckler
Chief Financial Officer

Enclosures

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 the Applicant(s), 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	Saint Vincent's Medical Center	
Doing Business As		
Name of Parent Corporation	St. Vincent's Health Services	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2800 Main Street Bridgeport, CT 06606	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes X No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Mr. John Gleckler Chief Financial Officer	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	2800 Main Street Bridgeport, CT 06606	
Contact Person Telephone Number	(203) 576-5412	
Contact Person Fax Number	(203) 576-5345	

Contact Person e-mail Address	jgleckler@stvincents.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Establishment of Hyperbaric Oxygen Therapy Service and Relocation of Ambulatory Wound Care Services

b. Project Proposal: Relocate existing ambulatory wound care services from 2800 Main Street/Bridgeport, CT to115 Technology Drive/Trumbull, CT due to space constraints on/near the hospital campus and the acquisition/purchase of two hyperbaric oxygen chambers to serve existing wound care patients.

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☒ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☒ Other Outpatient *(specify)* Wound and Hyperbaric Oxygen Therapy Center

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

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

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

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

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

☐ New equipment acquisition and operation
☐ Replacement equipment with disposal of existing equipment
☐ Major medical equipment
☐ Change in ownership or control

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

115 Technology Drive, Trumbull, CT 06611

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

Primary market: Bridgeport, Easton, Fairfield, Monroe, Shelton, Stratford, and Trumbull
Secondary market: Milford, Newtown, Norwalk, Wilton, Weston, and Westport

h. Estimated starting date for the project: 2/1/08

i. If the proposal includes change in the number of beds provide the following information:

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$521,368**

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

Major Medical Equipment Purchases*	$183,100
Medical Equipment Purchases*	24,748
Non-Medical Equipment Purchases*	33,520
Land/Building Purchases	
Construction/Renovation	280,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$521,368**
Major Medical Equipment – Fair Market Value of Leases 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	**$521,368**
Total Project Cost	**$521,368**
Capitalized Financing Costs (Informational Purpose Only)	

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

An itemized list of other medical and non-medical equipment has been included as *Attachment I.*

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Hyperbaric Oxygen Chambers	Perry Baromedical Corporation	Sigma 34 Monoplace Hyperbaric Chamber	2	$88,000 Installation and start-up $3,800.00 Delivery $3,300.00

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

A copy of the vendor quotation for the equipment noted above has been included in *Attachment II.*

e. 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

In paragraph format, 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.

   St. Vincent's Medical Center ("St. Vincent's") is a 397-bed acute care hospital located in Bridgeport, Connecticut. St. Vincent's has provided health care services for more than one hundred years and today is a leading referral center for open-heart surgery, total joint replacement and cancer serving Southwestern Connecticut. The Hospital has earned national and regional recognition for the compassion of its staff, the commitment to patient satisfaction and the quality of its care. SVMC has an active medical staff of 450 physicians representing a comprehensive range of more than 50 specialty and subspecialty medical and surgical disciplines. The hospital offers a full range of medical and surgical services including centers of excellence in cardiovascular disease, cancer prevention, women's services including senior services and behavioral health services.

   St. Vincent's provides wound care services in its outpatient clinics, emergency department and inpatient service. The Hospital is licensed by the Department of Public Health in the State of Connecticut (see *Attachment II* for a copy of the DPH license).

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

   St. Vincent's currently provides care to patients suffering from chronic wounds. Such wounds are often the result of disease processes such as diabetes, vascular disease, or other conditions such as paralysis or limited mobility Care includes the diagnosis, treatment, and prevention of future wounds. Standard treatment may include surgical debridement, medications, and regular wound cleansing and

dressing. Patients currently receive such care at several locations throughout St. Vincent's include outpatient clinics, the emergency department and the inpatient units. All of these services are provided under the Hospital's acute care license.

The proposed service involves the consolidation and relocation of all existing ambulatory wound services and the addition of Hyperbaric Oxygen therapy (HBOT). St. Vincent's proposes to consolidate all of its ambulatory wound care services, add two Hyperbaric Oxygen tanks and locate the entire program at 115 Technology Drive in Trumbull, CT. All of the wound services will be provided under the Hospital's existing acute care license.

The proposed relocation of the ambulatory wound services is necessary due to the following two major factors:

- **There is no available space within the Hospital to house the wound care program and the HBOT tanks.**
- **The main medical center campus is currently under a major construction project and will be for several more years. Access to the main campus is difficult during this time and parking is very limited.**

The proposed location offers patients a convenient and easily accessible location. The site can be accessed either by car or public bus transportation. There is ample surface parking adjacent to the building. The building can be easily accessed by patients who require a wheelchair or other ambulation assistance. The Hospital currently operates a surgical physician practice at the same location and the building is also occupied by many SVMC affiliated physician practices.

HBOT has been proven to improve healing since it stimulates the growth of new blood vessels and improves tissue oxygenation. HBOT has become a routine component of comprehensive wound care. St, Vincent's has retained the consulting and management expertise of National Healing Corporation. National Healing Corporation specializes in the development and management of high quality wound care programs and will provide St. Vincent's with treatment protocols, quality standards, and management oversight.

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

   The current and the target population are the same. St. Vincent's currently serves a large patient population with cardiovascular disease and diabetes. These patients are at risk for the development of ulcers or wounds. A percentage of these patients will have wounds that do not heal or respond to standard therapy and will require more aggressive care and HBOT.

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

   There is a need for centralized and comprehensive wound care services to be provided to St. Vincent's patients. Community physicians have requested such services and encouraged the Hospital to provide this level of service. Currently these services are fragmented throughout the Hospital and HBOT services are not available.

   As previously stated, HBOT has become a standard of care for wound programs within Connecticut and nationally. St. Vincent's seeks to provide complete and

comprehensive wound care to its current and future patient populations. A certain percentage of chronic wound patients do not respond to standard treatment and can significantly benefit from HBOT.

The proposed centralization and relocation of existing ambulatory wound care services and the addition of HBOT will meet this unmet need.

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

   Bridgeport Hospital and Griffin Hospital offer wound care services and HBOT treatments.

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

   This proposal will have a positive effect on the health care delivery system in the State of Connecticut. Access will be enhanced to comprehensive wound care services and HBOT for St. Vincent's existing and future patient populations. The delivery of comprehensive wound care services will promote improved patient care and reduce the need for surgical intervention and/or hospitalization for some chronic wound care patients.

7. Who will be responsible for providing the service?

   St. Vincent's Medical Center 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?

   Payors for this service include all government and commercial insurance plans. There are no anticipated payer changes when the project becomes operational.

AFFIDAVIT

To be completed by each Applicant

Applicant: St. Vincent's Medical Center

Project Title: Establishment of Hyperbaric Oxygen Therapy Service and Relocation of Ambulatory Wound Care Services

I, John Gleckler, Chief Financial Officer
(Name) (Position – CEO or CFO)

of St. Vincent's Medical Center 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 St. Vincent's Medical Center complies with the appropriate and
(Facility Name)

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

Signature 11/6/07
Date

Subscribed and sworn to before me on November 6, 2007

Melissa M. Miele
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2011

RECEIVED
2007 NOV -7 A 11:51
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

ATTACHMENT I

ST VINCENT'S MEDICAL CENTER
WOUND CARE CENTER
CAPITAL SPENDING
NON-MEDICAL EQUIPMENT

Description	Bus Off	HBO Tech	MD Work Area	Nursing Station	Nurse Mgr Off	Treatment Room	WHC Director	Waiting Area	TOTAL	Cost Per Unit	Total Cost
Cabinet – Office Supplies	1								1	$300.00	$300.00
Chair - Visitor			1		1	4	2		8	$200.00	$1,600.00
Chair - Wheeled	2	1		2					5	$200.00	$1,000.00
Chair w/arms and wheels			1		1		1		3	$250.00	$750.00
Chairs w/arms – large (Qty varies w/size of waiting room)								10	10	$250.00	$2,500.00
Chart Racks – Wall / Door - *4 Pocket set*		1		1		4			6	$1,500.00	$9,000.00
Credenza w/knee space							1		1	$500.00	$500.00
Desk/Workstation *(fit to space)*	1	1	1	3	1		1		8	$750.00	$6,000.00
Facsimile Machine – Multifunctional	1			1					2	$2,640.00	$5,280.00
File Cabinet – 4 Draw Lateral	1						1		2	$1,000.00	$2,000.00
File Cabinet –2 Draw Lateral – HBOT depending on space*	1	1	1		1				4	$500.00	$2,000.00
Literature Cabinet – *Floor or Wall Model*								1	1	$250.00	$250.00
Paper Shredder – per Hospital policy	1								1	$300.00	$300.00
Side Tables								2	2	$350.00	$700.00
Telephone–main line plus (3) rollover lines with voicemail	2	1	1	3	1		1		9	$100.00	$900.00
TV								1	1	$440.00	$440.00

$33,520.00

ST VINCENT'S MEDICAL CENTER
WOUND CARE CENTER
CAPITAL SPENDING
MEDICAL EQUIPMENT

Item description of HBO Chambers, Accessories, and TCOM	Cost Per Unit	Quantity Unit	Total Cost
Procedure chair *	$2,500.00	4	$ 10,000.00
Doppler, bi-directional 5and 8mHz probe	$750.00	1	$ 750.00
Dressing Cart - 5 drawer (if insufficient cabinetry)	$1,500.00	1	$ 1,500.00
Electronic Monitoring system	$1,800.00	1	$ 1,800.00
Oto-opthalmoscope	$800.00	1	$ 800.00
Refrigerator - regular	$550.00	1	$ 550.00
Refrigerator - small or under counter	$200.00	1	$ 200.00
Thermometer, electronic with disposable probe cover	$259.00	2	$ 518.00
Wheelchair extra wide w/ detachable foot & arms	$320.00	1	$ 320.00
Exam Light base w/casters	$1,200.00	1	$ 1,200.00
Mayo stand w/casters	$230.00	1	$ 230.00
Stretcher for TCOM tests	$3,000.00	2	$ 6,000.00
TV with DVD/VCR	$440.00	2	$ 880.00

$ 24,748.00

ATTACHMENT II

PERRY BAROMEDICAL CORPORATION
3660 Interstate Parkway
Riviera Beach, FL 33404

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

013

PERRY SIGMA 34 MONOPLACE QUOTATION

Prepared For: **St. Vincent's Medical Center**
2800 Main Street
Bridgeport, CT 06606
Attn: Brooke Karlsen, Director of Surgical Services
203-576-5865
Bkarlsen@stvincents.org

***** Please note that prices quoted are only valid if the Hospital is contracted with National Healing Corporation for program management.**

Quotation Date:	10/24/2007
Quotation Num:	S34-1818
Quotation Valid:	30 Days
Prepared By:	AHD

PART NO.	SIGMA 34 MONOPLACE HYPERBARIC CHAMBER	Qty	List Price	Total Price
D-903160	**Sigma 34 Monoplace Hyperbaric Chamber**	2	$129,900.00	$259,800.00
	LESS 32.256% PREFERRED CUSTOMER DISCOUNT		$41,900.00	$83,800.00
			$88,000.00	$176,000.00
	The Sigma 34 has a larger 34" diameter clear acrylic cylinder. This larger diameter allows the patient's upper torso to be elevated up to 25 degrees for added comfort and for increased compliance.			
	(In accordance with Technical/Building Service Specs TECH-34-902703,Rev E)			
	Each Chamber Includes:			
D-902537	Wide Hydraulic Adjustable-Height Patient Transfer Gurney with Stretcher and Mattress Hydraulic height-adjustment makes patient transfer easier. Wide mattress cushion is extra thick for maximum comfort. Includes handrail assembly.	2	Included	Included
	(Right Hand Door Configuration is Standard. Alternate Configuration Available If Specified on Purchase Order)			

PART NO.	ACCESSORIES FOR PERRY SIGMA 34	Qty	List Price	Total Price
B-902679	Perry IV Penetrator and Plug Assembly Provides the through-hull interface for intravenous drug/fluid delivery.	2	$175.00	Included
D-902637	Assembly Patient Monitoring Cabling Allows connection of electrical monitoring cables between the patient and an external monitor. The penetrator comes complete with a set of mating end-connectors which can be adapted for use with various brands of monitors.		$1,946.34	
B-901981	Perry Patient Air Break Mask Assembly Provides the means to supply Medical Air to the patient for short-term air breathing. Includes demand valve, penetrator fittings, internal & external hose, and two disposable masks.	2	$898.00	Included
'00	Chamber cover	2	$300.00	Included
B-903475	Sigma 34 Tool Kit Includes Tool Box (1); ohmmeter and extension with small clamps (1); screwdriver 4 in 1 Allen key set (small) (1); Adjustable wrench 6", adjustable		$354.16	

PERRY BAROMEDICAL CORPORATION
3660 Interstate Parkway
Riviera Beach, FL 33404

wrench 12" (1 wrench each); brass brush (1); lip seal (1) B-902488

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

014

QUOTATION NO. S34-1818

B-903096	Wedge Cushion		$295.92	
B-901433	Cable Assembly and penetrator for Transcutaneous Monitor Provides the connection path from tcpO2 monitor to chamber and chamber to patient monitoring cable. The penetrator is specially constructed to accept the standard monitor extension cables.	2	$1,797.18	Included
D-902537	Add'l Hydraulic Transfer Gurney With Stretcher and Mattress		$9,400.00	
	Patient Entertainment System			
D-903529	20"LCD Flat Panel Video w/DVD Player Tie Rod universal mounting bracket and all cables/ adapters with installation instructions		$3,200.00	
D-902136	Air/O2 Select Manifold Enables user to quickly, easily switch the chamber pressurization gas supply between air and oxygen.		$3,042.82	
2704	BIBS (Built-in Breathing System) Allows the user to pressurize the chamber with air and deliver oxygen or air through a head tent or mask system.		$6,830.00	

PART NO.	OPTIONAL ITEMS FOR PATIENT CARE	Qty	List Price	Total Price
HPMED-20230	Hypermed OxyVu-1 Device The OxyVu-1 is an Hyper Spectral Technology Oxygenation Monitoring Unit that monitors the metabolic status of tissues, estimates arterial oxygen saturation and provides a gradient map of the region of interest.		$30,000.00	
	OxyVu-1 CalPak Carton (20)		$1,000.00	
P-10046A	Hyperbaric Ventilator		$12,300.00	
B-902888	Ventilator Bracket Assembly		$92.00	

PERRY BAROMEDICAL CORPORATION
3660 Interstate Parkway
Riviera Beach, FL 33404

Phone: (561) 840-0395
Fax: (561) 840-0398
www.perrybaromedical.com

015

QUOTATION NO. S34-1818

INSTALLATION AND TRAINING	Qty	List Price	Total Price
System Installation and Start-up Including: Operator and Maintenance Training One Operation and Maintenance Manual All Required Installation Fittings and Equipment (Final installation pricing may vary in accordance with system location)			$3,800.00

Based on ground floor location and adequate and unrestricted pathway from dock to room location.

The SIGMA 34 is designed, manufactured, tested and installed in accordance with the current regulations of the FDA, ASME PVHO-1, and NFPA. The customer is responsible for meeting local and state regulations regarding the installation and operation of the system.

Customer is responsible for ensuring the facility meets Technical / Building Services Specification TECH-34-902703, Revision E

FREIGHT AND DELIVERY	Qty	List Price	Total Price
Delivery FOB Riviera Beach, Florida Delivery charges to be paid by customer Allow 2-3 Months For Delivery After Receipt Of Purchase Order			$3,300.00

(Final freight and delivery pricing may vary in accordance with system location)

WARRANTY

One Year Warranty Is Standard
Limited Parts and Labor

PAYMENT TERMS

30% Down Payment Due With Purchase Order
60% Due 30 Days After Date Of P.O. Or Prior to Delivery (whichever comes first)
10% Due Upon Installation

Perry and St. Vincent's Medical Center agree that the title in any hyperbaric medical equipment ordered and shipped pursuant to this agreement will remain with Perry until the entire purchase price for equipment has been received by Perry.

(Buyer shall pay all sales and use taxes attributable to the sale)

TOTAL	**$183,100.00**

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 19, 2007

John Gleckler
Chief Financial Officer
Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

RE: Certificate of Need Application Forms, Docket Number 07-31060-CON
Saint Vincent's Medical Center
Proposal To Consolidate Existing Ambulatory Wound Services and Add Hyperbaric Oxygen Therapy To 115 Technology Drive, Trumbull

Dear Mr. Gleckler:

Enclosed are the application forms for Saint Vincent's Medical Center's Certificate of Need ("CON") proposal to consolidate its existing ambulatory wound services and add hyperbaric oxygen therapy to 115 Technology Drive, Trumbull with an associated capital expenditure of $521,368. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between January 6, 2008, and March 6, 2008.

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 in Adobe PDF format. OHCA requests that an additional electronic copy of the Application (attachments optional) be in MS Word or similar format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact him/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 January 6, 2008, and may be submitted no later than March 6, 2008. 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: 07-31060-CON

Applicant's Name: Saint Vincent's Medical Center

Contact Person: John Gleckler
Contact Title: Chief Financial Officer
Saint Vincent's Medical Center
Contact Address: 2800 Main Street
Bridgeport, CT 06606

Project Location: Trumbull

Project Name: The Hospital proposes to consolidate its existing ambulatory wound services and add hyperbaric oxygen therapy to 115 Technology Drive, Trumbull

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

Est. Capital Expenditure: $521,368

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.

B. Provide the following information:
   i) List the service area towns.
   ii) The units of service for the past three fiscal years and the current fiscal year-to-date for each location currently providing would care services.
   iii) Describe the population to be served, including the number of individuals to receive the proposed service and demographic information as appropriate.
   iv) Identify the diabetic population, the number that develop chronic wounds, and those that may require hyperbaric oxygen treatment ("HBOT").
   v) Identify other patients that receive HBOT.
   vi) Scheduling backlogs in service area.
   vii) Travel distance from the proposed site from each of the sites currently providing wound care services.
   viii) Hours of operation of existing and the proposed service.

C. Provide the units of service projected for the first three years of operation of the proposed service. Consider responses provided above and include all calculations or derivations used to arrie at the project units of service.

D. Provide the information as outlined in the following table concerning the existing providers in the service area:

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

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

F. 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.

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

☐ Epidemiological studies
☐ Public information reports
☐ Needs assessments
☐ 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 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-Council for Radiation Oncology	☐ American College of Radiology	☐ 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	☐ JCAHO
☐ Fire Marshall Report	☐ Other States Health Dept. Reports (New Out-of-State Providers)
☐ AAAHC	☐ AAAASF
☐ Other (identify):	

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. Miscellanous

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
- ☐ Limited Liability Company (LLC)
- ☐ Professional Corporation (PC)
- ☐ 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) If the Applicant is a hospital, provide the name and units of service for the new cost center to be established for the proposal.

iv) 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 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	

11. 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.

12. Revenue, Expense, and Volume Projections

A.1. Payer Mix Projection

Please provide both the payer mix for the wound services currently provided by the Hospital and the projected payer mix with the CON proposal, i.,e, wound care services provided at the Trumbull location, based on Gross Patient Revenue in the following reporting format:

Total Facility Description	FY____ Current Payer %	FY ___ Year 1 Projected Payer %	FY____ Year 2 Projected Payer %	FY_____ Year 3 Projected Payer %
Medicare (includes managed care activity)	%	%	%	%
Medicaid (includes managed care activity and other medical assistance)				
CHAMPUS and TriCare				
Total of Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total of Non-Government Payers				
Grand Total of Payers	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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.** ***Note:*** *The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. See attached, 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.). ***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.*

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.

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: _____

12. D (i). Please provide one year of actual results and three years of projections of SFMC's revenue, expense and volume statistics
s

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.

12. 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 _____ (Year _)	(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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2007

John Gleckler
Chief Financial Officer
Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606

Re: Letter of Intent, Docket Number 07-31060
Saint Vincent's Medical Center
Hospital Proposes to Consolidate its Existing Ambulatory Wound Services and Add Hyperbaric Oxygen Therapy to 115 Technology Drive, Trumbull
Notice of Letter of Intent

Dear Mr. Gleckler:

On November 7, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Saint Vincent's Medical Center ("Applicant") for the hospital's proposal to consolidate its existing Ambulatory Wound Services and add Hyperbaric Oxygen Therapy to 115 Technology Drive, Trumbull, at a total capital expenditure of $521,368.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Connecticut Post* 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

November 14, 2007

Requisition # HCA08-084
Fax: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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, November 18, 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:LG:lmg

c: Sandy Salus, OHCA

Connecticut Post
Docket Number 07-31060

Letter of Intent
November 14, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Saint Vincent's Medical Center
Town:	Trumbull
Docket Number:	07-31060
Proposal:	Hospital proposes to consolidate its existing Ambulatory Wound Services and add Hyperbaric Oxygen Therapy to 115 Technology Drive, Trumbull
Capital Expenditure:	$521,368

The Applicant may file its Certificate of Need application between January 6, 2008 and March 6, 2008. 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	2877
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	11/14 12:49
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 14, 2007

Requisition # HCA08-084
Fax: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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, November 18, 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,

CONNPOST.com
CONNECTICUT POST

CLASSIFIED DEPARTMENT

LEGAL NOTICES *(only)*

410 State Street, Bridgeport, CT 06604

Fax 203-384-1158

publicnotices@ctpost.com

Call 203 330 6213

800-423-8058

DIANE – IN LEGALS

TO: Rimberg

OUTGOING FAX NUMBER: 860 418 1053

DATE: 11/15/07

YOUR AD FOR PROOF AND PAYMENT.

THANK YOU.

Diane

DIANE - LEGALS

STATE OF CONNECTICUT
LETTER OF INTENT
November 14, 2007
DOCKET NUMBER 07-31060

Statute Reference:	19a - 638
Applicant:	Saint Vincent's Medical Center
Town:	Trumbull
Docket Number:	07-31060
Proposal:	Hospital proposes to consolidate its existing Ambulatory Wound Services and add Hyperbaric Oxygen Therapy to 115 Technology Drive, Trumbull
Capital Expenditure:	$521,368

The Applicant may file its Certificate of Need application between January 6, 2008 and March 6, 2008. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA, PO 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.

Order Confi...ation

Ad Order Number	Customer	Payor Customer	PO Number
0001107805	ST OF CT OFFICE OF	ST OF CT OFFICE OF	laurie greci
Sales Rep.	**Customer Account**	**Payor Account**	**Ordered By**
dsettani	129573	129573	martone
Order Taker	**Customer Address**	**Payor Address**	**Customer Fax**
dsettani	HEALTH CARE ACCESS,410 CAPITOL AVE. HARTFORD CT 06134 USA	HEALTH CARE ACCESS,410 CAPITOL AVE. HARTFORD CT 06134 USA	860-418-7053
Order Source			**Customer EMail**
E-mail	**Customer Phone**	**Payor Phone**	
	860-418-7001	860-418-7001	**Special Pricing**
	860-418-7001	860-418-7001	None

Tear Sheets	Proofs	Affidavits	Blind Box	Promo Type	Materials
0	0	1			

Invoice Text

Ad Order Notes

Net Amount	Tax Amount	Total Amount	Payment Method	Payment Amount	Amount Due
$228.25	$0.00	$228.25		$0.00	$228.25

Ad Number	Ad Type	Ad Size	Color	Production Method	Production Notes
0001107805-0	Legal Liners	: 2.0 X 38 Li	<NONE>	AdBooker	

External Ad Number	Ad Attributes	Ad Released	Pick Up
		No	0001107800

Product Information Run Schedule Invoice Text	Placement/Classification Sort Text	Run Dates	# Inserts	Cost
Connecticut Post: :	Public Notices	11/18/2007	1	$203.25
STATE OF CONNECTICUT LETTER OF	STATEOFCONNECTICUTLETTEROFINT			
Connpost.com: :	Public Notices	11/18/2007	1	$0.00
STATE OF CONNECTICUT LETTER OF	STATEOFCONNECTICUTLETTEROFINT			