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JENNIFER L. GROVES
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F: 203.772.2037
jgroves@uks.com

December 5, 2007

Cristine Vogel, Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: ***Danbury Surgical Center, L.P.***

Dear Commissioner Vogel:

Please be advised that this office represents Danbury Surgical Center, L.P. Enclosed please find an original and three (3) copies of a Letter of Intent Form 2030 for the proposed sale of additional limited partnership interests in Danbury Surgical Center, L.P. Should you require anything further at this time, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer L. Groves

Enclosures

cc: Ms. Helen Faga (w/enc.)
Ms. Marc Goff (w/enc.)

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	**Danbury Surgical Center, L.P.**	RECEIVED 2007 DEC -6 A11:50 OFFICE OF HEALTH CARE ACCESS
Doing Business As	**Danbury Surgical Center**	
Name of Parent Corporation	**ASC Acquisition LLC**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**73 Sandpit Road Danbury, CT 06810**	
Identify Applicant Status: P for Profit or NP for Nonprofit	**Profit**	
Does the Applicant have Tax Exempt Status?	**No**	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	**Jennifer L. Groves Legal Counsel for Applicant**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**Updike, Kelly & Spellacy One Century Tower 265 Church Street New Haven, CT 06510**	
Contact Person Telephone Number	**(203) 786.8316**	
Contact Person Fax Number	**(203) 772.2037**	

Contact Person e-mail Address	jgroves@uks.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Sale of Additional Limited Partnership Interests in Danbury Surgical Center, L.P.**

b. Project Proposal: **Danbury Surgical Center, L.P. proposes to sell an additional eleven (11) limited partnership interests to physicians, their professional practices, and/or trusts established for the benefit of such physicians and their practices.**

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)* _____

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:

73 Sandpit Road, Danbury, CT 06810

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

Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield, New Milford, Redding, Southbury, and Woodbury

h. Estimated starting date for the project:

Danbury Surgical Center, L.P. intends to offer the additional limited partnership interests for sale immediately upon receipt of regulatory approval.

i. If the proposal includes change in the number of beds provide the following information: **N/A**

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: **$0.00**

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

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

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

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: **N/A**

Equipment Type	Name	Model	Number of Units	Cost per unit

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

e. Type of financing or funding source (more than one can be checked): N/A

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

SECTION IV. PROJECT DESCRIPTION

Danbury Surgical Center, L.P. (the "Partnership") owns a freestanding multi-specialty ambulatory surgery facility located at 73 Sandpit Road in Danbury, which operates under the name Danbury Surgical Center (the "Center"). At present, forty-eight percent (48%) of the partnership interests in Danbury Surgical Center, L.P. are held by physician limited partners. Another one percent (1%) of the partnership interests are authorized for sale to physician investors without CON approval. The Partnership is requesting permission to sell eleven (11) additional limited partnership interests (on top of the forty-nine (49) that it is authorized to sell) to physicians, their practices, and/or trusts established for the benefit of such physicians and their practices.

CON History of Danbury Surgical Center

The Center was established pursuant to a CON issued by the former Commission on Hospitals and Health Care on June 8, 1982 (Docket No. 82-506). A CON Determination issued by OHCA on November 2, 2000 (Report No. 00-B4) authorized HealthSouth Surgery Center of Danbury, Inc. (the "HealthSouth Corporation"), then-owner of Danbury Surgical Center, to transfer ownership of the Center to HealthSouth Surgery Center of Danbury, L.P. (the "HealthSouth Partnership") without obtaining a CON. OHCA further authorized the sale of forty-nine percent (49%) of the HealthSouth Partnership, in the form of limited partnership interests, to physicians, their families and/or trusts established for the benefit of such physicians, their families or their professional practices. The HealthSouth Corporation was required to maintain at all times at least fifty-one percent (51%) of the interests of the HealthSouth Partnership as General Partner. OHCA determined that no CON was required because "the proposed change in ownership structure [would] not result in changes in control, transfer or powers, or the delivery of health care services." *See* Report No. 00-B4.

On February 10, 2006, OHCA determined that CON approval was required for the Center to syndicate sixty percent (60%) of its interests to physician limited partners, because this would constitute a change of ownership and control (Report No. 05-30611-DTR).

On August 16, 2007, OHCA approved the sale of HealthSouth Corporation's interests in certain ambulatory surgical facilities in Connecticut, including Danbury Surgical Center, to ASC Acquisition LLC (Docket No. 07-30955-CON). This transfer of ownership was completed on August 22, 2007. At present, Danbury Surgical Center is owned by Danbury Surgical Center, L.P., which is fifty-two percent (52%) owned by SCA Danbury Surgical Center, LLC (51% as General Partner and 1% as Limited Partner) and forty-eight percent (48%) owned by physician limited partners. SCA Danbury Surgical Center, LLC is a wholly owned subsidiary of SUN Surgery, LLC, which is a wholly owned subsidiary of Surgical Care Affiliates, LLC, which is a wholly owned subsidiary of ASC Acquisition LLC. An organizational chart reflecting the current structure of Danbury Surgical Center, L.P. is attached as ***Exhibit A***.

Proposed Change of Ownership

The Partnership now seeks CON approval to sell an additional eleven (11) limited partnership interests beyond the previously authorized forty-nine (49) interests, for a total of sixty (60) limited partnership interests, to individual physicians, their practices and/or trusts established for the benefit of such physicians and their practices. The sale of additional partnership interests will accommodate the needs of area physicians, including existing partners and their practices, will foster growth and will help to maintain the viability of the Center. SCA Danbury Surgical Center, LLC, a wholly owned subsidiary of Surgical Care Affiliates, LLC (the operating entity for ASC Acquisition LLC), will at all times maintain at least forty (40) percent of the partnership interests of Danbury Surgical Center, L.P.

As with the initial syndication authorized under Report No. 00-B4, the proposed change of ownership will not result in a change in control or transfer of powers with respect to the Center. SCA Danbury Surgical Center, LLC will remain the General Partner with complete control over the Center and its operations. In addition, there will

be no change in the membership and/or structure of the governing body of the Center specifically as a result of the sale of additional partnership interests. Nor will there be any change in the governing board of the Partnership, any change in the governing powers of the board of any parent company or affiliate, or any change or transfer of the power or control of a governing or controlling body of any affiliate.

Services Provided/Payers for Services/Population Served

The Center currently provides comprehensive facilities for uncomplicated elective surgical procedures not requiring hospitalization but requiring medical facilities exceeding that which is normally found in a physician's office. Services include, but are not limited to, outpatient surgical procedures in the following specialties: gastroenterology; general surgery; gynecology; ophthalmology; oral surgery; orthopedics; otolaryngology (ENT); pain management; plastic surgery; podiatry; and urology. After the proposed sale of limited partnership interests, the Center will continue to provide the same services that it currently provides.

Services will continue to be provided by existing professional staff.

Payers for services at the Center will remain the same if this proposal is approved. They include private pay, Medicare, Medicare Managed Care, traditional indemnity insurance, health maintenance organizations, and Medicaid.

The Center is licensed by the Department of Public Health as an Outpatient Surgical Facility (copy attached as ***Exhibit B***). No additional licenses will be sought from the Department of Public Health as a result of this proposal.

The current population served by the Center includes residents of the greater Danbury area in need of outpatient surgical services. The target population is the same as that presently served by the Center.

Existing Providers/Unmet Need/Impact of Healthcare Delivery System

Ridgefield Surgical Center is the only other freestanding outpatient surgical facility in the greater Danbury area. Ambulatory surgical services are also offered at Danbury Hospital and New Milford Hospital.

This proposal will address unmet need in as much as it will allow physicians the opportunity to acquire interests in the Center, thereby increasing the accessibility of outpatient surgical services for their patients. It will strengthen physicians' investments in the Center and, in turn, the quality of care provided to surgical patients. The proposal will also help to maintain the viability of the Center. This will impact favorably on the healthcare delivery system in the state.

AFFIDAVIT

To be completed by each Applicant

Applicant: **Danbury Surgical Center, L.P.**

Project Title: **Sale of Additional Partnership Limited Interests in Danbury Surgical Center, L.P.**

I, Helen Faga (Name), Administrator (Position – CEO or CFO)

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

Helen Faga
Signature

12/4/07
Date

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Subscribed and sworn to before me on Dec. 4, 2007

Kaye Wood
Notary Public/Commissioner of Superior Court

My commission expires: August 31, 2012

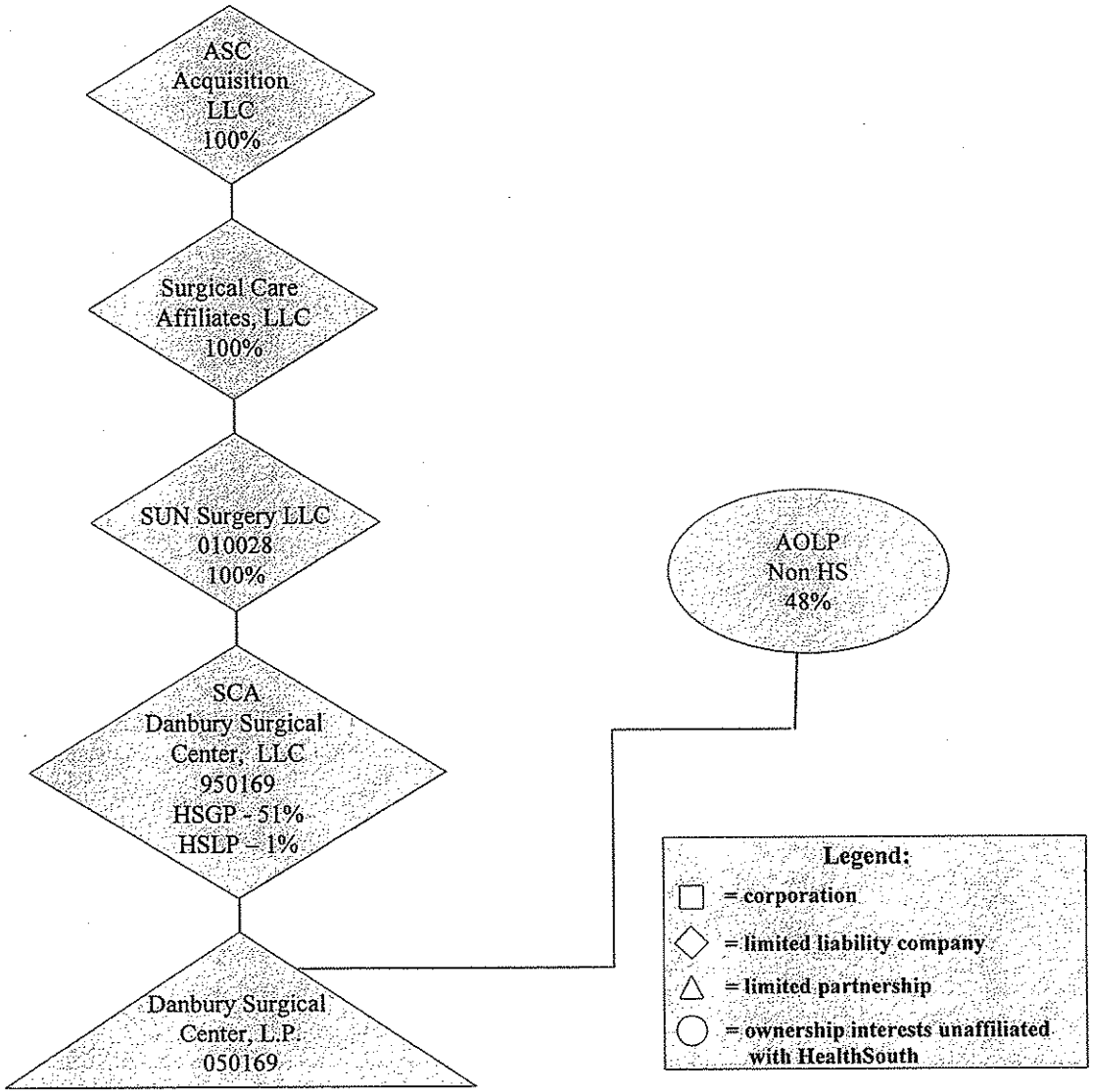
Subscribed and sworn to before me
this 4th **day of** Dec, 2007
Kaye Wood
Notary Public
Date Commission Expires: 8-31-12

Form 2030
Revised 10/2007

AFTER

Danbury Surgical Center, L.P. - 050169

Facility # 050169



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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0269

Outpatient Surgical Facility

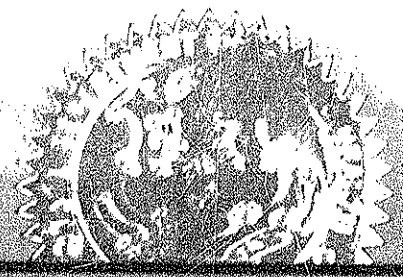
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493

Healthsouth Surgical Center of Danbury Limited Partnership of Birmingham, AL, d/b/a Healthsouth Surgery Center of Danbury is hereby licensed to maintain and operate an Outpatient Surgical Facility.

Healthsouth Surgery Center of Danbury is located at 73 Sandpit Road, Danbury, CT 06810.

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

Dated at Hartford, Connecticut, April 1, 2007. RENEWAL.



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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 17, 2007

Helen Faga
Administrator
Danbury Surgical Center
73 Sandpit Road
Danbury, CT 06810

RE: Certificate of Need Application Forms; Docket Number: 07-31072-CON
Danbury Surgical Center
Sale of Additional Limited Partnership Interests in
Danbury Surgical Center, LP to other Physicians

Dear Ms. Faga:

Enclosed are the application forms for Danbury Surgical Center's Certificate of Need ("CON") proposal for the sale of additional limited partnership interests in Danbury Surgical Center to other physicians at no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between February 4, 2008, and April 4, 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 the electronic copy of the Application (attachments optional) be in 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, a response of "Not Applicable" may be considered an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than February 4, 2008, and may be submitted no later than April 4, 2008. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access by dialing (860) 418-7034.

Docket Number:	07-31072-CON
Applicant Name:	Danbury Surgical Center
Contact Person:	Helen Faga
Contact Title:	Administrator
Contact Address:	Danbury Surgical Center 73 Sandpit Road Danbury, CT 06810
Project Location:	Danbury
Project Name:	Sale of Additional Limited Partnership Interests in Danbury Surgical Center, LP to other Physicians
Proposal Type:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$ 0

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: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____	FOR OHCA USE ONLY:	DATE	INITIAL
PROJECT TITLE: _____	1. Check logged (Front desk)	_____	_____
DATE: _____	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: _____	$ 1,000.00
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)	$_____.00
c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____	$_____.00
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE:_____	$_____.00

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

1. Expansion of Existing or New Service

What services are currently offered at your surgery center that the proposal 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 that there was a need for the proposed sale of additional limited partnership shares in ambulatory surgery center.

B. List the service area towns for the ambulatory surgery center. Provide a rationale for the inclusion of the selected towns.

C. Describe the population that is being served by the ambulatory surgery center. Include demographic Information as appropriate in your response.

D. The units of service for the past three completed fiscal years by service area town (by zip code) ***and*** type of procedure for the ambulatory surgical center. Please report the total time required to perform the procedures in each category.

E. Using the total number of procedures performed and the total number of minutes identified above, report the operating room utilization for the ambulatory surgical procedures using the following format:

Item	FY 2005	FY 2006	FY 2007	FYTD 2008*
Total number of procedures performed				
Annual increase in procedures performed	-	%	%	
Number of operating rooms				
Average annual number of procedures per room				
Total number of procedure hours				
Number of hours available per year				
Percent of Total Hours Utilized	%	%	%	

Note: * Year-to-date statistics reported from __/__/____ to __/__/____.

F. Scheduling backlogs for ambulatory surgery services in the service area.

G. Travel distance from the surgery center to service area towns.

H. Hours of operation of the surgery center, prior to and after the proposed sale of shares.

I. Provide the information as outlined in the following table concerning your ambulatory surgery center and other existing or proposed surgery center providers in your service area.

Service Area:

Name of Provider	List Similar Services Provided?	Affiliated Physicians/Specialists

J. Provide the information as requested in the following table concerning your ambulatory surgery center and other existing and proposed surgery center providers identified in response to question G. above:

Service Area (PSA or SSA)	Provider Name	Number of Operating Rooms				Estimated Capacity with 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.

K. Please describe the referral patterns for patients seeking ambulatory surgery services in the service area. In addition, please provide the following:

1) For fiscal year ("FY") 2007, provide the number of patients treated by physician/specialist by site of service.

2) For FY 2008, provide the number of anticipated patients treated by physician/specialist by your ambulatory surgery center.

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

M. Provide the units of service projected for the first three full fiscal years of operation of the reconstituted ambulatory surgery center. **Include all assumptions and calculations used in the derivation of your volume projections.**

N. Provide the number of procedures projected for the first three full fiscal years of operation by service area town (by zip code) ***and*** type of procedure preformed at the reconstituted ambulatory surgery center. In addition, please report the total time required to perform the procedures in each category.

O. Using the information reported for the projected number of procedures and the total number of minutes required to perform the projected procedures, report the projected operating room utilization at the ambulatory surgical center for the surgical procedures using the following format:

Item	FYTD 2008*	FY 2009	FY 2010	FY 2011
Total number of procedures performed				
Annual increase in procedures performed		%	%	%
Number of operating rooms				
Average annual number of procedures per room				
Total number of procedure hours				
Number of hours available per year				
Percent of Total Hours Utilized	%	%	%	

Note: * Year-to-date statistics reported from __/__/____ to __/__/____.

P. 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.

Q. 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:

1.

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 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:

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) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, 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.*

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

E. 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

[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 surgical center 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 any 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.

D. Explain how the proposal will affect the delivery of patient care at the ambulatory surgery center.

8. Offering of Additional Ownership Shares

A. Provide a copy of the written agreement or memorandum of understanding between the existing surgery center and prospective entities related to the proposal.

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

B. Identify the following items for the Applicant as they relate to the proposal prior to and after completion of the additional ownership share offering:

i) Health care services provided.
ii) Physician utilization of the ambulatory surgery center.
iii) Corporate or entity structural relationships.
iv) Current and proposed percentage of ownership shares by individual or group.

9. Financial Information

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

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

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that is currently billing for service provided. If different, identify the entity that will be billing for services after the change in the ownership composition is realized.

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. 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 current payer mix and the projected payer mix with the CON proposal for the ambulatory surgery center based on Net Patient Revenue in the following reporting format:

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

*Includes managed care activity.

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

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

C. Provide a copy of the charity care policy for the surgery 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. **Please complete Financial Attachment I included in the forms package. Please note: *that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.***

ii) Please provide three years of projection of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. Please complete Financial Attachment II included in the forms package**.

iii) List 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.). Please 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.

E. Provide a copy of the current and prospective surgery center's rate schedule.

F. Describe how this proposal is cost effective.

G. Provide a copy of any "turn-around" plan which the Applicant may have in place concerning the Applicant's current financial position.

Danbury Surgery Center

12. D (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility: / Description	FY 2007 Actual Results	FY 2008 Projected W/out Project	FY 2008 Projected Incremental	FY 2008 Projected With Project	FY 2009 Projected W/out Project	FY 2009 Projected Incremental	FY 2009 Projected With Project	FY 2010 Projected W/out Project	FY 2010 Projected Incremental	FY 2010 Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
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

*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.

Danbury Surgery Center

12.D(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:
Provide FYs 2008 through 2010.

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	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by 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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 18, 2007

Helen Faga
Administrator
Danbury Surgical Center
73 Sandpit Road
Danbury, CT 06810

Re: Letter of Intent; Docket Number: 07-31072
Danbury Surgical Center's Proposal for the Sale of Additional Limited Partnership Interests in the Surgical Center to Other Physicians
Notice of Letter of Intent

Dear Ms. Faga:

On December 6, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Danbury Surgical Center ("Applicant") for the sale of additional limited partnership interests in the Applicant's surgical center to other physicians at no associated capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The News Times* of Danbury, 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:jah

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 18, 2007

Requisition # HCA08-102
Fax: (203) 792-4211

The News Times
333 Main Street
Danbury, CT 06810

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, December 23, 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) 418-7034.

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

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Danbury Surgical Center, LP
Town:	Danbury
Docket Number:	07-31072
Proposal:	Sale of Additional Limited Partnership Interests in Danbury Surgical Center to Other Physicians
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between February 4, 2008 and April 4, 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.

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*** TX REPORT ***
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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

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