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 17, 2008

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

Re: The Stamford Hospital
Establishment of Physical Therapy Services at 1500 Post Road, Darien, CT

Dear Commissioner Vogel:

Please find enclosed an original and five copies of Stamford Hospital's Letter of Intent with respect to the above project. We look forward to working with you and the OHCA staff on this Certificate of Need application. Please feel free to contact me should you have any questions 203-276-7510.

Respectfully submitted,

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

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	The Stamford Hospital	
Doing Business As	The Stamford Hospital	
Name of Parent Corporation	Stamford Health System	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	30 Shelburne Road, P.O. Box 9317, Stamford, CT 06904	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes X No	
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	David L. Smith, Senior Vice President, Strategy and Market Development, The Stamford Hospital	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	30 Shelburne Road, P.O. Box 9317, Stamford, CT 06904	

Contact Person's Telephone Number	203-276-7510	
Contact Person's Fax Number	203-276-5529	
Contact Person's e-mail Address	dsmith@stamhealth.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establishment of Physical Therapy Services at 1500 Post Road, Darien, CT

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

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

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

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

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

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

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

☐ Equipment Acquisition

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

☐ Imaging ☐ Linear Accelerator

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

c. Location of proposal, identifying Street Address, Town and Zip Code: 1500 Post Road, Darien, CT 06820

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

d. Estimated starting date for the project: September 2008

e. Type of project: 14
(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
Not Applicable				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $594,522

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

Medical Equipment Purchases	$68,236
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	$526,286
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$594,522**
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	**$594,522**
Total Project Cost	**$594,522**
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

Project Title: Establishment of Physical Therapy Services at 1500 Post Road

I, Brian G. Grissler, (Name) Chief Executive Officer (Position – CEO or CFO)

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

Signature 3/17/08 Date

Subscribed and sworn to before me on 3/17/08

Notary Public/Commissioner of Superior Court

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

RECEIVED
2008 MAR 19 A 11:58
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

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 ("SH") is proposing to provide physical therapy ("PT") services at an expanded medical office building ("MOB") site located at 1500 Post Road in Darien, CT. The MOB, which formerly housed SH's Darien Imaging Center ("DIC") until that facility was relocated to Thorndale Circle in 2006, currently provides office space to a number of physicians who have admitting privileges with SH. Physician occupancy of the MOB is expected to grow significantly in the next year as the MOB is being expanded from its present size of 9,400 square feet to just over 18,000 square feet.

PT services offered by SH enjoy an excellent reputation in the community with patient satisfaction levels over 96%. In 1996, outpatient rehabilitation services at the hospital were moved to and made part of the integrative therapeutic services offered by its corporate affiliate, The Rehabilitation Center of Southwestern CT, Inc. (the "Rehab Center"), located at the Jeanne S. Rich Campus at 26 Palmer's Hill Road in Stamford. In 2002, outpatient rehabilitative services were opened at the Tully Health Center ("Tully"), located at 32 Strawberry Hill Court in Stamford. In 2004, the Rehab Center was merged with SH and the services offered at the Rich Campus were combined with the physical medicine and rehabilitation programs provided at the Tully. Since then, the number of PT visits at Tully has increased by an average of 14% annually with nearly 25,500 such visits in FY 2007.

In addition to supporting medical practices in the MOB, the proposed project will provide improved access to comprehensive PT services for more than 23,000 residents of the towns of Darien and Rowayton. Expansion of PT services at the Darien MOB represents an opportunity to meet the needs of a growing population of adults who require rehabilitative care for orthopedic and musculoskeletal disorders while furthering SH's commitment to improving access to ambulatory health care for residents of the communities it serves.

Location of PT services in the MOB will allow many adults who have sustained some form of diminished physical capacity due to trauma, surgery, medical problems or aging to be treated locally and in close proximity to both treating physicians as well as the diagnostic imaging services of the DIC for follow-up care. This is an especially important benefit for patients undertaking extended therapeutic regimens for care after fractures or surgery, neck and lower back disorders as well as other diagnoses that inhibit travel.

There are two other providers of outpatient rehabilitative services in the Darien/Rowayton service area. These include Darien PT at 264 Heights Road and Moore Center for Rehabilitation at 53 Old Kings Highway. SH will provide the service under its acute care hospital license and no impact on SH's payor sources is anticipated.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 27, 2008

David L. Smith
Senior Vice President, Strategy and Market Development
The Stamford Hospital
30 Shelburne Road
PO Box 9317
Stamford, CT 06904

RE: Certificate of Need Application Forms, Docket Number 08-31124-CON
Stamford Hospital, The
Establishment of Physical Therapy Services in Darien

Dear Mr. Smith :

Enclosed are the application forms for The Stamford Hospital's Certificate of Need ("CON") proposal for the Establishment of Physical Therapy Services in Darien with an associated capital expenditure of $594,522. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between May 18, 2008, and July 17, 2008.

When submitting your CON Application, please paginate and date each page contained in your submission. Subsequent filings to OHCA dealing with responses to completeness letters, prefile testimony, late file submissions and the like must similarly be paginated and dated. **Pagination of each of these subsequent filings must be numbered sequentially from the document which precedes it.** For example, if the CON application concludes with page 100, your completeness letter response would begin with page 101.

Please submit one (1) original and six (6) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachments and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Alexis Fedorjaczenko. 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 18, 2008, and may be submitted no later than July 17, 2008. The Analyst assigned to your application is Alexis Fedorjaczenko, who may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31124-CON

Applicant(s) Name: Stamford Hospital, The

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

Contact Address: 30 Shelburne Road
PO Box 9317
Stamford, CT 06904

Project Location: Darien

Project Name: Establishment of Physical Therapy Services in Darien

Type of proposal: Section(s) 19a-638

Est. Capital Expenditure: $594,522

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.

B. Please provide a copy of the needs assessment completed for the proposed project. If a needs assessment was not conducted, explain why not.

C. Provide the following information:
   a) List the primary service area (PSA) towns. Provide a rationale for choosing the selected PSA towns.
   b) List the secondary service area (SSA) towns. Provide a rationale for choosing the selected SSA towns.
   c) The units of service for the past three fiscal years and the current fiscal year- to-date by service area town *for each Applicant.*
   d) The units of service for the past three fiscal years and the current fiscal year- to-date by service type f*or each Applicant.*
   e) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
   f) Scheduling backlogs in service area.
   g) Travel distance from the proposed site to service area towns.
   h) Hours of operation of existing and the proposed service.

ii) Identify the existing providers of the proposed service in your service area.

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

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

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

Primary Service Area:

Name of Provider	Similar Services ided? (Y/N) (List the services)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services ided? (Y/N) (List the services)	Affiliated Physicians

D. 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.

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, 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.*

D. 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]

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 facility undertaken any of the following activities to improve productivity and contain costs?

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

7. Miscellaneous

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

C. Provide the following licensing information:

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

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

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

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

B. Provide the following financial information:

i) 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) If the Applicant is a hospital, provide the total current assets balance as of the date of submission of this application.

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

iv) If the Applicant is a hospital, provide the name and units of service for the new cost center to be established for the proposal.

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

vi) 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 current payer mix and the projected payer mix with the CON proposal for the proposed service based on Gross Patient Revenue in the following reporting format:

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

Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

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

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

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

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

ii) Please 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.

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

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or 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)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ $_____.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)

Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating 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				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.

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	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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	0	$0				$0	$0	$0
Uninsured		$0	0	$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 27, 2008

David Smith
Senior Vice President Strategy and Market Development
The Stamford Hospital
Shelburne Road at West Broad Street
P.O. Box 9317
Stamford, CT 06904

Re: Letter of Intent, Docket Number 08-31124
The Stamford Hospital
Establishment of Physical Therapy Services in Darien

Dear Mr. Smith:

On March 19, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Stamford Hospital ("Applicant") for the Establishment of Physical Therapy Services in Darien at The Stamford Hospital, at a total capital expenditure of $594,522.

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 27, 2008

Requisition # HCA08-159
Email: legal.notices@scni.com

The Advocate
75 Tresser Blvd.
Stamford, CT 06903

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, April 1, 2008.**

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 Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:AGF:lmg

c: Sandy Salus, OHCA

Stamford Hospital **Letter of Intent**
Docket Number 08-31124 **March 27, 2008**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	The Stamford Hospital
Town:	Darien
Docket Number:	08-31124-LOI
Proposal:	Establishment of Physical Therapy Services in Darien
Capital Expenditure:	$594,522

The Applicant may file its Certificate of Need application between May 18, 2008 and July 17, 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.

Greer, Leslie

From: Ginia Hines [Ginia.Hines@scni.com]
Sent: Thursday, March 27, 2008 1:31 PM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31124

All set.

Thank you
Ginia Hines

From: Greer, Leslie
Sent: Thursday, March 27, 2008 10:27 AM
To: legals
Subject: Legal Ad 08-31124

<<File: 08-31124 LOI Advocate.doc>>
Legal Ad,

Please run the attached public notice in your newspaper no later than April 1, 2008. Also please notify me that you have received this request.

Thank you,

Leslie M. Greer

Office of Health Care Access

State of Connecticut

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7001

Fax: (860) 418-7053

Website: www.ct.gov/ohca