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	Endoscopy Center of Connecticut, LLC	
Doing Business As	Endoscopy Center of Connecticut, LLC	
Name of Parent Corporation	Gastroenterology Center of Connecticut, P.C.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2200 Whitney Avenue Suite 380 Hamden, CT 06518	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Michael T. Koff CEO Endoscopy Center of Connecticut, LLC	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	2200 Whitney Avenue Suite 360 Hamden, CT 06518	
Contact Person Telephone Number	(203) 281-5100	
Contact Person Fax Number	(203) 287-2929	
Contact Person e-mail Address	mkoff@gastrocenter.org	

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2008 JUN 10 A 11:26
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: ~~Surgical Center Relocation~~ 'Relocation of the Endoscopy Center' Endoscopy Center of Connecticut, LLC

b. Project Proposal: Move location from Hamden to North Haven

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

Inpatient Service(s): N/A

- ☐ 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)* Ambulatory Endoscopy Center

Imaging: N/A

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

Non-Clinical: N/A

- ☐ 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:
162 State Street North Haven, CT 06473

g. List each town this project is intended to serve: Hamden, North Haven, New Haven E. Haven, W. Haven, Cheshire, Wallingford, Orange, Milford, Meriden

h. Estimated starting date for the project: December 2008

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: $ 750,000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	50,000*
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	700,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	750,000
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	750,000
Total Project Cost	750,000
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased. * To replace any worn out equipment upon move

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 N/A

   ☐ 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). N/A

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):

☑ Applicant's Equity	☐ Capital Lease	☑ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	

☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION Attached

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.

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

3. Identify the current population served and 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: Endoscopy Center of Connecticut, LLC.

Project Title: Relocation of the Endoscopy Center

I, Michael T. Koff, CEO
(Name) (Position – CEO or CFO)

of Endoscopy Center of Connecticut, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Endoscopy Center of Connecticut, LLC 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.

Michael T. Koff 6/5/08
Signature Date

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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on June 5, 2008

Notary Public/Commissioner of Superior Court

My commission expires: January 31, 2009

SECTION IV. PROJECT DESCRIPTION

The Endoscopy Center of Connecticut, LLC ("ECC") opened in Hamden, Connecticut in November of 1998 as the State's first free-standing single-specialty ambulatory endoscopy center. The ECC is licensed by the Connecticut State Department of Public Health (License No. 0279), certified by Medicare, (Supplier No. 07C0001018) and accredited by the Joint Commission[1] (a copy of the accreditation certificate is attached). It is 100% owned by the physicians who practice here. We propose to move our endoscopy center, which is currently located on Whitney Avenue in Hamden to a location on State Street in North Haven approximately two (2) miles away. By purchasing a condo in a new, state-of-the-art facility, we will fulfill our mission of providing "*sophisticated medical care, close to home in a warm and caring environment*" to our patients.

The current endoscopy center is housed in a 1960s building originally built for a computer company. Although the building was renovated to accommodate physician practices, there are numerous problems and design limitations, which include:

- The size of our waiting room is inadequate, and it does not allow us to bring patients in early for their procedures, often resulting in delays.
- The HVAC system is old and often malfunctions, resulting in wide and rapid temperature fluctuations, resulting in complaints from our patients.
- There are several support beams in the center of some of the recovery rooms making it difficult for nurses to move around the patients' beds.
- Elevators frequently break down, forcing patients to climb two flights of stairs to the third floor location of the ECC.
- Parking is congested; the front entrance allows for only one vehicle at a time to drop off or pick up individuals, further inconveniencing our patients.
- The current building location is adjacent to the Mill River. The parking lot floods after heavy rains, limiting parking for our patients.
- Since our patients have prepped for their procedures, they are not in a position to be rescheduled due to inadequate parking or an inaccessible building.

Our current endoscopy center is housed in space rented from the owners. We have no opportunity to negotiate with the building's owners regarding the cost of space which has escalated disproportionately each year. In addition, any repairs or renovations must be made under the paid supervision of the building's owners, which inflates the cost so that it is not cost effective. Suitable medical office space is hard to find in the immediate area. Therefore, it is time for us to seize the opportunity to enhance the environment for our patients by relocating the endoscopy center to a new building.

[1] The "Joint Commission" was formerly known as the Joint Commission on Accreditation of Healthcare Facilities.

Physician owners of the ECC perform upper and lower endoscopic examinations on ambulatory outpatients in three procedure rooms. The new location in North Haven, two miles away from the current location, will neither change our DPH licensure category nor change our patient population. Our center provides endoscopic services to patients in towns ranging from Milford in the South and West, to East Haven in the East and to Cheshire in the North.

The move of our ambulatory endoscopy center is not intended to address any unmet need. The same patients who come to Hamden will be served more effectively in the new facility with the same operational procedures enhanced by a modern patient-friendly building.

Our Hamden center has three procedure rooms as will the new North Haven location. Other providers of endoscopic services in the geographic area include the endoscopy centers at Yale-New Haven Hospital and the Hospital of Saint Raphael as well as an outpatient endoscopy facility affiliated with Yale at the Temple Surgical Center in New Haven. In addition, there is an endoscopy room in the multi-specialty surgery center located on Whitney Avenue in Hamden which is owned and operated by the Hospital of Saint Raphael. Since this proposal simply involves a move of the endoscopy facility from its present location in Hamden to the proposed location in North Haven serving the same patient population, there will be no effect on the health care delivery system in the State of Connecticut.

The physicians owners who currently provide services at the Hamden endoscopy facility are the same physicians who will provide services in the new location. We will not be changing providers as a direct result of the proposed move. The current payer mix for the Endoscopy Center of Connecticut is approximately: Medicare (30%), commercial insurers (65%) and self-pay and others (5%). There will be no change to the payer mix.

In summary, the proposed move of the Endoscopy Center of Connecticut, LLC from its current Hamden location to the proposed North Haven location will not affect the health care delivery system in the State of Connecticut. Since the physicians, target population and DPH licensure remain the same, as well as the services and the number of procedure rooms, the only change is the location from Hamden to North Haven.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0279

Outpatient Surgical Facility

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

Endoscopy Center of Connecticut, LLC of Hamden, CT, d/b/a Endoscopy Center of Connecticut, LLC is hereby licensed to maintain and operate an Outpatient Surgical Facility.

Endoscopy Center of Connecticut, LLC is located at 2200 Whitney Avenue, Hamden, CT 06514.

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

Dated at Hartford, Connecticut, January 1, 2008. RENEWAL.

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

9

The Joint Commission

May 2, 2008

Michael Koff
Chief Executive Officer
Endoscopy Center of Connecticut, LLC
2200 Whitney Avenue, Suite 380
Hamden, CT 06518

Joint Commission ID #: 224283
Accreditation Activity: Evidence of Standards Compliance
Accreditation Activity Completed: 5/2/2008

Dear Mr. Koff:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Ambulatory Health Care

This accreditation cycle is effective beginning March 22, 2008. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Linda S. Murphy-Knoll
Interim Executive Vice President
Division of Accreditation and Certification Operations

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 25, 2008

Michael Koff
Executive Director
Gastroenterology Center of CT, PC
2200 Whitney Avenue, Suite 380
Hamden, CT 06518

Re: Letter of Intent; Docket Number: 08-31184
Gastroenterology Center of CT, PC
Termination of the Endoscopy Center in Hamden and Establishment of the Endoscopy Center in North Haven

Dear Mr. Koff,

On June 10, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Gastroenterology Center of CT, PC ("Applicant") for the termination of the Endoscopy Center in Hamden and establishment of the Endoscopy Center in North Haven, at a total capital expenditure of $750,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The New Haven Register* 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

June 25, 2008

Requisition # HCA08-229
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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, June 29, 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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

New Haven Register
Docket Number: 08-31184

Letter of Intent
June 25, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Gastroenterology Center of CT, PC
Town:	Hamden
Docket Number:	08-31184-LOI
Proposal:	Termination of the Endoscopy Center in Hamden and establishment of the Endoscopy Center in North Haven
Capital Expenditure:	$750,000

The Applicant may file its Certificate of Need application between August 9, 2008 and October 8, 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 ***
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TRANSMISSION OK

TX/RX NO	3683
RECIPIENT ADDRESS	912038658360
DESTINATION ID	
ST. TIME	06/25 15:07
TIME USE	00'21
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 25, 2008

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If there are any questions regarding this legal notice, please contact Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

08-31184

Greer, Leslie

From: Fiducia, Paolo
Sent: Wednesday, June 25, 2008 11:19 AM
To: Greer, Leslie
Subject: FW: Newspaper Notice

From: Treiss, Carolyn
Sent: Wednesday, June 25, 2008 11:13 AM
To: Fiducia, Paolo
Subject: RE: Newspaper Notice

OK, go ahead and submit the notice.

Carolyn M. Treiss, JD, MSW
Chief of Staff

Office of Health Care Access
State of Connecticut
410 Capitol Avenue
3rd Floor, MS # 13HCA
Hartford, CT 06134-0308
(860) 418-7024

From: Fiducia, Paolo
Sent: Wednesday, June 25, 2008 10:56 AM
To: Treiss, Carolyn
Subject: RE: Newspaper Notice

The LOI came on June 10. According to statutes, it has to be submitted to the newspaper by the 15th day and today is the 15th day.

Paolo

From: Treiss, Carolyn
Sent: Tuesday, June 24, 2008 4:49 PM
To: Fiducia, Paolo
Subject: RE: Newspaper Notice

Paolo,
Can you tell me when this came into the agency and when the deadline for getting it published is? Then I can see if it can wait until after 7/1. thanks.
Carolyn

Carolyn M. Treiss, JD, MSW
Chief of Staff

Office of Health Care Access
State of Connecticut
410 Capitol Avenue
3rd Floor, MS # 13HCA
Hartford, CT 06134-0308
(860) 418-7024

From: Fiducia, Paolo
Sent: Tuesday, June 24, 2008 1:20 PM
To: Treiss, Carolyn
Cc: Greer, Leslie
Subject: Newspaper Notice

Hi Carolyn,

This is to request a newspaper notice approval for the following docket:

08-31184-LOI
Endoscopy Center of Connecticut, LLC
New haven Register

Thanxs,

Paolo

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 26, 2008

Michael Koff
Executive Director
Gastroenterology Center of CT, P.C.
2200 Whitney Avenue
Suite 300
Hamden, CT 06518

RE: Certificate of Need Application Forms, Docket Number 08-31184-CON
Gastroenterology Center of CT, P.C.
Termination of the Endoscopy Center in Hamden and Establishment of the Endoscopy Center in North Haven

Dear Mr Koff:

Enclosed are the application forms for Gastroenterology Center of CT, P.C.'s Certificate of Need ("CON") proposal to terminate the endoscopy center in Hamden and establish the endoscopy center in North Haven with an associated capital expenditure of $750,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 9, 2008, and October 8, 2008.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefiled testimony, late file submissions, and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please contact him at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

KM:pf

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 August 9, 2008, and may be submitted no later than October 8, 2008. The Analysts assigned to your application is Paolo Fiducia. He may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	08-31184-CON
Applicants' Names:	Gastroenterology Center of CT, P.C.
Contact Person:	Michael Koff
Contact Title:	Executive Director
Contact Address:	2200 Whitney Avenue, Suite 300 Hamden, CT 06518
Project Location:	Hamden
Project Name:	Termination of the Endoscopy Center in Hamden and Establishment of the Endoscopy Center in North Haven
Proposal Type:	Section 19a-638, C.G.S.
Est. Capital Cost:	$750,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicants' Long Range Plans

Is this application consistent with your long-range plan?

☐ Yes ☐ No If "No" is checked, please provide an explanation.

4. Clear Public Need

A. List the service area towns for both the existing (Hamden) and the proposed (North Haven) endoscopy center. Provide the rationale for choosing the selected towns.

B. Explain the Applicant's rationale terminating services in Hamden and establishing services in North Haven. Identify the process undertaken by the Applicant in making the decision.

C. Explain how it was determined there was a need for the proposal in North Haven, and whether the Applicant considered alternative locations other than North Haven. Provide a list and describe the alternative locations considered, if applicable.

D. Discuss how the termination of services in Hamden and establishment of services in North Haven will affect patient access. Address any special populations that are utilizing the service and explain how these clients will continue to access this service.

E. Report the population to be served in North Haven, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.

F. Report the number of procedures performed for the past three fiscal years by service area town (zip code) *and* type of procedure performed.

G. Scheduling backlogs in service area

H. Travel distance from proposed site to service area towns

I. Hours of operation of existing and proposed services.

J. Provide the information as outlined in the following table concerning the existing providers' in the Applicant's service area (for both the existing and proposed sites):

Provider Name, Street Address, Town, and Zip Code	Number of Operating Rooms				Estimated Capacity for Proposal		Current Utilization[7]
	Available[1]	Utilized[2]	Not Utilized[3]	Equipped for Proposal[4]	Minimum[5]	Maximum[6]	
				Total			

[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.
[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.

K. What will be the effect of the termination of the Hamden location and establishment of the North Haven location on existing providers?

L. Report the number of procedures projected for the first three **full** fiscal years of operation of the proposed service (in addition to projections for any partial first year) by service area town (zip code) *and* type of procedure performed.

M. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural
☐ Geographic
☐ Other (Identify)
☐ Transportation
☐ Economic

☐ None, Please provide an explanation.

N. 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. 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 Applicants' Chief Executive Officers (CEO) and Chief Financial Officers (CFO), Medical Directors, 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

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.

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[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.

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

ii) Provide a copy of the most recently completed internal monthly financial statements for the Applicant, including utilization volume totals to date.

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

iv) Submit audited financial statements for the most recently completed fiscal year for the Applicant. If no audited financial statements are available, submit a compilation report or an unaudited Balance Sheet as of the date of the submission of this application and a Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

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

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: _____

Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:
# of Months in Operation

FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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 equipment.

** Provide a current vendor quote for each piece of major medical equipment proposed for purchase or lease.

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:

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 Total Facility based on Gross Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	FY _____ Year 1 Projected Payer Mix	FY _____ Year 2 Projected Payer Mix	FY _____ 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				
Total 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) Provide 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 full years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, Financial Attachment II.**

iii) List the assumptions utilized in developing the projections reported on Financial Attachments I and II **(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.

vii) Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.