Saint Raphael
Healthcare System

659 George Street
New Haven, Connecticut 06511

J.C. Lubin-Szafranski
Vice President/General Counsel
(203) 789-3336

June 10, 2008

Ms. Cristine Vogel
Commissioner
Office of Health Care Access
State of Connecticut
410 Capital Avenue, 3rd Floor
Hartford, Connecticut 06134-0308

RE: Certificate of Need Determination Form 2020, Saint Raphael Healthcare System Hamden Surgery Center, LLC Proposal

Dear Commissioner Vogel:

Enclosed are three copies of our Certificate of Need ("CON") Determination Form 2020 for the Saint Raphael Healthcare System Hamden Surgery Center, LLC proposal for the sale of membership interests in the Saint Raphael Healthcare System Hamden Surgery Center, LLC.

This proposal will accommodate the needs of area physicians, foster growth and maintain the viability of the Hamden Surgery Center. Physicians will utilize the Center to acquire an ownership interest in the facility and provide a stake in its success. Ownership will encourage these physicians to utilize the Center as an extension of their medical practice, thus contributing to the Center's financial stability and ensuring continued access to ambulatory surgical care for the patients in the service area.

We look forward to receiving a determination from the Commission regarding the need for a CON at your earliest convenience. Please do not hesitate to contact me at (203) 789-4030 with any questions regarding this proposal.

Sincerely,

J.C. Lubin-Szafranski
Vice President/General Counsel

Enclosure
JCLS/gja/Letter - CON Hamden Surgery Center 6 10 08
CC: David Benfer
Terrie Estes
Pat Weitzman, Esq.

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted 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. PETITIONER INFORMATION

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

	Petitioner	Petitioner
Full Legal Name	Saint Raphael Healthcare System Hamden Surgery Center, LLC	
Doing Business As	Hamden Surgery Center	
Name of Parent Corporation	DePaul Health Services Corporation/Saint Raphael Healthcare System, Inc.	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	2080 Whitney Avenue Suite 100 Hamden, CT 06518-3645	
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	Janeanne C. Lubin-Szafranski, Esq. VP/General Counsel Saint Raphael Healthcare System, Inc.	Patricia D. Weitzman, Esq. Levett Rockwood P.C.

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	659 George Street New Haven, CT 06511	33 Riverside Avenue Westport, CT
Contact Person's Telephone Number	203-789-4030	203-222-3116
Contact Person's Fax Number	203-789-4244	203-226-8025
Contact Person's e-mail Address	jlubinszafranski @srhs.org	pweitzman @levettrockwood.com

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: Sale of Membership Interests in Hamden Surgery Center, LLC

b. Location of proposal, identifying Street Address, Town and Zip Code:
2080 Whitney Avenue, Suite 100, Hamden, CT 06518-3645

c. List each town this project is intended to serve: The current main service area of the Hamden Surgery Center: New Haven, Hamden, North Haven, West Haven, East Haven

d. Estimated starting date for the project: August 1, 2008

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☒	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):_____			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ N/A

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above) N/A

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space –Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal: N/A

☐ Petitioner's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROPOSAL 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 elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are 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 the entity that will be providing the service(s).
5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.
6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service.
7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.
8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.
9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.
10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.
11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

SECTION V. USE OF CON DETERMINATION FORM AS A LETTER OF INTENT

If the Petitioner's proposal requires a Certificate of Need, please check one of the following:

☒ OHCA may consider the form, and the information provided, as the Petitioner's Letter of Intent Form 2030 requesting initiation of the Certificate of Need process. OHCA will provide the Petitioner a CON application for the proposal.

☐ The Petitioner will submit a separate Letter of Intent Form 2030 to request the initiation of the Certificate of Need process.

SECTION VI. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Hamden Surgery Center, LLC

Project Title: Sale of Membership Interests in Hamden Surgery Center, LLC

I, David Benfer (Name), CEO (Position – CEO or CFO)

of Saint Raphael Healthcare System, Inc. (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Hamden Surgery Center, LLC (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

Date June 3, 2008

RECEIVED
2008 JUN 11 A 11:09
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Subscribed and sworn to before me on June 3, 2008

Notary Public/~~Commissioner of Superior Court~~

My commission expires:

Gloria Astarita
Notary Public, State of Connecticut
My Commission Expires Oct. 31, 2011

DESCRIPTION OF PROJECT

Hamden Surgery Center, LLC (the "LLC") currently operates a freestanding, multi-specialty ambulatory surgery center (the "ASC") located at 2080 Whitney Avenue, in Hamden, Connecticut. The sole member of the LLC is DePaul Health Services Corporation ("DePaul"). The sole member of DePaul is St. Raphael Healthcare System, Inc. ("SRHS").

The ASC was established pursuant to a certificate of need ("CON"), Docket Number 98-552, granted by final order of the Office of Health Care Access ("OHCA") on May 19, 1999. The ASC is used most often by patients living in the immediate service area comprised primarily of Hamden, New Haven, West Haven, East Haven and North Haven, but it is also used by patients throughout the greater New Haven area. The ASC offers comprehensive ambulatory surgery procedures including outpatient surgical procedures in general surgery, orthopedics, gynecology, ophthalmology, urology, otolaryngology, cosmetic and reconstructive plastic surgery, oral/maxillofacial, podiatry, pain management and gastroenterology. The ASC is licensed by the Connecticut Department of Public Health ("DPH") as an Outpatient Surgical Facility (copy of license attached hereto as Exhibit A).

Currently, DePaul owns 100% of the membership interests in the LLC. In order to accommodate the needs of area physicians, foster growth and maintain the viability of the ASC, DePaul intends to sell up to 49% of the membership interests in the LLC to physicians who will perform ambulatory procedures at the ASC, their professional practices and/or trusts established for the benefit of such physicians or their families. Allowing physicians who will utilize the ASC to acquire an ownership interest in the facility will give the physicians a stake in the ASC's success. Ownership will encourage these physicians to utilize the ASC as an extension of their medical practice, thus contributing to the ASC's financial stability and ensuring continued access to ambulatory surgical care for the patients in the service area.

DePaul would retain at all times at least 51% ownership of membership interests in the LLC and as majority owner, also would maintain ultimate control over the operations of the ASC. There will be a total of 200 membership units in the ASC; DePaul will hold at least 102 membership units and up to 98 membership units will be offered to physician investors via a private offering memorandum.

The ASC will be managed by a ten (10) member Board of Managers, seven (7) of whom will be voting Managers and three (3) of whom will be non-voting Managers. DePaul or SRHS will appoint four (4) voting Managers and the physician investor group will elect three (3) voting Managers. The three (3) non-voting, ex officio Managers will be the Executive Director and Medical Director of the ASC, and the President of the Hospital of Saint Raphael Medical Staff. In addition to having control and majority voting representation on the Board of Managers, DePaul/SRHS will maintain reserve powers, which will ensure its continued sole control over major ASC decisions as well as preserve its charitable mission and community service objectives.

Payors and billing for services at the ASC will remain the same. The principal payors include Medicare, private pay insurance, Medicare Managed Care, health maintenance organizations, traditional indemnity insurance and Medicaid. The ASC will continue to operate at its present location pursuant to its existing lease. Furthermore, the ASC will operate under its existing DPH license and will continue to provide the same outpatient ambulatory surgical services that it currently provides. There will be no

changes in the delivery of health care services as a result of the proposed sale of minority membership interests.

In prior decisions, OHCA has approved the sale to physicians of minority interests in ambulatory surgery centers, e.g., Docket 07-20020-MDF; Docket 06-20008 MDF; Docket 02-549; Docket 01-505; and Certificate of Need Determination, Report Number 00-B4. Pursuant to Section 19a-638(a)(3) of the Connecticut General Statutes, "Each health care facility or institution which intends to transfer all or part of its ownership or control....shall submit to the office, prior to the proposed date of such transfer or change...a request for permission to undertake such transfer or change....". Based on the foregoing description of the proposed transaction, we respectfully request that OHCA find that the purchase by physicians, their practices, or physician trusts of a minority interest of no more than 49% of the membership interests in the ASC does not change the current control of the ASC and thus, no CON is necessary.

Exhibit A

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0266

Outpatient Surgical Facility

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

Saint Raphael Healthcare System Hamden Surgery Center, LLC of Hamden, CT, d/b/a Hamden Surgery Center is hereby licensed to maintain and operate an Outpatient Surgical Facility.

Hamden Surgery Center is located at 2080 Whitney Avenue, Hamden, CT 06518.

This license expires March 31, 2010 and may be revoked for cause at any time.

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

J Robert Galvin MD, MPH, MBA

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 26, 2008

Janeanne C. Lubin-Szafranski, Esq.
Vice-President & General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511

RE: Certificate of Need Determination Request; Report Number: 08-31186-DTR
Hamden Surgical Center
Sale of Membership Interests by Saint Raphael Healthcare System Hamden Surgical Center, LLC, d/b/a Hamden Surgical Center to Other Physicians

Dear Ms. Lubin-Szafranski, Esq.:

On June 11, 2008, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of Saint Raphael Healthcare System Hamden Surgical Center, LLC, d/b/a Hamden Surgical Center to sell membership interests in Hamden Surgical Center to other physicians at no capital expenditure. Please be advised that OHCA has reviewed your request and makes the following findings:

1. Saint Raphael Healthcare System Hamden Surgical Center, LLC, d/b/a Hamden Surgical Center ("Petitioner") is a freestanding, multi-specialty ambulatory surgery center ("ASC") located at 2080 Whitney Avenue in Hamden, Connecticut.

2. The Petitioner is a health care facility pursuant to Section 19a-630(1) of the Connecticut General Statutes ("C.G.S."). Section C.G.S. 19a-630(1) provides in relevant part:

(1) "Health care facility or institution" means any facility or institution engaged primarily in providing services for the prevention, diagnosis or treatment of human health conditions, including, ... outpatient surgical facilities.....". "Health care facility or institution" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility or institution ..."

3. The ASC offers comprehensive ambulatory surgery procedures including outpatient surgical procedures in general surgery, orthopedics, gynecology, ophthalmology, urology, otolaryngology, cosmetic and reconstructive plastic surgery, oral/maxillofacial, podiatry, pain management and gastroenterology.

4. The sole member of Hamden Surgery Center is DePaul Health Services Corporation ("DePaul"), which owns 100 % of the membership interests in the ASC. The sole member of DePaul is Saint Raphael Healthcare System, Inc. ("SRHS").

5. In its attempts to accommodate the needs of area physicians, fostering growth and maintaining the viability of the ASC, DePaul is requesting that it be able to sell up to 49% of the membership interests in the Hamden Surgery Center to the following entities:
   - Physicians who will be performing ambulatory procedures at the ASC;
   - The physician's professional practices; and/or
   - Trusts established for the benefit of such physicians or their families.

6. Outpatient surgical facilities must meet certain requirements pursuant Section 19a-638 C.G.S. This section provides in relevant part:

   (1) "Each health care facility or institution that intends to (A) transfer all or part of its ownership or control... shall submit to the office, prior to the proposed date of such transfer or change, a request for permission to undertake such transfer or change."

7. DePaul indicates it will at all times retain at least a 51% ownership of membership interests in the ASC and as the majority owner it would maintain control over the operations of the ASC.

8. There will be a total of 200 membership shares in the ASC of which DePaul will hold at least 102 membership shares and up to 98 membership units will be offered physician investors via a private offering memorandum.

9. The proposal will not affect the following aspects of the ASC operation:
   - Payers and billing services will remain the same;
   - The facility will continue to operate at the same location, pursuant to the existing lease;
   - The center will continue to operate under its existing Connecticut Department of Public Health license; and
   - The array of outpatient ambulatory surgical services offered at the center will remain the same.

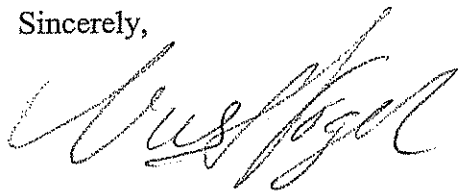
Based on the aforementioned findings, OHCA determines that Saint Raphael Healthcare System Hamden Surgical Center, LLC, d/b/a Hamden Surgical Center is a health care facility and that the sale of membership interests in Hamden Surgical Center to other physicians at no capital expenditure, represents a change in the ambulatory surgery center's ownership structure. Therefore, Hamden Surgery Center's proposal to sell membership interests in Hamden Surgical

Center to other physicians does require Certificate of Need authorization by OHCA, pursuant to Section 19a-638 of the Connecticut General Statutes.

OHCA considers the submission of information received on June 11, 2008, as the Letter of Intent for this matter. Therefore, the Hospital, may file a completed CON application with OHCA between August 10, 2008 and October 9, 2008. The CON application is being mailed to your attention separately.

If you have any questions concerning this letter, please contact Jack A. Huber, Health Care Analyst, at (860) 418-7034.

Sincerely,



Cristine A. Vogel
Commissioner

CAV:jah

Copy: Patricia D. Weitzman, Esq., Levett Rockwood, PC

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 30, 2008

Janeanne Lubin-Szafranski Esq.
Vice-President/General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511

RE: Certificate of Need Application Forms; Docket Number: 08-31186-CON
Saint Raphael Healthcare System, Inc.
Sale of Membership Interests by Saint Raphael Health Care System Hamden Surgical Center, LLC to Other Physicians at No Capital Cost.

Dear Ms. Lubin-Szafranski:

Enclosed are the application forms for Saint Raphael Healthcare System, Inc.'s Certificate of Need ("CON") proposal for the sale of membership interests by Saint Raphael Health Care System Hamden Surgical Center, LLC to other physicians at no capital cost. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 10, 2008 and October 9, 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 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

KRM:jah

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 an acceptable answer. Your Certificate of Need application will be eligible for submission no earlier than August 9, 2008 and may be submitted no later than October 9, 2008. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number:	08-31186-CON
Applicant Name:	Saint Raphael Healthcare System Hamden Surgical Center, LLC
Contact Person:	Janeanne Lubin-Szafranski Esq.
Contact Title:	Vice-President/General Counsel
Contact Address:	Saint Raphael Healthcare System, Inc. 659 George Street New Haven, CT 06511
Project Location:	Hamden
Project Name:	Sale of Membership Interests by Saint Raphael Health Care System Hamden Surgical Center, LLC 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: _____ 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, 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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
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 membership interests 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 I. 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]	

Notes:
[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. 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.

P. Provide copies of needs assessments and market share analyses performed to support the need for the proposal. If there are none, explain why no such assessments or analyses were undertaken by the Applicant.

Q. Provide copies of any epidemiological, public information or other similar studies related to your proposal. If there are none, please explain why none are available.

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 Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Abuse Society and Mental Health Services Administration
☐ Other, Specify:		

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 related sections of the Quality Assurance plan to the proposal and the corresponding sections of the latest annual evaluation report of the Hospital's Quality Assurance Committee.

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.

---

[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.

C. Provide a copy of the State of Connecticut Department of Public Health license currently held.

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

8. Offering of Additional Membership Interests

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 membership interest 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 membership interests by individual or group.

9. Financial Information

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

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

B. Provide the following financial information:

i) 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) Provide the latest cash equivalent balance as of the date of submission of this application.

iii) 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 membership interest 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	

Note: * Provide an itemized list of all medical and 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.

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:	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	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.

13.C(ii). Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description
Type of Unit Description:
# of Months in Operation

Year 1	(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
				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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 1, 2008

Janeanne Lubin-Szafranski, Esq.
Vice President/General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511

Re: Letter of Intent; Docket Number: 08-31186-LOI
Saint Raphael Healthcare System Hamden Surgical Center, LLC
Sale of Membership Interests by Saint Raphael Health Care System Hamden Surgical Center, LLC to Other Physicians

Dear Ms. Lubin-Szafranski,

On June 11, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Saint Raphael Healthcare System Hamden Surgical Center, LLC, ("Applicant") for the sale of membership interests by Saint Raphael Health Care System Hamden Surgical Center, LLC to other physicians, at no capital expenditure.

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 Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 1, 2008

Requisition # HCA08-003
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 **Saturday, July 5, 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 Jack Huber at (860) 418-7034.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

New Haven Register **Letter of Intent**
Docket Number: 08-31186-LOI **July 1, 2008**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Saint Raphael Healthcare System Hamden Surgical Center, LLC
Town:	Hamden
Docket Number:	08-31186-LOI
Proposal:	Sale of membership interests by Saint Raphael Health Care System Hamden Surgical Center, LLC, to other Physicians
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between August 10, 2008 and October 9, 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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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

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