

**JEFFERS & IRELAND
PROFESSIONAL CORPORATION**

55 WALLS DRIVE, FAIRFIELD, CT 06824
PHONE: (203) 259-7900 ♦ FAX: (203) 259-1070
www.jeffire.com

FACSIMILE TRANSMITTAL SHEET

TO:	Comm. Cristine Vogel	FACSIMILE NO.:	860-418-7053
CC:		FACSIMILE NO.:	
FROM:	Stephen M. Cowherd	DATE:	3/2/09
RE:	Letter of Intent	TOTAL NO. OF PAGES INCLUDING COVER:	11
NOTES/COMMENTS:			

Dear Commissioner Vogel:

We respectfully submit the attached Letter of Intent on behalf of North Haven Pain Medicine Center, LLC. We have sent via Federal Express the original and five (5) copies.

If you have any questions, please do not hesitate to contact me.

Regards,

Steve Cowherd

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2009 MAR -2 P 3:18
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

(00000-001,000004794,DOC) The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original document to us at the above address via the U.S. Postal Service. Thank you.

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CONNECTICUT OFFICE OF
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KAREN A. JEFFERS
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CAROLYN R. LINSEY

TINA PASSALARIS
JASON A. MARSH
MICHELLE S. GOGLIA
STEPHANIE E. SPRAGUE

JEFFERS & IRELAND

PROFESSIONAL CORPORATION

ATTORNEYS AT LAW

55 WALLS DRIVE

FAIRFIELD, CONNECTICUT 06824

TELEPHONE (203) 259-7900

TELECOPIER (203) 259-1070

WWW.JEFFIRE.COM

March 2, 2009

VIA FACSIMILE AND FEDERAL EXPRESS

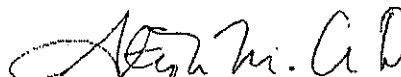
Hon. Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134-0308

**Re: North Haven Pain Medicine Center, LLC
Letter of Intent for Expansion of Ownership/Scope of Services**

Dear Commissioner Vogel:

Enclosed please find an original and five (5) copies of North Haven Pain Medicine Center, LLC's ("NHPMC") Letter of Intent to permit Drs. Craig Heet and David Astracan to purchase a 20% interest in NHPMC and permit the ear, nose and throat procedures that these same physicians perform to be carried out at its licensed outpatient surgical facility. Should you have any questions, please feel free to contact me at the number above or Steven P. Oster, the Administrator for NHPMC, at (203) 234-7727.

Respectfully submitted,



Stephen M. Cowherd

SMC/lsh
Enclosures



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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	North Haven Pain Medicine Center, LLC	
Doing Business As	same	
Name of Parent Corporation	not applicable	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	52 Washington St. Suite A, North Haven, CT 06473	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes No <input checked="" type="checkbox"/>	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Stephen M. Cowherd, Esq.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Jeffers & Ireland, P.C. 55 Walls Drive Fairfield, CT 06824	
Contact Person Telephone Number	203-259-7900	
Contact Person Fax Number	203-259-1070	
Contact Person e-mail Address	SCowherd@jeffire.com	

SECTION II. GENERAL APPLICATION INFORMATION

- a. Project Title: Purchase of Interest in North Haven Pain Medicine Center, LLC
- b. Project Proposal: Purchase of 20% interest in North Haven Pain Management Center by Drs. Craig Hect and David Astracan
- c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

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

Outpatient Service(s):

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

Imaging:

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

Non-Clinical:

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

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

☒ Yes☐ No

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

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

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

☐ Yes ☒ No

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

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

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

52 Washington Street, Suite A, North Haven, CT 06473

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

The Greater New Haven and Shoreline service area including New Haven, West Haven, East Haven, North Haven, Bridgeport, Shelton, Stratford, Milford, Hamden, Naugatuck, Wallingford, Woodbridge, Orange, Ansonia, Cheshire, Meriden, Bethany, Branford, Clinton, Madison, Seymour and Guilford.

- h. Estimated starting date for the project: Upon OHCA approval.

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

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

- a. Estimated Total Project Expenditure/Cost: \$296,183
- b. Please provide the following tentative capital expenditure/costs related to the proposal:

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	221,183
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	75,000
Other (Non-Construction) Specify: _____	
Total Capital Expenditure	296,183
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	296,183
Total Project Cost	296,183
Capitalized Financing Costs (Informational Purpose Only)	

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

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

☐ Yes

☐ No

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

☐ Energy Conservation

☐ Health, Fire, Building and Life Safety Code

☐ Non Substantive

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

- d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

c. Type of financing or funding source (more than one can be checked): [How will any capital improvements be paid for?]

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Applicant's Equity | <input type="checkbox"/> Capital Lease | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing |
| <input type="checkbox"/> Funded Depreciation | <input type="checkbox"/> Grant Funding | |
| <input type="checkbox"/> Other (specify) _____ | | |

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.
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: North Haven Pain Medicine Center, LLC

Project Title: Purchase of Interest in North Haven Pain Medicine Center, LLC

I, Sean Rambo, a Governing Board Member
(Name) (Position – CEO or CFO)

of North Haven Pain Medicine Center, 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 North Haven Pain Medicine Center, LLC 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.

S-RQ.
Signature

2/28/09
Date

Subscribed and sworn to before me on February 28, 2009

Brooks Bagley
Notary Public/Commissioner of Superior Court

My commission expires: May 1, 2010



RECEIVED
2009 MAR -2 P 3:18
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

PROJECT DESCRIPTION

North Haven Pain Medicine Center, LLC ("Applicant") is a limited liability company whose current members include Comprehensive Pain and Headache Treatment Centers, LLC ("CPHTC") and Titan Health Corporation ("Titan"). At present, the Applicant owns and operates a Medicare-certified ambulatory surgery center dedicated to interventional pain management services located at 52 Washington Avenue in North Haven, CT (the "Center"). The Center is licensed as an outpatient surgical facility by the Connecticut Department of Public Health and was given certificate of need approval under Docket No. 05-30492-CON. Since its inception, the Center has been successfully providing a variety of interventional pain procedures to residents of the Greater New Haven and Shoreline service area at its newly built 6,500 square foot facility.

Pursuant to this proposal, the Applicant proposes to expand its ownership and scope of services by selling a 20% interest in the Center to Drs. Craig Hect and David Astracan (the "Physician Investors"). The Physician Investors are principals in Ear, Nose and Throat Specialists of Connecticut, P.C., a specialty practice that has been in existence for over 17 years with a main office in Hamden and satellite offices in Madison and Milford. The Physician Investors will be shifting outpatient volume to the Center from another ambulatory surgery center that has closed in the area and both the Applicant and the Physician Investors would prefer that the Center's existing resources be utilized to perform these ear, nose and throat procedures rather than developing a new surgical venue for these cases. Like the CPHTC physicians, the Physician Investors are highly experienced clinicians with an established practice in the local community and will continue to perform procedures at acute care facilities in the service area. Accordingly, the impact on other providers from this proposal is expected to be minimal.

The expansion of services at the Center will meet an identified need for ear nose and throat ambulatory surgical services in a freestanding facility that will be readily accessible to residents of the region. No other suitable facility exists in the Hamden-North Haven area. In addition, the manageable volume forecasts associated with Drs. Hect and Astracan's practice make them a good clinical complement to the pain management activities of the Center and performance of their cases will not involve a major retrofitting of the facility or significant equipment purchases. Under the proposal, each of the Physician Investors will acquire a 10% interest in the Center with CPHTC retaining majority control with a 52% interest and Titan holding the remaining 28% interest.

The inclusion of the additional ear, nose and throat procedures will promote the Center's own cost-effectiveness by enhancing utilization of available capacity. All the procedures to be performed at the Center will be performed under its existing facility license and there will be no significant change in payor mix for the Center as the payor mix of the Physician Investors' practice, including services to Medicaid beneficiaries, is very comparable to the Center's. Accordingly, the investment to be made and the provision of medical services by the Physician Investors will allow the Center to operate closer to capacity, require minimal capital investment, and will enhance the health care delivery system by providing these services locally at an existing high quality facility with an experienced administrative staff that is focused exclusively on ambulatory surgery.

Attachment A

Item Description

Amsco-Steris Autoclave

Amsco-Steris Surgica Lights

Amsco 3080 OR Table

GE Aespire 7900 Anesthesia Machine

Zeiss Operating ENT Microscope

Electrosurgical Generator

Luxtec ENT Headlight with Lightsource

Install Additional Gas Manifold and Piping for Nitrous and Compressed Air

Infant/Child Cribs with Bumpers

Difficult Airway Cart - Pedi/Adult

JEFFERS & IRELAND

PROFESSIONAL CORPORATION

ATTORNEYS AT LAW

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FAIRFIELD, CONNECTICUT 06824

KAREN A. JEFFERS
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JASON A. MARSH
MICHELLE S. GOGLIA
STEPHANIE E. SPRAGUE

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2009 MAR -3 A 11:54

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

TELEPHONE (203) 259-7900
TELECOPIER (203) 259-1070
WWW.JEFFIRE.COM

March 2, 2009

VIA FACSIMILE AND FEDERAL EXPRESS

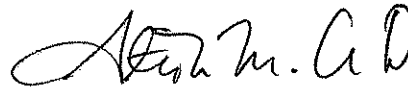
Hon. Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
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Respectfully submitted,



Stephen M. Cowherd

SMC/lsh
Enclosures



State of Connecticut

Office of Health Care Access

Letter of Intent Form

Form 2030

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Doing Business As	same	
Name of Parent Corporation	not applicable	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	52 Washington St. Suite A, North Haven, CT 06473	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes No X	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Stephen M. Cowherd, Esq.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Jeffers & Ireland, P.C. 55 Walls Drive Fairfield, CT 06824	
Contact Person Telephone Number	203-259-7900	
Contact Person Fax Number	203-259-1070	
Contact Person e-mail Address	SCowherd@jeffire.com	

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☒ Yes ☐ No

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

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- h. Estimated starting date for the project: Upon OHCA approval.

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

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

☐ No

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

☐ Energy Conservation

☐ Health, Fire, Building and Life Safety Code

☐ Non Substantive

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

- d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Applicant's Equity | <input type="checkbox"/> Capital Lease | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing |
| <input type="checkbox"/> Funded Depreciation | <input type="checkbox"/> Grant Funding | |
| <input type="checkbox"/> Other (<i>specify</i>) _____ | | |

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

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AFFIDAVIT**To be completed by each Applicant**

Applicant: North Haven Pain Medicine Center, LLC

Project Title: Purchase of Interest in North Haven Pain Medicine Center, LLC

I, Sean Rambo, a Governing Board Member
 (Name) (Position – CEO or CFO)

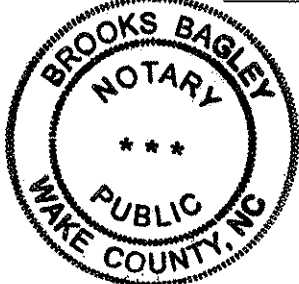
of North Haven Pain Medicine Center, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that North Haven Pain Medicine Center, LLC complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

S-RQ. 2/28/09
 Signature Date

Subscribed and sworn to before me on February 28, 2009

Brooks Bagley
 Notary Public/Commissioner of Superior Court

My commission expires: May 1, 2010



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 HEALTH CARE ACCESS

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Attachment A

Item Description

Amsco-Steris Autoclave

Amsco-Steris Surgica Lights

Amsco 3080 OR Table

GE Aespire 7900 Anesthesia Machine

Zeiss Operating ENT Microscope

Electrosurgical Generator

Luxtec ENT Headlight with Lightsource

Install Additional Gas Manifold and Piping for Nitrous and Compressed Air

Infant/Child Cribs with Bumpers

Difficult Airway Cart - Pedi/Adult