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	Connecticut Orthopaedic Specialists, P.C.	
Doing Business As	Connecticut Orthopaedic Specialists, P.C.	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2408 Whitney Avenue Hamden, CT 06518	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	No	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Glenn Elia Chief Executive Officer	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	2408 Whitney Avenue Hamden, CT 06518	
Contact Person Telephone Number	(203) 407-3576	
Contact Person Fax Number	(203) 407-4244	
Contact Person e-mail Address	gelia@ct-ortho.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Relocation of Existing Single Specialty Surgery Center

b. Project Proposal: Connecticut Orthopaedic Specialists, P.C. ("the Applicant") proposes to move its existing surgical center from Hamden, CT to Branford, CT. This location is within the Applicant's service area. The patients now receiving services in Hamden go to that facility because they are patients of the physicians who own the facility as part of their medical practice. These same patients will now be directed to the Branford location. This is not a new service.

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:

84 North Main Street Branford CT 06405

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

Response:

The towns in the service area will be exactly the same as the towns which make up the existing service area. Those towns are Branford, Cheshire, East Haven, Guilford, Hamden, Madison, Meriden, Milford, New Haven, North Haven, Orange, Wallingford, and West Haven.

h. Estimated starting date for the project:

Response:

Assuming an approval of CON application along with Branford P&Z approvals, we expect to break ground on or about January 1, 2010.

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: $ 2,120,000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	0
Non-Medical Equipment Purchases*	
Land/Building Purchases	0
Construction/Renovation ** see below for breakdown	$2,120,000
Other (Non-Construction) Specify	
Total Capital Expenditure	**$2,120,000**
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	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only) estimated	$ 1,484,000

- * 8,000 sq/ft of building construction up to vanilla box @ $140 / sq/ft = $1,120,000
- ** Internal fit up of surgical center is estimated to be $1,000,000

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
None				

N/A: COS will plan to use existing 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

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

Applicant: Connecticut Orthopaedic Specialists, P.C.

Project Title: Relocation of CT Orthopaedic Specialists Surgery Center

I, Glenn Elia, CEO of Connecticut Orthopaedic Specialists, P.C.,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 Connecticut Orthopaedic Specialists, P.C. 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.

Glenn Elia — August 13, 2009

Signature — Date

Subscribed and sworn to before me on August 13 2009

Michael Longo

Notary Public/Commissioner of Superior Court

My commission expires: 3/31/11

RECEIVED
2009 AUG 20 P 3:45
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Project Description

Connecticut Orthopaedic Specialists, P.C. ("COS") is a single specialty orthopedic group practice. It provides orthopedic surgery only to the patients of the physician/owners. COS is owned 100% by its physician/owners who have offices located in Branford, Guilford, Hamden, New Haven, Orange and Wallingford. The surgery center operated by COS is utilized by all of the physician/owners for orthopedic surgery and is licensed by the Department of Public Health ("DPH"). There is no new service being proposed. Orthopedic surgery will be provided to the patients of the existing physicians, and this will be the same as the service already being provided at the existing facility. No new licensure categories will be sought. COS has been located in Hamden for over fifteen years in space rented from a landlord who owns the medical office building. The space has grown increasingly unacceptable over the last few years, and is currently operating under waivers from the DPH. COS believes it is critical to relocate in order to provide a safe and efficient space to perform surgery for its patients. Based on this need for appropriate space for their surgery center, the physician/owners of COS have been looking for a suitable place to relocate for the past two years.

In order to guarantee a safe environment for their patients and in order to save money that is currently being spent on rent, the physicians of COS determined that they would like to purchase or build a building which could be used for the surgery center. A great deal of time and effort has been spent researching possible sites, from existing buildings to land where a building could be built. An intense search was undertaken in both Hamden and North Haven in an attempt to relocate near to the existing facility. However, after exhausting all possibilities in these two towns, the search was broadened within the service area of the facility, which encompasses most of New Haven County. COS determined that the location it has selected in Branford is the best choice for relocation. One reason that Branford was chosen is due to the fact that the property is already owned by the practice. 84 North Main Street in Branford is the site of one of the COS outpatient satellite offices. The land parcel has two building lots and sufficient space for a second, 16,000 sq ft building. The Town of Branford has already given COS positive indications that it supports the land use for a another medical building. Use of this available land space will save COS between $800,000 and $1,000,000 in land acquisition costs. Another reason that Branford makes sense for this proposed relocation is that COS patient trends have pointed to the fact that there is a growing number of patients coming to the practice from this eastern side of New Haven county. Last but certainly not least, over 50% of the COS physicians now reside in the Branford/Madison shoreline region.

The current patient population is comprised of the patients of the physician/owners who come from the service area for the group practice. Patients are from the following towns in New Haven County: Branford, Cheshire, East Haven, Guilford, Hamden, Madison, Meriden, Milford, New Haven, North Haven, Orange, Wallingford, and West Haven. There is no new target population. The practice is expected to remain the same, only in a new location. Some of the COS patients will now have a shorter drive to the surgery center, and others will have a longer drive, but the drive is all within the service area for the facility.

Within New Haven County, outpatient orthopedic surgery is currently offered at the following ambulatory surgery centers: Temple Surgical Center in New Haven, the Shoreline Surgery Center in Guilford and the COS Surgery Center in Hamden. There will be no effect on existing providers due to the relocation of the surgery center because the physicians and the patients will be the same in Branford as they are now in Hamden. No new physicians are being added to the practice, and the facility is only used by the physicians who are in the practice of Connecticut Orthopaedic Specialists, P.C.
The physicians who own Connecticut Orthopaedic Specialists, P.C. will be responsible for providing the service.

The current payers of the service provided are Medicare, commercial insurers, workers compensation and uninsured. This mix is not expected to change due to a change in location.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 25, 2009

Glen Elia
Chief Executive Officer
Connecticut Orthopaedic Specialists, PC
2408 Whitney Avenue
Hamden, CT 06518

Re: Letter of Intent, Docket Number 09-31440
Relocation of Existing Single Specialty Surgery Center from Hamden, CT to Branford, CT
Notice of Letter of Intent

Dear Mr. Elia,

On August 20, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Connecticut Orthopaedic Specialists, PC ("Applicant") for the relocation of an existing Single Specialty Surgery Center from Hamden, CT to Branford, CT with a total capital expenditure of $2,120,000.

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,

Harold M. Oberg
Certificate of Need Supervisor

HMO:DD:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 25, 2009

Requisition # HCA010-012
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, August 29, 2009.**

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 Diane Duran at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Attachment

HMO:DD:lmg

c: Marie Dempsey, OHCA

New Haven Register
Docket Number: 09-31440

Letter of Intent
August 25, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Connecticut Orthopaedic Specialists, PC
Town:	Branford
Docket Number:	09-31440-LOI
Proposal:	Relocation of Existing Single Specialty Surgery Center from Hamden, CT to Branford, CT
Capital Expenditure:	$2,120,000

The Applicant may file its Certificate of Need application between October 19, 2009 and December 18, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0497
RECIPIENT ADDRESS	912038658360
DESTINATION ID	
ST. TIME	08/26 11:34
TIME USE	00'27
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 25, 2009

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- 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 Diane Duran at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 26, 2009

via fax

Glen Elia
Chief Executive Officer
Connecticut Orthopaedic Specialists, P.C.
2408 Whitney Avenue
Hamden, CT 06518

RE: Certificate of Need Application Forms, Docket Number 09-31440-CON
Connecticut Orthopaedic Specialists, P.C.
Relocation of Existing Single Surgery Center from Hamden, CT to Branford, CT

Dear Mr. Elia:

Enclosed are the application forms for Connecticut Orthopaedic Specialists, P.C.'s Certificate of Need ("CON") proposal to relocate its existing single surgery center from Hamden, CT to Branford, CT with an associated capital expenditure of $2,120,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between Monday, October 19, 2009, and Friday, December 18, 2009.

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, prefile 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 five (5) 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 along with the financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Diane Duran. Please contact her at (860) 418-7007 if you have questions.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Enclosure

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 October 19, 2009, and may be submitted no later than December 18, 2009. The Analyst assigned to your application is Diane Duran. She may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31440-CON
Applicant(s) Name:	Connecticut Orthopaedic Specialists, P.C.
Contact Person:	Glen Elia
Contact Title:	CEO Connecticut Orthopaedic Specialists, P.C.
Contact Address:	2408 Whitney Avenue Hamden, CT 06518
Project Location:	Branford
Project Name:	Relocation of Existing Single Surgery Center from Hamden, CT to Branford, CT.
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$2,120,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Report the number of proposed operating rooms, identifying the number to be equipped and utilized and the number to be built and shelled for future use.

c. Provide the calculations used to determine the proposed number of operating rooms (relate this to the projected volumes, including information such as the estimated number of procedures per room), and include any documentation to support these estimates.

d. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How, what percent and where the proposed patient population is currently being served;

v. Complete the following table concerning the Applicant and existing providers in the towns listed above and also in nearby towns; and

Table 1: Utilization and Capacity of Existing Providers

Provider Name Street Address Town, 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 types 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 in one year. Provide an explanation of the criteria or basis used to estimate the number.
[7] Report the number of procedures for the most current 12 month period and identify the period covered

vi. The effect of the proposal on existing providers.

e. Attach a copy of any articles, studies, or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles.

2. Actual and Projected Volume

a. Provide total volumes for the most recently completed full FY by town.

b. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for the outpatient surgical volume of each of the Applicants and physicians involved in the proposal. In Table 2a, report the units of service by service or procedure type, and in Table 2b, report the units of service by each existing and proposed operating room. Add lines as necessary.

Table 2a: Historical, Current, and Projected Outpatient Surgical Volume, by Procedure Type

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Service or procedure type***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

Table 2b: Historical, Current, and Projected Outpatient Surgical Volume, by Operating room

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****	FY ****
Operating room***							
Total							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each operating room by location and any other identifier, and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume in the tables above.

d. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

e. Provide a discussion on any shift of surgical procedures from existing operating rooms to the proposed operating rooms.

f. Using the following table, categorize the outpatient surgical procedures that have been performed by the Applicants during the past three fiscal years and report the total time required to perform the procedures in each category.

Table 3: Procedure Time

	FY ***		FY ***		FY ***	
	No. of Procedures	Total Time	No. of Procedures	Total Time	No. of Procedures	Total Time
Procedure Category**						
Total *						

* Ensure that the totals in this table correspond to the totals in Table 2a, or provide an explanation for why they do not.
** Identify each procedure category, and add lines as necessary.
*** Fill in years. In a footnote, identify the period covered by each Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

g. In the following table, using the total number of procedures performed and the total number of minutes as reported above, report the Applicants' historical operating room utilization for outpatient surgical procedures.

Table 4: Historical Operating Room Utilization

	FY ****	FY ****	FY ****	CFY ****
Total number of procedures performed				
Annual increase in procedures performed	-	%	%	
Number of operating rooms				
Avg. annual number of procedures per room				
Total number of procedure hours				
Number of hours available per year				
Percent of Total Hours Utilized	%	%	%	

**** Fill in years. For current fiscal year, report annualized volume, identifying the number of actual months covered and the method of annualizing if different from above.

3. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

d. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

e. Provide a transfer agreement with the hospital(s) closest to facility

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Identify the proposed ownership structure for the Ambulatory Surgery Center.

c. Provide copies of Articles of incorporation, Articles of Organization, or Partnership Agreements (all that are appropriate) **related to the proposal.**

d. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

e. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

f. Provide copies of all signed written agreements or memorandum of understanding including all exhibits/attachment etc. **related to the proposal.**

g. Provide audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

h. Submit a final version of all capital expenditures/costs as follows:

Table 6: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	**$**
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

i. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate, term, monthly payment, pledges received to date, letter of interest or approval from a lending institution.

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

5. Patient Population Projections

a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 7: Patient Population Mix

	Current	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

e. Identify the entity that will be billing for the proposed service(s).

f. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

g. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

h. Describe how this proposal is cost effective.

7. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

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: _____

Connecticut Orthopaedic Specialists, P.C.

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

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

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): 19a-638.Additional function or service. change of ownership. service termination. **No Fee Required**. _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required**. _____ 19a-638 and 19a-639. **Fee Required**. 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only. otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment. imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment) _____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($ _____ 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)

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

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

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

****
*** TX REPORT ***
****

TRANSMISSION OK

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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: GLEN ELIA

FAX: (203) 407-4244

AGENCY: CONNECTICUT ORTHOPAEDIC SPECIALSITS, P.C.

FROM: DIANE DURAN

DATE: 8/26/09 **TIME:**

NUMBER OF PAGES: 14
(including transmittal sheet

Comments: Docket 09-31440-CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.