

Confidential Facsimile



Zeno N. Chicarilli, M.D., DMD

5 Durham Road, Suite A1

Guilford Ct 06437

Office of Health Care Access

To: Kimberly Martone

From: Dr. Chicarilli

Fax: 860-707-1919

Fax: 203-453-7769

Phone: _____

Phone: 203-453-7766

Date: 9-16-14

Number of Pages: 6

Re: Ct Center for Plastic Surgery

This is a confidential fax and is intended for the person named above. If you have received this fax in error, please call the office at 203-453-7766 and then destroy this document. Thank You!

Kimberly,
For your review.

ZENO N. CHICARILLI, M.D., D.M.D.
CHIEF, PLASTIC & RECONSTRUCTIVE SURGERY
ST. RAPHAEL'S CAMPUS, YALE NEW HAVEN HOSPITAL

ASSOCIATE CLINICAL PROFESSOR
DEPT. OF SURGERY, SECTION PLASTIC SURGERY
YALE UNIVERSITY MEDICAL SCHOOL

GUILFORD GLEN MEDICAL CAMPUS
5 DURHAM ROAD
GUILFORD, CT 06437
Telephone (203) 453-7766
Fax (203) 453-7769

PRINCE PROFESSIONAL BUILDING
46 PRINCE STREET #401
NEW HAVEN, CT 06510
Telephone (203) 782-9720

September 16, 2014

VIA FACSIMILE AND U.S. MAIL

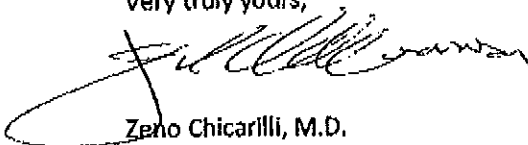
Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Connecticut Center for Plastic Surgery -- DPH License 0314

Dear Ms. Martone:

The purpose of this letter is to notify OHCA, as required by Connecticut General Statutes 19a-493b© and 19a-639c, respectively, of the planned transfer of physician ownership and relocation of the Connecticut Center for Plastic Surgery Operating Suite, LLC ("CCPS"). CCPS is an outpatient surgical facility, currently located at 5 Durham Road, Guilford, CT 06437. The details of the proposed transfer of ownership and relocation are described in the attached OHCA Form 2020 and related materials. Please do not hesitate to contact the undersigned if you require any further information.

Very truly yours,



Zeno Chicarilli, M.D.

Managing Member

Enclosure



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 Director 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	Connecticut Center for Plastic Surgery Operating Suite, LLC	
Doing Business As	Connecticut Center for Plastic Surgery	
Name of Parent Corporation	N/A	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	5 Durham Road Guilford, Connecticut 06437	
What is the Petitioner's Status: P for profit and NP for Nonprofit	P	
Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Zeno Chicarilli, M.D. Managing Member	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	5 Durham Road Guilford, Connecticut 06437	
Contact Person's Telephone Number	203-605-7914	
Contact Person's Fax Number	203-453-7769	
Contact Person's e-mail Address	zncplastics@aol.com	

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Transfer of Physician Ownership and Relocation of Outpatient Surgical Facility.
- b. Estimated Total Project Cost \$4,800,000
- c. Location of proposal, identifying Street Address, Town and Zip Code: 246 Goose Lane, Guilford, Connecticut 06437
- d. List each town this project is intended to serve: The project will serve patients from the geographic area currently served by Connecticut Center for Plastic Surgery Operating Suite, LLC, primarily the cities and towns in and adjacent to Fairfield and New Haven counties.
- e. Estimated starting date for the project: Upon OHCA Approval

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. If applicable, identify the types of services currently provided and 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.

PROPOSAL DESCRIPTION

Connecticut Center for Plastic Surgery Operating Suite, LLC (the "Applicant") operates a Connecticut-licensed outpatient surgical facility currently located at 5 Durham Road, Guilford, Connecticut 06437 (the "Center"). The Center provides ambulatory surgical services to patients and is owned exclusively by the following Connecticut-licensed physicians: Zeno Chicarilli, M.D., Stephano Fusi, M.D., Stephan Ariyan, M.D., Richard Stahl, M.D. (collectively, hereinafter the "Members"). Please see the attached DPH license at Exhibit A.

The Members wish to reorganize the Center to allow for additional physicians to become owners. As an initial matter, the Members intend to transfer certain assets of the Center to a newly formed Connecticut limited liability company, Guilford Surgery Center, LLC (the "Company"), of which the Members will be the owners. The Members then intend to allow for additional ownership interests in the Center by selling ownership interests in the Company to other physician investors. Each of the additional physician investors will be duly licensed to practice in the State of Connecticut. For reasons of confidentiality, these physician investors prefer to remain anonymous at the present time.

As part of this transaction, a minority ownership interest in the Center will also be sold to Merritt Healthcare ("Merritt"), which will act as the third party management firm for the Center. Each of the physicians will hold his or her membership interests in the Center individually or through an entity which the physician member controls. The interests of Merritt may be held by Merritt or an entity owned by persons who are owners in Merritt and involved in the management of the Center. Upon the admission of the new investors, physicians will continue to own and control well in excess of a sixty percent (60%) membership interest in the Center.

In conjunction with the reorganization and admission of new members described above, the Members also plan to relocate the Center to a new address at 246 Goose Lane in Guilford or, if negotiations for that property are not consummated, another site within the Town of Guilford. After the proposed relocation, the Center will continue to serve the same patient population as described in Section II(d) above, and maintain the same payor mix of government and commercially insured patients as well as self-pay patients. The physician members of the Center will continue to be responsible for the provision of surgical services at the Center. The Center will also be the entity that maintains responsibility for all billing for Center services.

Based on the foregoing, Applicant requests OHCA to make a determination that, in accordance with Conn. Gen. Stat. § 19a-493b(c), a Certificate of Need is not required for the reorganization of the Center and the admission of the new members to the Company as set forth herein since prior to any transfer or change of ownership or control, the Center is owned and controlled exclusively by licensed physicians, and after the transactions contemplated herein, physicians shall own and control no less than 60% of the Center. Additionally, Applicant requests a determination that, in accordance with C.G.S. § 19a-639c, a Certificate of Need is not required for the proposed relocation of the Center as there will not be a substantial change in population served by the Center or its payor mix.

S:\Doc\13 6001-6030\136033 Guilford ASC\Doc\OHCA Determination Request to add members (BYM 12.5.13).doc

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Connecticut Center for Plastic Surgery Operating Suite, LLC

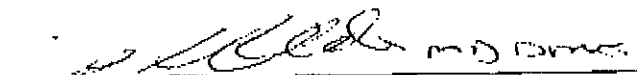
Project Title: Transfer of Physician Ownership and Relocation of Outpatient Surgical Facility

I, Zeno Chicarilli, M.D. Managing Member
(Name) (Position -- CEO or CFO)

of Connecticut Center for Plastic Surgery Operating Suite, LLC being duly sworn, depose and state that the information

Connecticut Center for Plastic Surgery Operating Suite, LLC

provided in this CON Determination form is true and accurate to the best of my knowledge.

 9/13/14
Signature Zeno W. Chicarilli M.D. Date

Subscribed and sworn to before me on 9/13/14


Notary Public/Commissioner of Superior Court Gay A. Butler

My commission expires: 2/28/2016

ZENO N. CHICARILLI, M.D., D.M.D.
CHIEF, PLASTIC & RECONSTRUCTIVE SURGERY
ST. RAPHAEL'S CAMPUS, YALE NEW HAVEN HOSPITAL

ASSOCIATE CLINICAL PROFESSOR
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PRINCE PROFESSIONAL BUILDING
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September 16, 2014

VIA FACSIMILE AND U.S. MAIL

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Connecticut Center for Plastic Surgery – DPH License 0314

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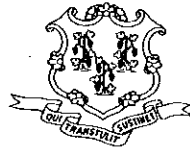
Very truly yours,

A handwritten signature in blue ink, appearing to read "Zeno Chicarilli".

Zeno Chicarilli, M.D.

Managing Member

Enclosure



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Doing Business As	Connecticut Center for Plastic Surgery	
Name of Parent Corporation	N/A	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	5 Durham Road Guilford, Connecticut 06437	
What is the Petitioner's Status: P for profit and NP for Nonprofit	P	
Contact Person at Facility , including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Zeno Chicarilli, M.D. Managing Member	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	5 Durham Road Guilford, Connecticut 06437	
Contact Person's Telephone Number	203-605-7914	
Contact Person's Fax Number	203-453-7769	
Contact Person's e-mail Address	zncplastics@aol.com	

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In conjunction with the reorganization and admission of new members described above, the Members also plan to relocate the Center to a new address at 246 Goose Lane in Guilford or, if negotiations for that property are not consummated, another site within the Town of Guilford. After the proposed relocation, the Center will continue to serve the same patient population as described in Section II(d) above, and maintain the same payor mix of government and commercially insured patients as well as self-pay patients. The physician members of the Center will continue to be responsible for the provision of surgical services at the Center. The Center will also be the entity that maintains responsibility for all billing for Center services.

Based on the foregoing, Applicant requests OHCA to make a determination that, in accordance with Conn. Gen. Stat. § 19a-493b(c), a Certificate of Need is not required for the reorganization of the Center and the admission of the new members to the Company as set forth herein since prior to any transfer or change of ownership or control, the Center is owned and controlled exclusively by licensed physicians, and after the transactions contemplated herein, physicians shall own and control no less than 60% of the Center. Additionally, Applicant requests a determination that, in accordance with C.G.S. § 19a-639c, a Certificate of Need is not required for the proposed relocation of the Center as there will not be a substantial change in population served by the Center or its payor mix.

S:\doc\13 6001-6050\136033 Guilford ASC\Docs\OHCA Determination Request to add members (BVM 12.5.13).doc

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Connecticut Center for Plastic Surgery Operating Suite, LLC

Project Title: Transfer of Physician Ownership and Relocation of Outpatient Surgical Facility

I, Zeno Chicarilli, M.D. Managing Member
(Name) (Position – CEO or CFO)

of Connecticut Center for Plastic Surgery Operating Suite, LLC being duly sworn, depose and state that the information

Connecticut Center for Plastic Surgery Operating Suite, LLC

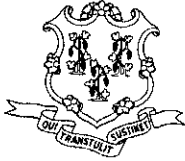
provided in this CON Determination form is true and accurate to the best of my knowledge.

Zeno W. Chicarilli, M.D. 9/13/14.
Signature Date

Subscribed and sworn to before me on 9/13/14

Gay A. Butler
Notary Public/Commissioner of Superior Court Gay A. Butler

My commission expires: 2/28/2016



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 24, 2014

VIA FACSIMILE ONLY

Zeno Chicarilli, M.D.
Managing Member
Connecticut Center for Plastic Surgery Operating Suite, LLC
5 Durham Road
Guilford, CT 06437

RE: Certificate of Need Determination Report Number 14-31945-DTR
Relocation and Transfer of Ownership of Ambulatory Surgery Center

Dear Dr. Chicarilli:

On September 16, 2014, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Connecticut Center for Plastic Surgery Operating Suite, LLC ("Petitioner") with respect to its relocation and the sale of ownership interests therein.

The Petitioner is a Connecticut licensed outpatient surgical facility located at 5 Durham Road, Guilford, Connecticut. The Petitioner plans to relocate its facility to 246 Goose Lane, Guilford, Connecticut or, if the transaction is not consummated, another site within the town of Guilford. The Petitioner will continue to serve the same population and payer mix that it currently serves.

Pursuant to Conn. Gen. Stat. § 19a-639c, the Petitioner has satisfactorily demonstrated that the population and payer mix currently served by the Petitioner will not substantially change as a result of the proposed relocation. Therefore, *no CON is required*.

The Petitioner also wishes to reorganize to allow for the transfer of physician ownership of the facility. Currently, the Petitioner is owned exclusively by four Connecticut licensed physicians ("Members"). The members wish to reorganize to allow for the addition of new physician owners. In addition, as part of the transaction, a minority ownership interest will be sold to Merritt Healthcare ("Merritt"). Upon admission of the new investors, Connecticut licensed physicians will continue to own and control well in excess of a sixty percent (60%) membership interest in the facility.

Connecticut General Statutes § 19a-638(a)(2) requires CON authorization for the "transfer of ownership of a health care facility." However, Connecticut General Statutes § 19a-493b(c) provides an exception for outpatient surgical facilities whose Connecticut licensed physician

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

members will maintain at least a controlling 60% ownership after a transfer of interest in a facility. Since physicians licensed in Connecticut pursuant to Conn. Gen. Stat. § 20-13 will hold well in excess of a sixty percent (60%) membership interest in the facility, OHCA hereby determines that a *CON is not required* for the proposed reorganization.

Sincerely,



Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

* * * COMMUNICATION RESULT REPORT (SEP. 24. 2014 10:43AM) * * *

FAX HEADER:

TRANSMITTED/STORED : FILE MODE	SEP. 24. 2014 10:39AM OPTION	ADDRESS	RESULT	PAGE
639 MEMORY TX		912034537769	OK	3/3

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



**STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF HEALTH CARE ACCESS**

FAX SHEET

TO: ZENO CHICARILLI, M.D.

FAX: 203 453-7769

AGENCY: CONNECTICUT CENTER FOR PLASTIC SURGERY
 OPERATING SUITE, LLC

FROM: OHCA

DATE: 9/24/14 **Time:** _____

NUMBER OF PAGES: 3
(including transmittal sheet)

Comments:

Please see attached determination

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

*410 Capitol Ave., MS#13HCA
 P.O.Box 540308
 Hartford, CT 06134*