MidState Medical Center
Connect to healthier.

November 29, 2016

Ms. Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue,
MS#13HCA
P.O. Box 340308
Hartford, CT 06106

RE: The Establishment of a Gastrointestinal Outpatient Surgery Facility in Wallingford, Connecticut- "Wallingford Endoscopy, LCC"

Dear Ms. Martone:

Enclosed please find a Certificate of Need application for the Establishment of a Gastrointestinal Outpatient Surgery Facility in Wallingford, Connecticut- "Wallingford Endoscopy, LCC." Included is one (1) original hardcopy in a 3-ring binder and a USB flash drive containing a scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format and an electronic copy of responses in MS Word (the applications) and MS Excel (the financial attachment).

Please do not hesitate to contact me at 860-972-4231 if you have any questions. Thank you for your time and consideration.

Sincerely,

Barbara A. Durdy

Enclosures

Checklist

Instructions:

1. Please check each box below, as appropriate; and
2. The completed checklist *must* be submitted as the first page of the CON application.

☒ Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.

☒ (**New**). A completed supplemental application specific to the proposal type, available on OHCA's website under "OHCA Forms." A list of supplemental forms can be found on page 2.

☒ Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.

☒ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: 16-32136-CON **Check No.:** 058054
OHCA Verified by: SC **Date:** 11/30/16

HARTFORD HEALTHCARE
ATTN: ACCOUNTS PAYABLE
PO BOX 5037
HARTFORD, CT 06102-5037

COPY

51-57
119

Check Number
058054
Bank of America

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

Five hundred and 00/100 Dollars

Pay to the order of

TREASURER, STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATI
PO BOX 1080
HARTFORD, CT 06143--108

Date	Payment Amount
11/29/2016	*******$500.00

VOID AFTER 90 DAYS

THE BACK OF THIS DOCUMENT CONTAINS LAID LINES AND AN ARTIFICIAL WATERMARK. HOLD AT AN ANGLE TO VIEW.

[redacted]

TREASURER, STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATI
PO BOX 1080
HARTFORD, CT 06143--108

Entity	Vendor ID / Location	Check Number
30100	1000004913	058054

HARTFORD HEALTHCARE

Invoice Number	Invoice Date	Gross Amount	Discount Amount	Withholding Amount	Net Amount
C11221650000	11/22/2016	500.00			500.00

0002

HH571485 1/09

TOTALS	$500.00	0.00	0.00	$500.00

RJ media group Record-Journal myrecordjournal.com HOMEBASE DIGITAL

3205170
50850

AFFIDAVIT OF PUBLICATION

THIS IS TO CERTIFY that the attached clipping is a true copy of a notice published in the RECORD-JOURNAL **SEPTEMBER 2 & 3 & 4, 2016.**

CONNECTICUT LEGAL NOTICE

Public Notice Filing for
Wallingford Endoscopy Center, LLC
Establishment of Outpatient Surgical Facility

Statutory Reference:	**Connecticut General Statutes §19a-638**
Applicant:	**Wallingford Endoscopy Center, LLC**
Project Address:	**863 North Main Street Wallingford, CT 06492**
Proposal:	**The Applicant intends to file a Certificate of Need application with the State of Connecticut Office of Health Care Access for approval to establish an outpatient surgical facility in Wallingford, CT. Connecticut.**
Capital Expenditure:	**$2,008,825.**

50850

The Record-Journal Publishing Company

State of Connecticut

} SS. Meriden

Pam Adamski, Business Office Manager

Pam Adamski

Pam Adamski, Business Office Manager

The foregoing affidavit was signed and sworn
Before me this 5th day
Of SEPTEMBER 2016.

Angela Grabiec

Angela Grabiec
Notary Public
My Commission Expires June 30, 2018

meride
27401

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form

Required for all CON applications

Contents:

Supplemental Forms
In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. All CON forms can be found on the OHCA website at OHCA Forms.

Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
(3)	**Transfer of ownership of a group practice**
(4)	**Establishment of a freestanding emergency department**
(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
(6)	**Establishment of an outpatient surgical facility**
(9)	**Establishment of cardiac services**
(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
(12)	**Increase in licensed bed capacity** of a health care facility
(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	**Transfer of Ownership / Sale of Hospital**

*****This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) -

hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

General Information

Name of Applicant:	Name of Co-Applicant:
Wallingford Endoscopy Center, LLC	**MidState Medical Center**

Connecticut Statute Reference:

§ 19a-638 (a) (6)

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Wallingford Endoscopy Center, LLC		**OSF**	**Wallingford Endoscopy Center, LLC**

STREET & NUMBER	
863 North Main St Ext	
TOWN	ZIP CODE
Wallingford	**06492**

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
Wallingford Endoscopy Center, LLC		**OSF**	**Wallingford Endoscopy Center, LLC**

STREET & NUMBER	
863 North Main St Ext	
TOWN	ZIP CODE
Wallingford	**06492**

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
		Wallingford Endoscopy Center, LLC

STREET & NUMBER	
863 North Main St Ext	
TOWN	ZIP CODE
Wallingford	**06492**

Chief Executive				
NAME			TITLE	
Lucille Janatka			**Sr. Vice President, Hartford HealthCare President, Central Region President, MidState Medical Center**	
STREET & NUMBER				
100 Grand Street				
TOWN			STATE	ZIP CODE
New Britain			**CT**	**06050**
TELEPHONE	FAX	E-MAIL ADDRESS		
203-694-8202		**Lucille.Janatka@hhchealth.org**		

Title of Attachment

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☐ NO ☒	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☒	
Identify the Applicant's ownership type.	PC ☐ LLC ☒ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start **10/1** End **9/30**	

Contact:
Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information			
NAME		TITLE	
Barbara A. Durdy		**Director, Strategic Planning Hartford HealthCare**	
STREET & NUMBER			
181 Patricia M. Genova Blvd			
TOWN	STATE	ZIP CODE	
Newington	**Connecticut**	**06111**	
TELEPHONE	FAX	E-MAIL ADDRESS	
860-972-4231		**Barbara.durdy@hhchealth.org**	
RELATIONSHIP TO APPLICANT	**Employee**		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
	NAME		TITLE
	Barbara A. Durdy		**Director, Strategic Planning Hartford HealthCare**
	STREET & NUMBER		
	181 Patricia M. Genova Blvd		
	TOWN	STATE	ZIP CODE
	Newington	**Connecticut**	**06111**
	TELEPHONE	FAX	E-MAIL ADDRESS
	860-972-4231		**Barbara.durdy@hhchealth.org**
	RELATIONSHIP TO APPLICANT	**Employee**	

Affidavit

Applicant: **Wallingford Endoscopy Center, LLC**

Project Title: **The Establishment of a Gastrointestinal Outpatient Surgery Facility in Wallingford, Connecticut.**

I, **Lucille Janatka** , **Sr. Vice President , Hartford HealthCare and President , Central Region**
(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 L. Janatka 11/28/16
Date

Subscribed and sworn to before me on 11/28/2016

Linda R. Tompkins

Notary Public/Commissioner of Superior Court

My commission expires: _____

LINDA R. TOMPKINS
NOTARY PUBLIC
MY COMMISSION EXPIRES APRIL 30, 2017

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

This proposal is for the establishment of an outpatient surgery facility ("OSF") dedicated to gastroenterological services. The OSF will be owned and operated by a Connecticut limited liability company known as Wallingford Endoscopy Center, LLC ("WEC").

WEC is a proposed 3 procedure room gastroenterology OSF to be located at 863 North Main St Ext, Wallingford, CT. The proposed WEC will be operated as a joint venture between MidState Endoscopy Center Holdings, LLC ("MEC") (to be established) and MidState Medical Center (the "Hospital").

The Hospital will own a 51% controlling membership interest in WEC with the remaining 49% interest being held by MEC, a new company that will be owned by 9 gastroenterologists (the "Physicians"). The Physicians are all members of the medical staff of the Hospital.

The proposed OSF will be located within a medical office building in which the Hospital holds the master lease. Medical and administrative oversight of the proposed facility will be provided by two (2) of the Physicians.

The proposed WEC will provide greater access to high quality, lower cost gastroenterology services in an outpatient setting. Through increased alignment with the Hospital, WEC will provide seamless coordination between the inpatient and outpatient settings for gastroenterology services.

No change to the service area or payer mix is expected.

The expected total capital cost is $2,788,600

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

   This proposal is for the establishment of an outpatient surgery facility ("OSF") dedicated to gastroenterological services. The OSF will be owned and operated by a Connecticut limited liability company known as Wallingford Endoscopy Center, LLC ("WEC").

   WEC is a proposed 3 procedure room gastroenterology OSF to be located at 863 North Main St Ext, Wallingford, CT. The proposed WEC will be operated as a joint venture between MidState Endoscopy Center Holdings, LLC ("MEC") and MidState Medical Center (the "Hospital").

   The Hospital will own a 51% controlling membership interest in WEC with the remaining 49% interest being held by the nine (9) affiliated gastroenterology physicians (the "Physicians") who jointly own MEC. The Physicians are all members of the medical staff of the Hospital.

   The proposed outpatient surgery facility will be located in the Wallingford Family Health Center on North Main Street in Wallingford, Connecticut. Initially two of the three procedure rooms will be equipped and operational and the third procedure room will be shelled for future use to accommodate volume growth.

   The Applicants' decision to establish an outpatient surgery facility dedicated to the provision of high-quality and cost-effective gastrointestinal services at the Wallingford location is based upon the following considerations:

   (i) the physicians who are affiliated with the Hospital desire to perform their gastrointestinal procedures in an ambulatory center dedicated to the delivery of cost-effective and high-quality gastrointestinal services in the Central Connecticut region;

   (ii) patients in the Central Connecticut region desire and would benefit from access to outpatient procedural facilities dedicated to the provision of high-quality, cost-effective and efficient gastrointestinal services; and

   (iii) payers are expecting providers to offer enhanced value at a lower cost.

Endoscopic Outpatient Surgery Centers

Health care reform has necessitated a re-alignment of the traditional interactions between hospitals and physicians through the creation of new models to accelerate change and bring higher quality services at a lower cost to patients and payers alike. Consistent with national trends, and due to technological advances in gastroenterological surgery permitting more volume to be performed on an outpatient basis, the Hospital and its affiliated physicians are shifting more surgical cases to a more cost-effective ambulatory surgical setting.

It is well documented that endoscopic outpatient surgery centers are more efficient than hospital-based centers, and are less costly to both payers and patients, while providing a superior customer experience. The continued growth in demand for endoscopic OSFs is driven by an aging population, rising healthcare costs and a shortage of physicians in certain markets. The demands of an aging population necessitates that physicians become more efficient to keep up with the increasing volume of procedures.

Please see Exhibit 1 for articles describing the cost and efficiency benefits of OSFs dedicated to endoscopy services.

The Provision of High Quality Services in a Lower Cost Environment

The proposed WEC will be considered a freestanding outpatient surgical facility for reimbursement purposes. As a result, the payment rates paid by payers and patients will be substantially lower than those paid for hospital-based surgical services. As Table A below illustrates, significant savings accrue to both the payer and the patient when the gastroenterology services are provided in an outpatient surgical facility.

	Outpatient Endoscopy Services											
	2016 Medicare Rates - Hartford County				Savings							
	2016 OSF		2016 HOPD		CMS		Patient		Total System			
Procedure Description	CMS Payment	Patient Payment*	CMS Payment	Patient Payment*	$	%	$	%	$	%		
Colonoscopy	$ 328.00	$ 109.00	$ 565.00	$ 188.00	$ 237.00	42%	$ 79.00	42%	$ 316.00	42%		
Endoscopy	$ 324.00	$ 108.00	$ 561.00	$ 184.00	$ 237.00	42%	$ 76.00	41%	$ 313.00	42%		

* Assumes 25% patient co=pay

Table A: Comparison of OSF Rates to Hospital-Based Rates for Select GI Procedures

Cost disparities between sites of service have caused organizations such as MedPAC to encourage providers and patients to utilize lower cost settings in order to lower Medicare spending and heighten patient autonomy. Colonoscopies and upper endoscopic procedures accounted for almost a third of Medicare ASC spending growth between 2000 and 2007. Therefore, OSFs dedicated to gastroenterology are well positioned to drive cost savings to both patients and payers.

As presented in Table A above, when compared to hospital-based rates, outpatient endoscopy procedures on average save payers (CMS) approximately 42% while patients save 42% on out-of-pocket costs.

Projected Strong Volume Growth for Outpatient Gastroenterology Procedures

Strong volume growth is projected for outpatient gastroenterology procedures both on a national and regional level. As presented below, in Table B, The Advisory Board Company projects outpatient gastroenterology procedures to increase by 30.2% over the next ten years nationally and 23.1% for the primary service area defined in this application. Please see OHCA Table 9 for a list of primary service area towns. National data suggests that disease prevalence related to outpatient gastroenterology procedures will increase by 3.94% over the next ten years. The Advisory Board Market Scenario Planner tool also projects a national volume growth of 46.1% for outpatient GI services in an ambulatory surgery setting in the next 10 years.

Market	Service Line	2015 Volume	2020 Volume	2025 Volume	5 Yr Growth	10 Yr Growth
Primary Service Area	Gastroenterology	10,502	11,890	12,928	^13.2%	^23.1%
Connecticut	Gastroenterology	277,517	316,875	346,469	^14.2%	^24.8%
National	Gastroenterology	23,199,656	27,051,970	30,217,321	^16.6%	^30.2%

Source: Advisory Board Market Scenario Planner

Table B: Growth Volume Projections for Outpatient Gastroenterology Services

GI Service Line Growth in Ambulatory Surgery Centers					
	2015 Volume	2020 Volume	2025 Volume	5 Yr Growth	10 Yr Growth
National	3,041,962	3,779,953	4,443,345	^24.3%	^46.1%
Primary Service Area	1,377	1,661	1,900	^20.7%	^38.0%

Source: Advisory Board Market Scenario Planner

Table C: Volume Projections for Gastroenterology Procedures in Ambulatory Surgery Centers

The two factors contributing the most to the overall projected growth in gastroenterology services are the aging population and the rise in the incidence of obesity. Please see Exhibit 1 for journal articles describing the increasing demand for endoscopic services. As presented below in Table D, the population of the primary service area as defined in this application is expected to increase by 1.44% over the next 5 years and 2.77% over the next 10 years. The population for the defined service area is represented below. Almost 50% of the population in each town has a population of 45 years or older. Clinical guidelines suggest that all individuals should have an initial colorectal screening at age 50.

Driver	5 Yr % Impact	10 Yr % Impact
Population Change	1.44%	2.77%

Source: Advisory Board Market Scenario Planner

Table D: Population Growth, Primary Service Area

Age Cohort by Town			
Age	**Cheshire**	**Meriden**	**Wallingford**
45-54	18.0%	15.0%	16.7%
55-64	14.4%	12.8%	14.0%
65+	14.7%	14.6%	17.3%
Total 45+	**47.1%**	**42.4%**	**48.0%**

Source: CERC Town Profile

Table E: Population by Age Cohort, Primary Service Area

Patient and Physician Preference

From the patient's perspective, a freestanding gastroenterology (GI) center provides a needed service in a more efficient, effective and lower cost setting; the delay between scheduling and procedure performance is much shorter; and the procedure is performed in a more convenient, comfortable and accessible setting. A study conducted by the US Department of Health and Human Services Office of the Inspector General found that 98% of the people were satisfied with their experience at an ambulatory surgical center. Reasons cited for a preference for ASCs over larger institutions included less paperwork, lower cost, a more convenient location and parking. Also cited were minimal wait times at the ASC, and more organized and friendlier staff as compared to crowded and sometimes uncomfortable settings found at larger organizations. These results are not based on an isolated occurrence; rather they represent a very common statistical trend found in ASCs nationwide.

Please see Exhibit 1 for articles related to this proposal.

There has been increased utilization of freestanding GI centers driven by patient preference and lower cost to the payer as compared to hospital-based outpatient centers as well as physician preference. Physician engagement and leadership is essential in order to positively impact efficiency, quality and patient satisfaction. Physicians prefer to work in an environment that allows them to have greater input with respect to operations, equipment and scheduling. In this case, the Physicians have been the impetus for the development of this proposal. The desire by the Physicians to establish a freestanding OSF dedicated to gastroenterology is likely due to the fact that physicians in an OSF setting: 1) obtain more favorable scheduling because they do not have to coordinate appointment times with other physicians; 2) can assemble and train specialized teams of highly skilled staff; 3) can be assured that the appropriate and necessary equipment and supplies are available for their patients; and 4) can operate more efficiently with quicker room turnover times between cases which equates to less down time for physicians. Providing lower cost,

high quality health care requires a team of people who work well together. Specialization in preoperative nursing care, intraoperative medical care by anesthesiologists and postoperative care lead to greater efficiency, less deviation from best practice and higher quality.

Impact on MidState Medical Center

As previously mentioned in this application, the Physicians are highly interested in and motivated to establish a freestanding OSF dedicated to GI procedures. In fact, the Physicians communicated to the Hospital that they were interested in either partnering with Hospital to establish a freestanding GI center or if the Hospital was not interested, pursuing this option on their own.

This proposal allows the Hospital to more efficiently align with the affiliated gastrointestinal physicians to address all of the foregoing market and industry challenges to ensure the delivery of cost-effective ambulatory gastrointestinal services in the Central Connecticut region.

Patients who are at higher-risk due to medical complications or comorbidities or who prefer to be treated in a hospital environment will continue to be able to schedule their procedures at the Hospital. The Applicants estimate that approximately 30% of patients receiving endoscopy services at the Hospital will continue to have those procedures performed at the Hospital due to patient or physician preference.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

   Discussions regarding a partnership between the Physicians and MidState Medical Center began in 2014. To date, the Applicants have located a site that will meet the needs of all parties while increasing access to patients. They have also negotiated an operating agreement, a management structure, and a physician services agreement.

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

      Please see OHCA Table 1.

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

Please see OHCA Table 2.

4. List the health care facility license(s) that will be needed to implement the proposal;

   Upon OHCA approval, the Wallingford Endoscopy Center, LLC will apply for a license with the Department of Public Health.

5. Submit the following information as attachments to the application:

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

      Please see Exhibit 2 for MidState Medical Center's Department of Public Health Hospital license.

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

      Lucille Janatka, Sr. VP Hartford HealthCare and President of Harford HealthCare - Central Region
      Gary Havican, VP Operations for Hartford HealthCare Central Region
      Carolyn Freiheit, VP Finance Central Region
      Douglas Miller, MD, Connecticut GI, PC
      Housein Wazaz, MD, MidState Gastroenterology Specialists, PC

      Please see Exhibit 3 for copies of curriculum vitae for these key personnel.

   c. copies of any scholarly 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;

      Please see Exhibit 1 for articles and studies related to this proposal.

   d. letters of support for the proposal;

      Please see Exhibit 4 for copies of letters of support related to this proposal.

   e. the protocols or 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 the protocols or guidelines.

      Please see link below to the Standard of Practice Guidelines for Ambulatory Surgery Centers, Accreditation Association for Ambulatory Health Care Centers (the "AAAHC"). The OSF will meet and maintain all national standards required to achieve accreditation by the AAAHC.

www.aaahc.org

f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Please see Exhibit 5 for a draft of the Operating Agreement for the proposed WEC.

In addition, please see Exhibit 6 for a draft of the Patient Transfer Agreement Between MidState Medical Center and WEC.

Public Need and Access to Care

§ *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

The proposed alignment of WEC and MidState Medical Center enhances care coordination, and provides efficiencies that result in high quality, affordable, and more accessible care.

For a description of how the project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, please see the response to Question 7 below.

§ *"The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

The proposal is consistent with the Statewide Health Care Facilities and Services Plan (the "Plan") published by OHCA in October of 2012 and supplemented in 2014.

"The guiding principles of the Plan are intended to:

- **Promote and support the long term viability of the state's health care delivery system;**
- **Ensure that any regulated service will maintain overall access to quality health care;**
- **Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;**

• Encourage collaboration among health care providers to develop health care delivery networks;
• Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
• Maintain and improve the quality of health care services offered to the state's residents;
• Promote planning that helps to contain the cost of delivering health care services to its residents;
• Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
• Promote public policy development through measuring and monitoring unmet need; and
• Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state." (Plan at p. 2).

As stated in the Plan, mergers, affiliations and acquisitions are part of Connecticut's health care system as a response to changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5). The proposed WEC will provide high-quality and lower-cost gastrointestinal procedure services. Both quality and lower costs will contribute to the financial strength of the State's health care system.

Such benefits include economies of scale when purchasing supplies and services, sharing of best practices, increased ability to participate in evolving payer models, improved access to capital, and integration with the Hospitals' Centers of Excellence in the wider Hartford HealthCare network.

Further, the proposal will maintain and expand patient access to GI services in an outpatient setting. Equitable access to WEC's health care services will be promoted through the proposal as WEC will adopt the Hospital's charity care policy.

Quality will be improved as the proposal will encourage WEC and the Hospital to collaborate to provide the highest quality GI services. The proposal also promotes planning to contain costs by utilizing any applicable economies of scale and promoting the use of freestanding outpatient surgical services in the Service Area as a lower cost alternative to hospital-based surgery. This proposal provides patients with an alternative to hospital-based procedures, provides patients with more flexibility in selecting treatment options, and further ensures that patients receive care in the most appropriate setting.

§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))

8. With respect to the proposal, provide evidence and documentation to support clear public need:

   a. identify the target patient population to be served;

      The proposed WEC will continue to serve those patients currently receiving services at MidState Medical Center and will provide close access to Wallingford and the surrounding communities.

   b. discuss how the target patient population is currently being served;

      Please see the response to Question 8a above. MidState Medical Center provides gastrointestinal services to the Central Connecticut region including Wallingford and the surrounding communities. No change in services or patient population is anticipated due to the implementation of this proposal.

   c. document the need for the equipment and/or service in the community;

      N/A. No new equipment or services will be added.

   d. explain why the location of the facility or service was chosen;

      The medical office building in Wallingford was chosen as the location for the proposed OSF for the following reasons: (i) the Wallingford location is easily accessible for residents of the Service Area; (ii) the Wallingford has existing procedure room capacity and space, and (iii) the Wallingford Family Health Center located within the same medical office building is considered a patient- and consumer-oriented site that provides additional health services in a value-based setting.

   e. provide incidence, prevalence or other demographic data that demonstrates community need;

      The two factors contributing the most to the overall projected growth in endoscopic services are an aging population and rise in the prevalence of obesity. Please see the link below for a copy of MidState Medical Center's 2015 Community Health Needs Assessment.

      http://midstatemedical.org/File%20Library/Unassigned/2015-PRC-CHNA-Report.pdf

      According to Connecticut's legislative committee on aging, by 2040, Connecticut's population of people age 65 and older is projected to grow 57% but the population of people 20-64 is only projected to grow by less than 2%. CERC Town Profile data shows that in the Hospital's primary service area, 45.8% of the population is 45 years old or older. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in

adults, beginning at age 50 years and continuing until age 75 years. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. According to the Hospital's CHNA the population of the Hospital's service area age 50-75 that receive colorectal cancer screening is 84.2%, which exceeds the US percentage and proves that colorectal screenings are being highly utilized and there is a need for this service.

The MidState Medical Center CHNA identified obesity as an area of opportunity, as 66.5% of adults in the Hospital's Area are considered overweight or obese while 33.4% are considered obese. Obesity is overwhelmingly prevalent in the United States. As of the 2004 National Health and Nutrition Examination Survey, 1 in 3 Americans had a body mass index (BMI) exceeding 30 kg/m2, and the obesity epidemic shows no signs of abating. Functional gastrointestinal disorders (FGIDs) such as irritable bowel syndrome (IBS) and functional dyspepsia are also extremely prevalent. It is well established that obesity is associated with gastroesophageal reflux disease (GERD). Further, epidemiologic data indicates that obesity is associated with a wide range of chronic gastrointestinal (GI) complaints, many of which overlap with Functional gastrointestinal disorders (FGIDs) such as IBS or dyspepsia. This association raises the possibility that obesity and FGIDs may be mechanistically linked and that studying this relationship might provide insights into the pathophysiology of several FGIDs. Studies also conclude that gastro-oesophageal reflux (GORS) is associated with obesity; this appears to be explained by increased upper endoscopy findings in obesity.

Please see Exhibit 1 for a copy of an article on the relationship between obesity and functional gastrointestinal disorders.

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

MidState Medical Center provides services to all patients regardless of race, ethnicity, religion, income or ability to pay for services. The proposed WEC will adopt the same policy and the charity care policies of the Hospital.

Please see Exhibit 7 for a copy of Harford HealthCare's Financial Assistance Policy, which applies to the Hospital.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

N/A. The proposed OSF will shift low-risk procedures to an outpatient setting at the proposed WEC.

h. explain how access to care will be affected;

Access to care will not be disrupted or negatively affected as a result of this proposal. Access to care will increase as this proposal as patients in the Central Connecticut region desire and would benefit from access to outpatient procedural facilities dedicated to the provision of high-quality, cost-effective and efficient gastrointestinal services.

i. discuss any alternative proposals that were considered.

As previously stated, the Physicians considered two (2) options: 1) partnering with the Hospital to establish a freestanding OSF, or 2) pursuing this proposal without the Hospital as a partner.

§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))

9. Describe how the proposal will:

a. improve the quality of health care in the region;

This proposal will ensure continued provision of high quality gastrointestinal services. Both of the applicants seek to provide the highest quality care possible and the proposed OSF will allow for this to occur with better access at a lower cost.

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

b. improve accessibility of health care in the region; and

Please see the response to Question 8h above.

c. improve the cost effectiveness of health care delivery in the region.

The ASC will provide greater value with respect to gastrointestinal procedural services for less cost. For all the reasons described herein, the ASC is an important health-care delivery model in a value-based purchasing environment. By reducing costs and enhancing value, the ASC will have an overall positive impact on the health care delivery system with little or no adverse impact on other providers.

A study from the American Journal of Gastroenterology states that ASCs are paid a fraction of what is paid to hospitals for the same procedures under Medicare, and a

migration from other settings to ASCs could reduce Medicare spending. Further, the results from the study suggest that ASC growth at the historical rates could save Medicare millions of dollars.

Further, a Medicare beneficiary could pay as much as $186 in coinsurance for a colonoscopy performed in a hospital outpatient department, whereas they would pay only $89 if the same procedure was performed in an ASC. The study represented in article by the AJG also suggests that ACSs could play an important role in moving to a healthcare system that offers greater value through high quality care at a lower cost.

Please see Exhibit 1 for copies of articles describing the efficiency and cost benefits of an OSF.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

    The proposed OSF would provide single specialty care. Clinical focus on a single specialty allows greater opportunity for patient education and engagement, quality enhancement, improved outcomes, better efficiency in facility utilization and focused follow-up and coordination of care. In addition, WEC will be an EPIC medical record site, connecting WEC to patient records at MidState Medical Center and other Hartford HealthCare facilities.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

    If this proposal is approved, Wallingford Endoscopy Center, LLC will comply with Hartford HealthCare's Financial Assistance policy which includes the provision of services to indigent populations. In addition, please see the responses to Questions 8f and 8h, above.

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

    Please see Exhibit 7 for a copy of Hartford Healthcare's Financial Assistance Policy.

> *§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

    The proposal does not fail to provide or reduce access to services by Medicaid recipients or indigent persons. No changes to the services are anticipated. WEC will adopt Hartford

HealthCare's Financial Assistance Policy.

> § *"Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

    Patient health care costs will not be negatively affected in any way with the approval of this proposal. In fact, this proposal lowers overall costs to both payers and patients.

Financial Information

> § *"Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))*

15. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

    In large part due to health care reform, historically independent operations such as physician practices and hospitals are forming mutually beneficial partnerships. The shift from independent to integrated systems provides efficiencies that result in high quality, affordable care. Further, Wallingford Endoscopy Center, LLC will be a lower cost provider of gastrointestinal services in the Central Connecticut Region. Payers encourage utilization of OSFs through the use of deductibles and co-pays that incent patients to seek care at WEC.

16. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**. **Please see OHCA Table 3.**

17. 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 and funds received to

date; letter of interest or approval from a lending institution.

Equity Contribution	**773,775**
Long Term Debt	**2,014,825**
Capital	**2,788,600**

Terms: 7 years, 6% interest, monthly payment $29,434

Please see Exhibit 8 for a copy of the Letter of Interest from Bank of America.

18. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

    Please see the FY 2015 audited financial statements for Hartford HealthCare on file with the Office of Health Care Access.

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

    Please see Exhibit 9 for the completed Financial Worksheet A and B.

19. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

    Please see OHCA Table 4.

20. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

    Please see Exhibit 10 for all financial assumptions used in developing the Financial Worksheets.

21. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

N/A

22. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

	FY2018	FY2019	FY2020	FY 2021
***Units required to show incremental gain**	**4,869**	**4,972**	**4,991**	**5,006**

*Minimum number of units based on actual costs divided by average reimbursement per case.

Utilization

§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))

23. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

Projected Growth at MidState and WEC						
	FY2015	Base Year FY 2016	FY2018	FY2019	FY2020	FY2021
MidState	8,977	10,128	2,940	3,028	3,119	3,213
WEC	-	-	6,860	7,066	7,278	7,496
Total	8,977	10,128	9,800	10,094	10,397	10,709
*Assumed growth for MidState Medical Center and WEC 3% year over year						

Projected volumes for assume an approximate 70% shift of outpatient endoscopy services from MidState to WEC.

Please see OHCA Table 5 and Table 6

24. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

Explanation for the increased volume from FY 2015 to FY 2016 is as follows:
(1). Increased number of endoscopic retrograde cholangiopancreatography (ERCP) procedures performed in FY16 than the previous year.
(2). MidState began an outpatient acid reflux clinic and referred patients there for endoscopy diagnosis.

25. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

Please see OHCA Table 7.

> § *"Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

26. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.

    Not applicable. No new services are being provided.

27. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

    Please see OHCA Table 8.

> § *"The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))*

28. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

    Please see OHCA Table 9.

29. Describe the effect of the proposal on these existing providers.

    There will be little or no impact on existing providers since the gastrointestinal physicians who are performing their procedural cases in the Service Area will be the same physicians who will be performing gastrointestinal procedures at the proposed OSF. Specifically, this application does not add operating rooms, but adds procedure rooms and shifts outpatient volume from the Hospital's procedure rooms to a more cost-effective, patient accessible and operationally efficient environment.

30. Describe the existing referral patterns in the area served by the proposal.

    The existing referral patterns for outpatient endoscopy services are primarily from providers in the Service Area whose patients require procedures due to illness or for

screening and can safely be formed at an outpatient center.

31. Explain how current referral patterns will be affected by the proposal.

Current referral patterns will not be affected by the proposal.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

32. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

This proposal will not result in unnecessary duplicative services as low-risk patients previously treated in a higher cost hospital-based setting will be treated in the proposed OSF at significantly lower cost.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))*

33. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The diversity of health care providers in the region will not change as a result of this proposal. The proposal will enhance consumer choice in the Service Area by offering an alternative high-quality, lower-cost option for certain surgical procedures.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Wallingford Endoscopy Center, LLC	**Proposed location at 863 North Main St Ext, Wallingford, CT**			**New Service**

[back to question]

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Wallingford, Cheshire, Meridian	**More than 80% of all MidState Medical Center discharges originate from these towns.**

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	**Cost**
Equipment (Medical, Non-medical, Imaging)	598,825
Land/Building Purchase*	
Construction/Renovation**	1,683,775
Other (specify)****	506,000
Total Capital Expenditure (TCE)	**2,788,600**
Lease (Medical, Non-medical, Imaging)***	**N/A**
Total Lease Cost (TLC)	**N/A**
Total Project Cost (TCE+TLC)	**2,788,600**

* 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.

******Other includes Pre Opening Development expense.**

[back to question]

TABLE 4
WEC PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2018*	**FY 2019***	**FY 2020***
Revenue from Operations	3,947,648	4,132,129	4,326,166
Total Operating Expenses	2,799,668	2,907,709	2,964,520
Gain/Loss from Operations	1,147,980	1,224,420	1,361,646

* Fill in years using those reported in the Financial Worksheet attached.

[back to question]

TABLE 4
MIDSTATE PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2018*	**FY 2019***	**FY 2020***
Revenue from Operations	$585,470	$624,454	$694,440
Total Operating Expenses	0	0	0
Gain/Loss from Operations	$585,470	$624,454	$694,440

* Fill in years using those reported in the Financial Worksheet attached.

TABLE 5
MIDSTATE MEDICAL CENTER HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (Last 3 Completed FYs)			Last completed fiscal year	CFY Volume*
Service**	**FY 2013*****	**FY 2014*****	**FY 2015*****	**FY 2016*****	**FY 2017**
Endoscopy	3,473	3,857	4,142	5,685	317
Colonoscopy	4,599	4,949	4,835	4443	410
Total	8,072	8,806	8,977	10,128	727

* 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 6 months, report actual volume and identify the period covered.

** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

Data Source: Internal Decision Support

FY 2017 represents 1 month of volume.

Please see response to Question 24 for an explanation of volume increase from FY2015 to FY2016.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2018**	**FY 2019****	**FY 2020****
Endoscopy	2,610	2,688	2,769
Colonoscopy	4,250	4,378	4,509
Total	6,860	7,066	7,278

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** 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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

Projected volume assumes approximately 70% of the outpatient GI volume will shift from MidState Medical Center to WEC.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX
Wallingford Endoscopy Center, LLC

Payer	Projected					
	FY 2018**		FY 2019**		FY 2020**	
	Discharges	%	Discharges	%	Discharges	%
Medicare*	2,041	29.75%	2,102	29.75%	2,165	29.75%
Medicaid*	1,915	27.92%	1,973	27.92%	2,032	27.92%
CHAMPUS & TriCare	52	0.76%	54	0.76%	55	0.76%
Total Government	**4,008**	**58.43%**	**4,129**	**58.43%**	**4,252**	**58.43%**
Commercial Insurers	2,802	40.85%	2,886	40.85%	2,972	40.85%
Uninsured	50	0.73%	52	0.73%	54	0.73%
Workers Compensation	0	0.00%	0	0.00%	0	0.00%
Total Non-Government	**2,852**	**41.57%**	**2,938**	**41.57%**	**3,025**	**41.57%**
Total Payer Mix	**6,860**	**100.00%**	**7,006**	**100.00%**	**7,278**	**100.00%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

This table reflects the projected payer mix for the proposed WEC.

[back to question]

TABLE 8
MidState Medical Center Outpatient GI UTILIZATION BY TOWN

Town	Utilization FY 2016**
Meriden	4351
Cheshire	710
Wallingford	1808
Southington	473
New Britain	369
Waterbury	264
All other towns	2,153
Total	10,128

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Masonic Care	N/A	N/A	22 Masonic Ave, Wallingford CT	8am-4:30pm	N/A
MidState Medical Center	Please see table 8 above		435 & 455 Lewis Avenue Meriden, CT 06451	7am-5pm	N/A

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

Supplemental CON Application Form

Establishment of an Outpatient Surgical Facility

Conn. Gen. Stat. § 19-638(a)(6)

Applicant: Wallingford Endoscopy Center, LLC and MidState Medical Center

Project Name: The Establishment of a Gastrointestinal Outpatient Surgery Facility in Wallingford, Connecticut.

1. **Project Description: Outpatient Surgical Facility**

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

   The proposed outpatient surgery facility will be located in the Wallingford Family Health Center on North Main Street in Wallingford, Connecticut. Initially two of the three procedure rooms will be equipped and operational and the third procedure room will be shelled for future use to accommodate volume growth.

2. Clear Public Need

a. List all existing providers of the proposed service in the towns listed in Table 2 of the Main Application (Applicant's service area towns) and in nearby towns.

TABLE A
EXISTING SERVICE PROVIDERS AND OPERATING ROOM CAPACITY

Facility Name	Facility ID*	Facility Address	Number of Operating Rooms				Estimated Capacity for Proposal		Current Utilization[7]
			Available[1]	Utilized[2]	Not Utilized[3]	Equipped for Proposal[4]	Min[5]	Max[6]	
MidState Medical Center		435 Lewis Ave, Meriden	9	n/a	n/a	n/a	n/a	n/a	n/a
MasoniCare Health Center		22 Masonic Ave, Wallingford	2	n/a	n/a	n/a	n/a	n/a	n/a
Central Connecticut Endoscopy Center		440 New Britain Ave, Plainville	3	n/a	n/a	n/a	n/a	n/a	n/a
Middlesex Endoscopy Center		410 Saybrook Rd, Middletown	3	n/a	n/a	n/a	n/a	n/a	n/a

* Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[1] Include used, equipped, and shell space.

[2] Include those actually used to perform surgeries.

[3] Include those that are equipped but not used.

[4] Include those rooms that are uniquely equipped to perform the types of surgeries included in the proposal.

[5] Minimum number of surgical cases 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 surgical cases 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 surgical cases for the most current 12 month period and identify the period covered

Much of the operating and utilization information requested in Table A above is proprietary and not publicly available.

3. Projected Volume

a. 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). Include relevant documentation to support these estimates.

Volume projections were conservatively projected at an increase of 3% per year based on expected increases in volume due to aging population and increased access to services.

b. Complete the following tables for the first three projected FYs of the proposal for the outpatient surgical volume of each of the Applicants and physicians involved in the proposal.

TABLE B

PROJECTED SURGICAL VOLUME BY SPECIALTY (E.G., THORACIC, ORTHOPEDIC, ETC.)

Specialty**	**Projected Surgical Case Volume (First 3 Full Operational FYs)***		
	FY 18	FY 19	FY 20
Endoscopy	2,610	2,688	2,769
Colonoscopy	4,250	4,378	4,509
Total	**6,860**	**7,066**	**7,278**

* 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 the number of surgical cases for each specialty – 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 C
PROJECTED SURGICAL VOLUME BY OPERATING ROOM

Operating Room**	Projected Surgical Case Volume (First 3 Full Operational FYs)*		
	FY 18	FY 19	FY 20
Procedure Room 1	3,430	3,533	3,639
Procedure Room 2	3,430	3,533	3,639
Total	**6,860**	**7,066**	**7,278**

* 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 the number of surgical cases for each operating room – 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. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

Please see Exhibit 10.

4. Quality Measures

a. <u>For non-hospital Applicants only</u>, provide transfer agreements with hospitals in close proximity to the proposed facility.

Please see Exhibit 6, from the Main Application, for a copy of a Draft Transfer Agreement Between Wallingford Endoscopy Center, LLC and MidState Medical Center.

List of Exhibits

Exhibit 1: Articles related to this proposal.

Exhibit 2: MidState Medical Center Department of Public Health Hospital License.

Exhibit 3: Curriculum vitae for key personnel.

Exhibit 4: Letters of support related to this proposal.

Exhibit 5: Draft Operating Agreement.

Exhibit 6: Draft Transfer Agreement between MidState Medical Center and WEC.

Exhibit 7: Hartford Healthcare's Financial Assistance Policy.

Exhibit 8: Letter of Interest from Bank of America.

Exhibit 9: Financial Worksheet A and B.

Exhibit 10: Financial assumptions used in this proposal.

Exhibit 1: Articles related to this proposal.

nature publishing group

Growth of Ambulatory Surgical Centers, Surgery Volume, and Savings to Medicare

Lane Koenig, PhD[1] and Qian Gu, PhD[1]

We studied the impact of the growth of ambulatory surgical centers (ASCs) on total Medicare procedure volume and ASC market share from 2000 to 2009 for four common outpatient procedures: cataract surgery, upper gastrointestinal procedures, colonoscopy, and arthroscopy. ASC growth was not significantly associated with Medicare volume, except for colonoscopy. An additional ASC operating room per 100,000 population results in a 1.8% increase in colonoscopies performed in all outpatient settings. Increases in the number of ASCs were associated with greater ASC market share with effects ranging from 4- to 6-percentage-point gains for each additional ASC operating room per 100,000. The study demonstrates that continued growth of ASCs could reduce Medicare spending, because ASCs are paid a fraction of the amount paid to hospital outpatient departments for the same services.

SUPPLEMENTARY MATERIAL is linked to the online version of the paper at http://www.nature.com/ajg

Am J Gastroenterol 2013;108:10–15; doi:10.1038/ajg.2012.183

Introduction

The past decade has seen a rapid increase in the number of ambulatory surgical centers (ASCs), facilities where surgeries that do not require a hospital stay can be performed. Between 2004 and 2009, the number of Medicare-certified ASCs increased by 28%, growing from 4,106 to 5,260 (1). These facilities often offer specialized care by focusing on a single condition or a small number of conditions, such as cataract surgery, colonoscopy, or orthopedic surgery.

Policy makers' reaction to the rapid growth of ASCs has been mixed, as a result of perceived offsetting benefits and costs to patients and payers. On the benefits side, ASCs and other specialized surgical facilities may offer convenient locations, short wait times, high quality, and high patient satisfaction (2–8). For Medicare, ASCs also offer significant savings, with ASC payment rates approximately 56% of those paid to hospital outpatient departments for the same services in 2011.

On the negative side, physician ownership of ASCs raises concerns of self-referral, whereby a physician increases his or her procedure volume for financial gain. Although incentives for physician self-referral are inherent in any fee-for-service system, the issue is whether profits derived from an ASC facility fee paid to physician owners result in more surgical services.

A few studies have examined the relationship between the presence of an ASC, physician ownership, and procedure volume, providing limited evidence on the "induced demand" hypothesis. Using data from Florida, Hollingsworth *et al.* found a greater increase in annual caseloads of presumed ASC owners from the pre- to the post-ownership period as compared with nonowners for five common types of procedures performed in ASCs (9). Hollingsworth *et al.* inferred ownership status from surgical volume at an ASC, based on the safe-harbor rules in the anti-kickback statute that require physicians to perform at least a third of their surgeries at the outpatient facility in which they have a financial interest (10). In similar work, Hollingsworth and others reported a higher level and growth of annual caseloads of urological surgery for physician owners than for nonowners (11,12). Using data from one private insurer and 42 ASCs and specialty hospitals in Idaho, Mitchell compared the frequency of use of three procedures between physician owners and nonowners of ASCs (13). Mitchell observed a substantially higher frequency of procedure use among patients treated by physician owners than among those treated by nonowners.

Although the findings noted above are supportive of the induced demand hypothesis, these studies have important limitations, often noted by the researchers. First, prior studies are unable to determine whether factors other than financial considerations explain the connection between the volume of surgeries performed by owners and their decision to invest in an ASC. For example, it may be that physician owners, on the basis of their patient populations, were constrained by capacity and unable to satisfy patient demand prior to ASC ownership. This hypothesis is consistent with the findings of Hollingsworth *et al.* (9) and others who observed higher

[1]KNG Health Consulting LLC, Rockville, Maryland, USA. **Correspondence:** Lane Koenig, PhD, KNG Health Consulting LLC, 1445 Research Boulevard, Suite 320, Rockville, Maryland 20850, USA. E-mail: lane.koenig@knghealth.com

annual caseloads of eventual owners in the pre-ownership period than those of nonowners. Second, the studies are unable to capture market phenomena that affect the underlying (and potentially unmet) demand for surgical care in a community. Finally, these studies are limited by the use of data from a specific geographic area (e.g., Idaho, Florida) and/or a specific population (e.g., workers' compensation patients) for selected surgery types.

Along with the question of whether the growth of ASCs induces demand, the question of whether this hypothesized induced demand drives up Medicare spending remains to be answered. Prior papers have not studied the financial impact of increased ASC utilization on the Medicare program. Growth in the number of ASCs may raise total procedure volume, but its effect on aggregate Medicare spending also depends on the migration of procedures from hospital outpatient departments to ASCs. Since ASCs are paid a fraction of what hospitals are paid, the migration could potentially result in net savings to Medicare.

In this paper, we address two questions. First, we studied the issue of induced demand by examining the effect of ASCs on the total volume of selected outpatient procedures covered by Medicare. Second, we projected the net financial effect of ASCs on Medicare spending between 2011 and 2015 under illustrative scenarios of ASC growth.

In addition to examining the potential financial effects of ASC use on Medicare, this study has other important advantages over prior work. We separately examined the ASC effects on total procedure volume and ASC market share. Thus, our study provides a more complete picture of the market dynamics associated with ASC growth and allows us to estimate the net financial effect of ASC growth on Medicare spending. We use national Medicare data rather than rely on single-state data. Finally, we use a fixed-effects model to control for underlying population demand.

Methods

Data source. The study's primary data source was the Medicare Physician/Supplier Procedures Summary (PSPS) files from 2000 to 2009. The PSPS files contain information on the number of Medicare-covered procedures by place of services. Medicare Provider of Services files were used to measure the number of health-care facilities, including ASCs and hospitals. We used the Census State Population Estimates to measure total state population and demographic distribution (age, sex, race, and ethnicity) among the elderly population. Medicare enrollment data were used to measure the number of Medicare Part B Fee-For-Service (FFS) enrollees and the percentage of disabled enrollees.

Several sources of data were used to obtain state-level demographic characteristics and health-care resources: the Area Resource File to measure the number of health-care professionals; the Behavior Risk Factor Surveillance System to compute the percentage of overweight people and people with poor health among the elderly population; and the Census State Median Income data.

Procedure selection. For our analyses, we selected four common groups of procedures that are performed in outpatient settings using Current Procedural Terminology (CPT) codes: (i) cataract removal/lens insertion (CPT 66830–66986); (ii) arthroscopy (CPT 29800–29899); (iii) upper gastrointestinal (GI) procedures (CPT 43200–43273); and (iv) colonoscopy (CPT 45355–45392, G0105, G0121). Cataract removal, upper GI procedures, and colonoscopy are all common procedures performed on the elderly population. Orthopedic surgery is a growing service area of ASCs. We chose arthroscopy as a specific set of procedures to represent orthopedic procedures. Together, these four procedure categories accounted for 51% of all Medicare-allowed services or 62% of all Medicare-allowed charges for ASCs in 2009.

Unit of observation and modeling approach. The unit of observation in the analytical file is the state-year. The sample covers 50 states in the United States and stretches over 10 years from 2000 to 2009. We used multivariate regression analysis to assess the effect of ASCs on total procedure volume and market share in Medicare. For each procedure group, we fitted one regression model for total procedure volume and the other for the ASC market share. Total procedure volume includes Medicare-billed procedures performed in ASCs, hospital outpatient departments, and physicians' offices per 1,000 Medicare Part B FFS beneficiaries. Only procedures that are covered under both the Medicare outpatient payment schedule and the ASC payment schedule are included in the computation of total procedure volume. ASC market share is defined as the number of procedures performed at ASCs divided by the total volume for each procedure group.

The procedure volume regression model assesses the impact of ASC growth on service utilization of the entire market. If ASCs (and associated physician ownership) induce demand, we would observe a positive effect of the number of ASCs on total procedure volume. The ASC market share regression examines the extent to which the growth of ASCs leads to the migration of procedures from other outpatient settings to ASCs. The key independent variable in the regressions is the number of ASC operating rooms per 100,000 people.

We used three types of measures to control for health-care demand: (i) demographic composition of the elderly population (age, sex, race, and ethnicity distribution in people aged 65 or older and median household income); (ii) health status of the elderly population (percentage overweight and percentage in poor health among people aged 65 or older and percentage of disabled in Medicare FFS population); and (iii) health-care resources (number of practicing MDs and number of hospitals providing outpatient surgery services per 100,000 people and percentage of surgeons among practicing MDs). The models included state fixed effect and time fixed effect to control for unobserved demand factors.

We simulated the impact of ASC growth on Medicare spending in 2011–2015 under a variety of scenarios based on the regression results. Statistically insignificant coefficients for the number of ASC operating rooms were treated as zero in the simulation. We first determined the projected values of the independent variables for 2011–2015. We used the Census state population projection files for population estimates and

Table 1. Summary statistics of procedure volume, ASC market share, and ASC operation rooms

	2000	2003	2006	2009
Procedure volume per 1,000 Medicare beneficiaries				
Cataract removal/lens insertion	55.8 (9.1)	57.9 (9.5)	61 (12.2)	60.5 (8.7)
Arthroscopy	6.3 (1.8)	7.5 (1.9)	10.5 (3)	11.71 (3)
Upper gastrointestinal procedures	38.2 (6.4)	45.8 (7.1)	52.1 (8.3)	54.4 (9.1)
Colonoscopy	58.6 (10)	84.5 (12.3)	90.9 (11.4)	83.7 (10.8)
ASC market share (%)				
Cataract removal/lens insertion	43.4 (15.3)	50.6 (16)	54.2 (16.5)	60.5 (16)
Arthroscopy	18.1 (9.6)	24.2 (12.1)	30.1 (12.9)	31.8 (13.4)
Upper gastrointestinal procedures	20 (12.5)	26.4 (15.2)	33.1 (17.4)	35.7 (16.7)
Colonoscopy	22.2 (13.5)	29.5 (16.4)	37 (18.7)	40.9 (18)
ASC operation rooms per 100,000 population	2.9 (1.6)	3.6 (1.8)	4.2 (2.1)	4.5 (2.0)

Mean and s.d. (in parentheses) across states in selected years are reported. Medicare beneficiaries are Medicare Part B Fee-For-Service plan enrollees. Procedure volume includes procedures from all outpatient care settings, including ASCs, hospital outpatient departments, and offices.
ASC, ambulatory surgical center.
Source: Authors' analysis of the analytical sample.

Table 2. Summary statistics of demographic distribution, health status, and health-care resources

	2000	2003	2006	2009
Aged 75–84 in elderly population (%)	35.1 (1.4)	35.7 (1.4)	35.2 (1.3)	33.0 (1.1)
Aged 85+ in elderly population (%)	12.2 (1.5)	12.7 (1.6)	13.5 (1.7)	14.0 (1.7)
Male in elderly population (%)	41.6 (1.8)	42.0 (1.7)	42.4 (1.7)	42.9 (1.6)
Hispanic origin in elderly population (%)	3.1 (5.1)	3.5 (5.4)	3.9 (5.7)	4.3 (5.9)
Black in elderly population (%)	8.0 (11.1)	8.0 (10.9)	8.1 (10.6)	8.1 (10.3)
People with poor health in elderly population (%)	29.3 (5.6)	29.2 (5.4)	28.2 (5.3)	25.7 (4.7)
Overweight people in elderly population (%)	58 (4.1)	59.7 (4.1)	61.8 (3.6)	63.4 (3.6)
Disabled in Medicare Part B Fee-For-Service population (%)	13.9 (3)	15.2 (3.2)	16.6 (3.4)	17.1 (3.4)
Median household income ($000)	52.2 (8)	50.7 (7.6)	51.6 (8.3)	49.9 (7.6)
Practicing MDs per 100,000 population	167.9 (30.1)	179 (31.9)	182.8 (34.5)	174.6 (32.1)
Surgeons in practicing MDs (%)	24.9 (1.8)	24.2 (1.8)	23.3 (1.8)	22.9 (1.9)
Hospitals with outpatient surgery services per 100,000 population	1.8 (0.9)	1.8 (1.0)	1.8 (1.0)	1.9 (1.1)

Mean and s.d. (in parentheses) across states in selected years are reported. Elderly population includes people aged 65 or older.
Source: Authors' analysis of the analytical sample.

demographic distribution. For other variables, we used a 4-year moving average of the annual growth rate of the most recent years to project the growth rate from 2010 to 2015. For example, we used actual data from 2008 and 2009 and projected data from 2010, 2011, and 2012 to project values in 2013. The state and time fixed effects were included in the projection estimates. For the time fixed effects, we used a 4-year moving average. For ASC rooms per capita, we designed four scenarios assuming different ASC growth rates (described further below).

Using the projected values for the independent variables and the coefficients from the regression models, we projected total Medicare procedure volume and ASC market share. For Medicare payments, we used the 2011 Medicare outpatient prospective payment system (OPPS) fee schedule, the Medicare ASC fee schedule, and the Medicare physician fee schedule (MPFS) for payments for physician practice expenses. These payment rates were multiplied by the projected volume at ASCs, hospital outpatient departments, and physician offices to estimate Medicare spending. We projected an increase at an annual rate of 1% in the rates of future Medicare payments for services under the OPPS and the MPFS, and growth of 0.5% for ASC services for 2012–2015. These assumptions are based on Medicare Payment Advisory Commission recommendations for updating the Medicare OPPS, ASC Fee Schedule, and Medicare physician fee schedules.

Results

Descriptive analysis. **Table 1** presents trends and cross-sectional variation of key variables. Volume per capita increased in the past decade across all four procedures at different rates. Colonoscopy experienced a rapid growth in the first half of the decade and then slowed considerably. Upper GI procedures and arthroscopy have been increasing at a relatively steady pace. The growth of cataract procedures was mild compared with growth in other procedures.

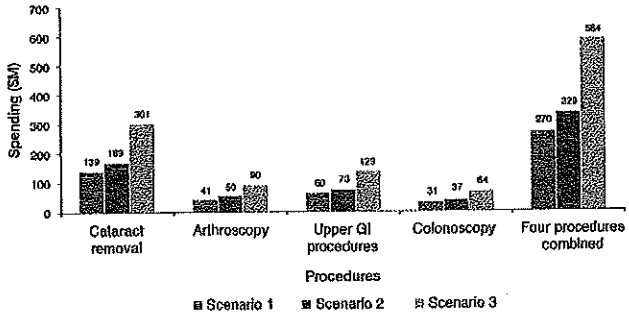


Figure 1. Total additional Medicare spending from 2011 to 2015 under alternative scenarios that restrict the growth of ambulatory surgical centers (ASCs). Additional cost compared with base scenario. The base scenario assumes that ASCs grow at historical rates in 2011–2015. Scenario 1 assumes that per capita ASC rooms stay at 2009 levels in 2011–2015. Scenario 2 assumes that the number of ASC rooms stays at 2009 levels in 2011–2015. Scenario 3 assumes that ASC rooms decrease in 2011–2015 at a rate so that the number of ASC rooms in 2015 is the same as that in 2007. Cost shown is the total cost from 2011 to 2015 and is expressed in million dollars. (Source: Authors' analysis of the analytical sample.)

ASCs have been gaining market share across all years. Procedures performed at ASCs now account for more than 60% of cataract procedures and 30–40% of other procedures performed on FFS Medicare beneficiaries. The number of ASC operating rooms has been growing across all years, although the growth in recent years has slowed down. Summary statistics of the control variables in the regression model are listed in **Table 2**.

Regression analysis. **Table 3** shows the estimated impact of ASC growth on the total procedure volume and ASC market share from the regression analysis. After controlling the variables and fixed effects specified above, we found statistically significant association between ASCs and service utilization for one procedure group, colonoscopy. The analysis revealed no statistically significant association between number of ASC operating rooms and Medicare utilization of cataract procedures, arthroscopy, or upper GI procedures.

With respect to colonoscopy, one additional ASC operating room per 100,000 population is associated with 1.47 more procedures per 1,000 Medicare Part B FFS beneficiaries. The effect of an additional ASC operating room per 100,000 represents a 5.3% increase from the average ASC volume of colonoscopies in the analytical sample (or an increase of 1.8% in colonoscopies performed in all outpatient settings). It is important to note that one additional ASC operating room per 100,000 is a substantial increase, considering that the mean number of ASC operating rooms per 100,000 in the analytical sample is 3.8.

The findings show a significant impact of the number of ASC operating rooms on ASC market share for each procedure category. One additional ASC operating room per 100,000 population leads to a 4-percentage-point gain in ASC market share for the procedure categories of cataract removal/lens insertion and arthroscopy. The ASC market share effect of an additional ASC operating room is 6% for the categories of upper GI procedures and colonoscopy.

Cost simulation. In light of concerns regarding physician ownership of ASCs, the focus has been on the potential cost of ASCs in increasing volume and spending. As a result, we designed scenarios to better understand the potential implications of different ASC growth rates for Medicare spending over the period from 2011 to 2015.

Four scenarios of ASC growth were modeled. The "base scenario" assumes projected growth of ASCs based on the 4-year moving average. Scenario 1 ("population growth rate") assumes that ASC operating rooms per capita remain at 2009 levels. Scenario 2 ("no growth") assumes that the number of ASC rooms remains at 2009 levels. Scenario 3 ("negative growth") assumes that the number of ASC rooms decreases at a rate such that the number of ASC rooms in 2015 is equal to the number in 2007. Modeling these scenarios provides insights into the potential impact of policies that would restrict growth of ASCs.

Figure 1 presents the change in Medicare spending under the three alternatives relative to the base scenario. Under all three alternatives, Medicare spending is higher than that under the base scenario. From 2011 to 2015, the most restrictive scenario (scenario 3) would result in Medicare spending $584 million more than in the base scenario across all selected procedure groups. The two less restrictive scenarios would increase Medicare spending by $329 million and $270 million relative to the base scenario, respectively.

The potential savings to Medicare if ASC growth continues at historical rates is easy to understand for cataract procedures,

Table 3. Impact of ASC operation rooms on procedure utilization and ASC market share

Impact of one additional ASC operation room per 100,000 population on:	Cataract procedures	Arthroscopy	Upper GI procedures	Colonoscopy
Procedures per 1,000 Medicare beneficiaries	0.56 (0.56)	0.10 (0.11)	−0.09 (0.28)	1.47* (0.46)
Market share of ASCs	0.04* (0.005)	0.04* (0.004)	0.06* (0.004)	0.06* (0.004)
Sample size	500	500	500	500

Standard deviations are listed in parentheses. Medicare beneficiaries include Medicare Part B Fee For Service plan enrollees. All regressions include control variables described in the Methods section and state and year fixed effects. Coefficients of market share are expressed in fractions, not percentage points; a coefficient of 0.06 means market share increases by 6 percentage points.

*$P < 0.01$.

ASC, ambulatory surgical center.

Source: Authors' analysis of the analytical sample.

arthroscopy, and upper GI procedures, as ASC growth does not increase total procedure volume but does increase ASC market share. Colonoscopy is an interesting case in that continued growth of ASCs would still result in Medicare savings. The reason is that the savings to Medicare from migration of services from other outpatient settings to ASCs is greater than the additional Medicare spending from increases in the total volume of colonoscopies associated with ASC growth.

Discussion

The study findings show that the association between ASC growth and service utilization is not as strong as previous studies suggest. We found that ASC growth is associated with increased total utilization for colonoscopy only. For other common procedures, including cataract procedures, arthroscopy, and upper GI procedures, we did not observe increased Medicare utilization as a result of ASC growth.

There are a number of potential reasons that our findings differ from those of previous studies. One explanation is that our approach (using state-level time series data and fixed effects) better enabled us to disentangle the potentially spurious relationship between ASCs and increased utilization by controlling for underlying demand factors. Previous studies note that induced demand is only one of many plausible reasons for their observed associations between ASCs and procedure volume. In addition, our analysis evaluated the association between ASCs and utilization at the national level. Prior research generally focused on a single state or region, which may generate results that are not generalizable to the national level.

Although we cannot reject the hypothesis that ASCs created greater Medicare volume of colonoscopy, the growth of ASCs may have helped meet the growing demand for these services. In early 1999, the Centers for Disease Control and Prevention launched its Screen for Life: National Colorectal Cancer Action Campaign. Since the initiative began, the percentage of adults aged 50 or older who have ever had a sigmoidoscopy or colonoscopy increased from 44% in 1999 to 53% in 2004 to 64% in 2010 (14). Moreover, new rules in the Affordable Care Act of 2010 waive beneficiary cost-sharing for screening colonoscopies, which is expected to further increase the demand for these services.

A careful examination of the impact of ASC growth should include both changes in total volume and the migration of services from other outpatient settings to ASCs, which was largely overlooked by previous studies. Our analysis shows that ASCs gain significant market share across all procedures as they grow. Since ASCs are paid a fraction of what is paid to hospitals for the same procedures under Medicare, a migration from other outpatient settings to ASCs could reduce Medicare spending. Our results suggest that ASC growth at historical rates could save hundreds of millions of dollars to Medicare over the next 5 years, compared with slower growth rates.

There are two potentially important limitations of the study. First, as with previous studies, our test of induced demand is indirect. Specifically, we do not observe physician ownership of ASCs directly, but, instead, determine the association between the number of ASC operating rooms and overall surgical volume.

Second, we used fixed effects to control for differences in unobserved demand factors across states and time. A concern with this approach is whether there is sufficient variation in the growth of ASCs and procedure volume across states and years to detect a significant relationship. However, our analysis indicates significant variation in key variables. For example, the interquartile range (i.e., the difference between the 75th and 25th percentiles) of the state-level cumulative growth in per capita ASCs was 62% (96% – 34%) from 2000 to 2009, while the interquartile ranges of state-level growth of procedure volume were 14% (17% – 3%) for cataract removal, 41% (112% – 71%) for arthroscopy, 17% (49% – 32%) for upper GI procedures, and 18% (55% – 37%) for colonoscopy during the same period. Further, we found statistically significant effects on volume for some control variables with limited variation across years, such as the percentage of the elderly population aged 85 or older. This suggests ample variations in our sample to detect statistical significance (see **Supplementary Tables S1** and **S2** online).

Our study suggests that ASCs could play an important role in moving to a health-care system that offers greater value by producing high-quality care at lower cost. The policy debate should address the concern of physician ownership of ASCs in a broader context that includes recognition of the benefits of ASCs. Movement in Medicare toward value-based purchasing and delivery system reforms should work to increase the value of ASCs to Medicare and beneficiaries.

ACKNOWLEDGMENTS

We thank Sharon Cheng, Marian Lowe, Vega Subramaniam, David Ruiz Jr., and Andrea Cornejo for their comments, and the Ambulatory Surgery Center Association for its financial support.

CONFLICT OF INTEREST

Guarantor of the article: Lane Koenig, PhD.
Specific author contributions: Lane Koenig: designing approach, interpreting results, drafting manuscript; Qian Gu: conducting analysis, interpreting results, drafting manuscript.
Financial support: This study was funded by the Ambulatory Surgery Center Association.
Potential competing interests: None.

REFERENCES

1. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Washington, DC, 2011.
2. Vila H, Soto R, Cantor AB *et al.* Comparative outcomes analysis of procedures performed in physician offices and ambulatory surgery centers. Arch Surg 2003;138:991–5.
3. Cram P, Vaughan-Sarrazin MS, Wolf B *et al.* A comparison of total hip and knee replacement in specialty and general hospitals. J Bone Joint Surg Am 2007;89:1675–84.
4. Paquette IM, Smink D, Finlayson SRG. Outpatient cholecystectomy at hospitals versus freestanding ambulatory surgical centers. J Am Coll Surg 2008;206:301–5.
5. Grisel J, Arjmand E. Comparing quality at an ambulatory surgery center and a hospital based facility: preliminary findings. Otolaryngol Head Neck Surg 2009;141:701–9.
6. Hagen TP, Vaughen-Sarrazin MS, Cram P. Relation between hospital orthopaedic specialisation and outcomes in patients aged 65 and older: retrospective analysis of US Medicare data. BMJ 2010;340:c165.

Document written by Calisher & Associates, Inc.

Calisher & Associates, Inc. is a family owned and operated company, and we have been providing services to the healthcare community for over 25 years The home offices are based in Orange County, California; however, our company has operated in more than 30 states since our inception. We provide a wide array of customized services including turnkey development, organizational, operational, and technical assistance in almost every facet of the healthcare industry. We have made it a point to only contract with a limited number of facilities each year so that our executive staff members can focus the necessary amount of attention on each project. With Calisher & Associates, Inc., your project does not get delegated to lower and mid level staff employees with little or limited experience. Every client receives direct and constant attention from all of the principals of our company, all the way up to the CEO. Our company is founded on the principle of never becoming too large to be able to focus full attention on any one client at any one time, no matter how "small" a client may be. We bring honesty, integrity, and dedication to every project we encounter.

Our advantage lies in the hands of our seasoned professional team; combined, they bring nearly 70 years of hands-on experience to every project. Our one and only objective is to help your facility achieve its maximum potential on every possible level. We want your facility to become an environment that all patients, families, physicians, and employees are ecstatic to be part of -- a center of excellence that provides everyone involved with a great sense of pride and satisfaction

Outpatient endoscopy centers are a well-established alternative to the traditional inpatient environment. Whether freestanding or hospital-based, outpatient healthcare offers distinct quality, convenience and cost advantages as compared to inpatient procedures.

Ambulatory surgery centers (ASC's) are not a new concept to today's ever changing healthcare industry. The first ASC opened in 1970 and today more than 23 million procedures are performed each year in the +5,500 surgery centers located throughout the United States. ASC's are able to provide a full range of covered procedures from almost every specialty, including but not limited to gastroenterology, orthopedics, opthalmology, ENT, gynecology, general surgery, urology, pain management, podiatry, and plastic surgery. Recent studies estimate that nearly 54% of all ASC's are single specialty surgery centers and gastroenterology (GI) remains the number one single specialty for procedures in ASC's by volume. It is estimated that gastroenterology makes up about 27% of the +23 million outpatient procedures performed each year; based on this data, it has been concluded that over 6.26 million GI procedures are performed in an outpatient setting each year. It is quite evident that GI is a dominating force in the outpatient healthcare market of today, and that it will continue to grow exponentially.

By (Federal) definition, ASC's are facilities where the procedures performed do not require hospital admission; outpatient endoscopy centers fall into the ASC classification. The psychological and social advantages of outpatient procedures have been documented and are considerable. Foremost is the fact that patients tend to perceive the procedural risk of outpatient endoscopy as diminished from that of the inpatient setting. As a result, patients are more willing to submit to care and less apprehensive about possible complications. Patient satisfaction is paramount in ASC's and satisfaction ratings are unparalleled in the industry. Recently the U.S. Department of Health and Human Services Office of the Inspector General (OIG) surveyed Medicare beneficiaries who had one of four procedures done in an ASC. They surveyed a total of 837 patients, a large percentage of which had undergone either upper gastrointestinal endoscopy or colonoscopy procedures. The OIG found that 98% of the people were satisfied with their experience. Reasons cited for a preference for ASC's over larger institutions included less paperwork, lower cost, a more convenient location and parking. Also cited were minimal wait times at the ASC, and more organized and friendlier staff as compared to crowded and sometimes uncomfortable settings found at larger organizations. These results are not based on an isolated occurrence, rather they represent a very common statistical trend found in ASC's nationwide.

Another factor in the success of these types of facilities is patient convenience. A contributing factor to high patient satisfaction is the inherent convenience in procedure scheduling. According to a study conducted by the Ambulatory Surgery Center Association (formerly FASA), 75% of ASC's started more than 95% of their cases on time. Another relative component to convenience is turnaround time. On average,

patients undergoing a GI procedure in an ASC experience a turnaround of approximately 1 ½ to 2 hours from the time of admission to discharge. This is in large contrast to the long wait and service times experienced at large institutions.

GASTROENTEROLOGY & HEPATOLOGY
The Independent Peer-Reviewed Journal

Gastroenterol Hepatol (N Y). 2008 Aug; 4(8): 572–578. PMCID: PMC3096111

The Relationship Between Obesity and Functional Gastrointestinal Disorders

Causation, Association, or Neither?

Wayne Ho, MD and Brennan M. R. Spiegel, MD, MSHS✉

Veterans Affairs (VA) Greater Los Angeles Healthcare System; David Geffen School of Medicine at the University of California, Los Angeles (UCLA); Center for Neurovisceral Sciences and Women's Health; UCLA/VA Center for Outcomes Research and Education (CORE)

✉Corresponding author.

Address correspondence to: Dr. Brennan M. R. Spiegel VA Greater Los Angeles Healthcare System 11301 Wilshire Blvd. Building 115, Room 215 Los Angeles, CA 90073; Tel: 310-268-3256; E-mail: bspiegel@mednet.ucla.edu

Abstract

Go to:

It is possible that functional gastrointestinal disorders (FGIDs) and obesity have more in common than merely sharing high population prevalence. Epidemiologic data indicate that obesity is associated with chronic gastrointestinal complaints, many of which overlap with FGIDs such as irritable bowel syndrome or dyspepsia. This raises the possibility that obesity and FGIDs may be mechanistically linked. In this paper, we review and summarize the literature linking obesity and FGIDs, comment on the clinical relevancy of existing data, and suggest next steps for future research in this field.

Keywords: Functional gastrointestinal disorders, irritable bowel syndrome, obesity

Obesity is overwhelmingly prevalent in the United States. As of the 2004 National Health and Nutrition Examination Survey,[1] 1 in 3 Americans had a body mass index (BMI) exceeding 30 kg/m^2, and the obesity epidemic shows no signs of abating. Functional gastrointestinal disorders (FGIDs) such as irritable bowel syndrome (IBS) and functional dyspepsia are also extremely prevalent. Population-based data indicate that 5-10% of the US population suffers from IBS, the most common FGID.[2–5] It is possible that FGIDs and obesity have more in common than merely high population prevalence rates. Epidemiologic data indicate that obesity is associated with a wide range of chronic gastrointestinal (GI) complaints, many of which overlap with FGIDs such as IBS or dyspepsia.[6–11] This association raises the possibility that obesity and FGIDs may be mechanistically linked and that studying this relationship might provide insights into the pathophysiology of several FGIDs. However, data linking obesity and FGIDs are inconsistent, suggesting that any epidemiologic associations may simply be spurious—a case of "true, true, and unrelated." This article reviews data linking obesity and FGIDs and summarizes the evolving theories regarding the possible mechanisms linking these common conditions. The article ends with recommendations on how this information might impact the practicing gastroenterologist, both now and in the future.

Evaluating the Possibility of an Association Between Obesity and Functional Gastrointestinal Disorders

Go to:

Before considering the potential mechanisms linking obesity with FGIDs, it is important to first establish whether there is even an epidemiologic link between these common conditions. If obesity and FGIDs were found to

reliably track together, this would support the hypothesis that these conditions are potentially linked and would warrant further investigation to understand why they might be associated with one another.

Although it is well established that obesity is associated with gastroesophageal reflux disease (GERD),[6,11,2] it remains less clear whether obesity is a risk factor for common FGIDs, including IBS and dyspepsia. There have been several studies measuring the association between obesity and various chronic bowel complaints.[6,11] In some cases, the relationship between obesity and specific syndromes appears to be strong, whereas in other cases, the link is tenuous. This section will review key studies that have investigated the relationship between obesity, FGIDs, and related GI symptoms.

Published studies have had inconsistent conclusions. As an example of a recent negative study, van Oijen and colleagues studied 1,023 consecutive patients referred for outpatient endoscopy in a university-based hospital in The Netherlands.[6] Subjects completed a validated bowel symptom questionnaire to evaluate the presence and severity of various GI symptoms, including dyspepsia and IBS-related symptoms (lower abdominal pain, bloating, diarrhea, and constipation). After performing logistic regression analysis adjusted for a range of confounders, the authors found no relationship between BMI and FGID symptoms. In contrast, as might be expected, there was a positive relationship between acid reflux symptoms and BMI. The authors concluded that BMI alone may not predict the occurrence of dyspepsia or IBS-type symptoms, but BMI may be linked to acid reflux disease. It should be noted that this study is limited, as the patient population was highly selected (patients who were undergoing endoscopy) and because the definitions of IBS and dyspepsia did not meet strict criteria such as those proposed by the Rome III Committee on FGIDs. Nevertheless, this study is notable for its large sample size and careful statistical approach. This large and well-designed study tends to cast doubt on the link between obesity and common FGIDs.

In a large population-based survey of over 1,900 subjects in Olmsted County, Minnesota, Delgado-Aros and colleagues studied the relationship between BMI and a range of upper and lower GI symptoms.[7] After performing logistic regression analysis to adjust for potential confounding variables, the authors found no statistically significant association between obesity and lower abdominal pain, constipation, or nausea. However, there was a significant association between obesity and upper abdominal pain, bloating, and diarrhea. This study is notable for its large sample size and use of a randomly selected, community-based sample. This study tends to support the study conducted by van Oijen and colleagues, in that it found no significant relationship with abdominal pain or constipation, which are the hallmark features of IBS. Nevertheless, the study did reveal strong relationships between obesity and various symptoms of dyspepsia, including upper abdominal pain and bloating. As with the previous study, analysis of the study conducted by Delgado-Aros and coworkers did not employ validated definitions of FGIDs and instead relied upon self-reported bowel symptoms. Nevertheless, self-reported symptoms are still clinically relevant, making these data important even if they do not reflect traditionally acknowledged symptom complexes such as Rome-positive IBS or dyspepsia.

Talley and colleagues performed two additional population-based studies investigating the connection between BMI and bowel symptoms.[8,9] The first study administered a validated bowel symptom questionnaire to a random sample of community-based subjects in Australia.[8] Similar to the Olmsted County survey, this study revealed a positive correlation between increased BMI and diarrhea, but it failed to show a relationship between BMI and bloating, lower abdominal pain, or constipation. The second study conducted by Talley and associates was a survey of a birth cohort of 26-year-old New Zealanders.[9] Using an abbreviated version of the bowel symptom questionnaire, the investigators found a significant relationship between obesity and a range of bowel symptoms, including abdominal pain, nausea, and diarrhea. However, this study also categorized patients with IBS (using Manning criteria) and found no association between obesity and IBS. The study is limited, however, because all the subjects were only 26 years of age.

Adding further debate to the association between obesity and FGIDs is a novel study conducted by Svedberg and coworkers, who performed two separate case-control studies to investigate the relationship between obesity and

IBS.[10] The authors compared the prevalence of obesity in a group of patients with IBS versus a control group of unrelated non-IBS subjects. Obese patients were 2.6 times more likely to have IBS compared to nonobese subjects (odds ratio, 2.6; 95% confidence interval, 1.0– 6.4). The authors then went a step further by performing a case-control study among monozygotic twins discordant for IBS (ie, sets of twins in whom one twin had IBS, but the other did not). This analysis attempted to control for genetic factors. In contrast to their nontwin case-control study, the authors found no significant relationship between obesity and IBS in the discordant twin analysis. However, it is possible that the lack of association is merely a reflection of inadequate variation in BMI within sets of twins, as twins tend to have similar physical characteristics (eg, BMI) because of high correlations within each set. Thus, the lack of a relationship between obesity and IBS within the discordant sets of twins may merely be an anomaly of inadequate intratwin variations in BMI.

In another Swedish study, Aro and colleagues measured the relationship between chronic GI complaints, including IBS, and obesity among patients undergoing endoscopy.[11] Unlike the study conducted by van Oijen and associates, these patients were randomly selected from the general Swedish population and were asked to undergo endoscopy as part of the study protocol. The patients did not otherwise have specific indications for endoscopy. Therefore, the cohort was more representative of the general population compared to the group in the previously described study by van Oijen and coworkers. Although the study was primarily designed to measure the relationship between obesity and GERD, as measured by symptoms and endoscopic findings of erosive esophagitis, the investigators also reported data on epigastric pain, diarrhea, and IBS. After adjusting for demographic characteristics and excluding subjects found to have esophagitis or peptic ulcer disease on endoscopy, the authors found that only diarrhea remained significantly associated with obesity. This study is notable for its population-based approach and exclusion of patients with objective evidence of organic foregut disease.

Table 1 summarizes the studies examining the link between obesity, FGIDs, and related GI symptoms. The most consistent relationship is between obesity and diarrhea. In contrast, none of the studies found a statistically significant relationship between obesity and constipation. This finding may appear to be surprising, as constipation has been historically linked with sedentary lifestyles. However, constipation is certainly a multifactorial disease, and lifestyle modifications likely have only a minor impact on its symptoms. In addition, with the exception of one study,[9] there is very little evidence linking obesity to lower abdominal pain and inconsistent evidence that obesity is related to IBS. The relationship between obesity and foregut symptoms such as epigastric pain, bloating, and nausea appears to be slightly more robust, yet it is still inconsistent. Overall, the weight of the evidence indicates that obesity may be a strong and consistent predictor of diarrhea, as well as an inconsistent predictor of other GI complaints, particularly of the foregut. Importantly, the link between obesity and foregut symptoms diminishes after adjusting for patients with endoscopically evident disease, suggesting that much of the relationship is driven by acid peptic disorders, rather than true FGIDs.

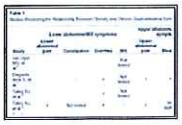


Table 1
Studies Measuring the Relationship Between Obesity and Chronic Gastrointestinal Symptoms

Obesity as the Cause of Functional Gastrointestinal Disorders and Chronic Gastrointestinal Symptoms

Go to:

The relationship between obesity, FGIDs, and related GI symptoms is sufficiently strong to at least raise the possibility that they are mechanistically linked. Therefore, it should be examined how obesity could lead to chronic GI symptoms or vice versa.

Epidemiologic data most strongly link obesity with diarrhea, and there are several potential explanations for this relationship. Aro and coworkers hypothesize that obese patients are more likely to ingest excess amounts of poorly absorbed sugars, which in turn can promote osmotic diarrhea.[11] In particular, fructose corn syrup is now

highly prevalent in Western diets, particularly in the United States, and obese patients are likely to consume more fructose than nonobese controls. This finding alone might explain part of the relationship between obesity and diarrhea. The existing epidemiologic studies have not controlled specific dietary variables such as ingestion of poorly absorbed sugars, making it impossible to judge whether the observed relationships may be muted, or altogether disappear, if the analyses were repeated after adjusting for fructose consumption.

Although never formally studied, it is also possible that the use of proton pump inhibitors (PPIs) might confound the relationship between obesity and FGID symptoms, as follows: obese patients are more likely than control patients to have GERD; GERD patients are much more likely to receive PPI therapy than patients without GERD; and PPI therapy may promote varying forms of bacterial overgrowth by eliminating gastric acid, which in turn can promote abdominal pain, bloating, diarrhea, constipation, and dyspepsia-related symptoms. In fact, between 5–10% of PPI users have one or more GI symptoms as a result of their therapy. Although this theory invokes several steps, each step is tenable, as it is now well established that obesity is a risk factor for GERD. In addition, there is no question that GERD leads to PPI use in many patients. Furthermore, it has long been established that PPI therapy can alter gastric, duodenal, and intestinal bacterial profiles. For example, Thorens and colleagues randomized 47 patients with peptic ulcer to receive 4 weeks of cimetidine versus omeprazole and then obtained cultured duodenal juice during follow-up endoscopy.[13] The authors found a higher incidence of bacterial overgrowth in the omeprazole arm (53% vs 17%). This finding was duplicated by Fried and coworkers, who further demonstrated that PPI-related bacterial overgrowth was due to both oral and colonic-type bacteria, not merely oral flora alone.[14] Theisen and colleagues found that suppression of gastric acid with omeprazole led to a high prevalence of bacterial overgrowth that in turn led to a markedly increased concentration of unconjugated bile acids.[15] Moreover, Lewis and associates documented that omeprazole-related bacterial overgrowth was associated with shorter intestinal transit times.[16] These studies suggest that PPI-related bacterial overgrowth could potentially lead to IBS symptoms such as diarrhea as a result of an increased osmotic load from bile acids coupled with more rapid intestinal transit. Of note, the studies linking obesity to diarrhea have not been adjusted for and have not reported PPI exposure in the cases versus the controls. Future studies should account for this variable, given its high prevalence in obese patients and its association with FGID-type symptoms. Even if the PPI effect is relatively rare in terms of causing clinically important symptoms, it would only take a minor imbalance between cases and controls to yield statistically significant results when amplified by a large sample size.

There have been several other proposed mechanisms explaining the imbalances in other GI symptoms beyond diarrhea. In particular, binge eating is common in obese patients and may contribute to increased GI symptoms, as these patients often eat to the point of abdominal discomfort. Crowell and colleagues surveyed both obese and normal-weight women on their eating behaviors and frequency of GI symptoms and found a positive association between BMI and the size of binge meals in obese patients with binge-eating disorder.[17] Obese patients were also found to have a larger percentage of calorie intake from fat than normal-weight controls, which may lead to delayed gastric emptying, which in turn may cause abdominal bloating, nausea, and vomiting. The authors also found a significant association among binge eating, obesity, and IBS symptoms.

Numerous studies have documented altered gastric physiology in the obese, including variations in gastric capacity and the gastric emptying rate. These variations are relevant because they may contribute to the increase in foregut symptoms reported in obese subjects. Nevertheless, the results are inconsistent between studies, possibly due to the varied tools used to measure these parameters (eg, gastric balloon, ultrasound, computed tomography).[18] Gastric balloon studies have found significantly larger gastric volumes in obese subjects than nonobese subjects, whereas studies employing imaging modalities to estimate gastric capacity did not find a significant difference.[19–23] Gastric emptying has also been studied using various techniques, with scintigraphy considered to be the gold standard. This line of inquiry is based upon the hypothesis that delayed gastric emptying might precipitate foregut symptoms. Thus, studies have sought to compare gastric transit in obese versus nonobese subjects. Interestingly, several studies have shown increased gastric emptying of solids in obese patients compared to nonobese subjects.[24,25] Other studies have shown no significant change in gastric emptying in

subjects of varying BMI.[26–28] This contrasts with a small study published by Jackson and coworkers in which 19 obese women were found to have significantly delayed gastric emptying when compared to 19 lean women.[29] Increased gastric emptying may decrease satiety, leading to more frequent meals, which may lead to or perpetuate weight gain. However, this is unlikely to contribute to functional GI symptoms. In short, gastric physiology studies may generate more questions than answers regarding the relationship between obesity and foregut symptoms.

Alterations in GI neuropeptide function in obesity have also been an area of great interest that may have implications in FGIDs. GI neuropeptides such as cholecystokinin, leptin, peptide YY, and glucagons-like peptides 1 and 2 are intricately involved in the regulation of satiety, eating behaviors, and GI motility.[30] It has been hypothesized that even a minor alteration in the highly regulated interplay between neural, hormonal, and muscular function of the GI tract could contribute to the development of obesity by altering motility and eating behaviors. Ghrelin, a novel endogenous natural ligand for the growth hormone secretagogue receptor that is mainly released from gastric fundic mucosa, has been shown to induce adiposity and weight gain.[31] Ghrelin is structurally categorized as a motilin-like peptide that potentiates phase III-like gastric contractions, increases gastric acid secretions, and increases gastric emptying. Serum concentrations of ghrelin have been found to increase during fasting and immediately prior to meal initiation and, conversely, fall postprandially.[31] Based upon this evidence, it is thought that ghrelin plays a role in hunger and satiety and, in the broader sense, regulation of energy homeostasis.

Normal-weight individuals have been shown to have higher ghrelin levels than their obese counterparts.[32] Cummings and associates and Hansen and coworkers have both shown that plasma ghrelin levels increase after diet-induced weight loss in obese individuals.[33,34] There have also been studies suggesting that weight loss improves symptoms of FGID, which will be presented below. Extrapolating from these data, perhaps weight loss may contribute to decreased FGID symptoms through an increase in plasma ghrelin levels, which improves gastric motility and emptying and decreases caloric intake in obese individuals for improved energy homeostasis. There have not been any studies published to date directly investigating this hypothesis. Although two studies from Japan have found fasting ghrelin levels to be higher in women with functional dyspepsia, neither the cases nor the controls were obese.[35,36] Further studies are needed to clarify the neurohormonal connection between obesity and FGID.

The Effect of Weight Loss on Functional Gastrointestinal Disorders and Related Symptoms

Go to:

The epidemiologic evidence linking obesity with FGIDs and GI symptoms is inconsistent, and there are numerous supporting hypotheses. However, any doubt regarding this relationship could be settled through proof-of-principle studies demonstrating that weight loss can abate or reverse the FGID-related symptoms; after all, if the relationship between obesity and GI symptoms were a causal link and not merely an association, one would expect weight change to be positively associated with GI symptom reporting.

Unfortunately, the available data for tracking changes in weight to changes in symptom reporting are relatively sparse and inconsistent. Research efforts thus far have mainly concentrated on weight changes and their effects on GERD symptoms, with several studies demonstrating that a decrease in BMI does improve GERD, albeit with somewhat inconsistent results between studies.[37–40] However, it is unclear if this is also true for FGID symptoms. Cremonini and colleagues used survey data from a large prospective natural history study of upper and lower GI symptoms in a population-based sample from Olmsted County, Minnesota.[41] The investigators measured the longitudinal relationship between body weight changes and upper GI symptoms. A random sampling of local residents was mailed either the GERD symptoms questionnaire or the bowel disease questionnaire and was followed-up with the same questionnaire roughly one decade after completion of the initial survey (median follow-up, 10.5 years). The authors focused on dyspepsia syndromes, including pain-predominant and dysmotility-predominant dyspepsia. The study revealed that weight gain over the study period, as defined by a

10-pound increase over time, was modestly associated with developing dysmotility-predominant dyspepsia (eg, bloating, early satiety). In contrast, weight loss did not correlate with a loss of baseline dyspepsia symptoms. However, the study is limited by the unknown temporal relationship between weight loss and the reported changes in symptoms, as the changes may have dissipated over time due to other psychosocial factors not surveyed in this study. Nevertheless, the study is notable for providing longitudinal data and a glimpse into causation, not merely cross-sectional association.

Additional data are provided by studies measuring the impact of bariatric surgery for treatment of morbid obesity. Two small studies have shown improvement in GI symptoms in patients following laparoscopic bariatric surgery.[42,43] Poves and colleagues surveyed 100 morbidly obese individuals (mean BMI, 47 kg/m^2) who were surgical candidates for laparoscopic Roux-en-Y gastric bypass, as well as 100 nonobese control patients using the Gastrointestinal Quality-of-Life Index (GIQLI).[42] These results were compared to GIQLI data from 100 participants who had undergone gastric bypass a mean of 17.2 months prior, with a mean preoperative BMI of 47.2 kg/m^2 and a mean postoperative BMI of 30.2 kg/m^2. Although the control and gastric bypass groups had comparable GIQLI scores with no statistically significant difference, the scores of morbidly obese patients were significantly lower. Unfortunately, there was no breakdown of data by specific digestive symptoms. A smaller study by Foster and associates addressed this issue by surveying 43 morbidly obese patients preoperatively and then 6 months after gastric bypass.[43] The authors measured the relationship between BMI changes and individual FGID-related symptoms, including abdominal distension, urgency, constipation, and diarrhea. Forty-three subjects completed the questionnaire preoperatively. Compared to normal-weight controls, obese subjects were more likely to report abdominal pain and IBS symptoms. When the same questionnaire was re-administered 6 months postoperatively, with a response rate of 81%, the preoperative BMI of 47.8 kg/m^2 decreased to a postoperative BMI of 31.6 kg/m^2. A significant improvement was noted in abdominal distention, urgency, diarrhea, and constipation. The authors postulated that altered eating habits resulting from the surgery may have improved the symptoms. They further surmised that improvements in psychological factors, including enhanced body image, may have been partially responsible for the decrease in GI symptoms. Whether the decrease is due to these changes or neurohormonal alterations from the surgical procedure is debatable.

Implications for Current Practice

Go to:

Although obesity is clearly linked to GERD, its relationship with FGIDs and related GI symptoms remains tenuous. Obesity has an epidemiologic association with diarrhea, in particular, but it has inconsistent associations with other foregut symptoms (eg, nausea, bloating, upper abdominal pain) and hindgut symptoms (eg, constipation, lower abdominal pain). Moreover, it remains unclear whether these associations, however tenuous, imply causations. The available data indicate that weight loss may modestly improve both upper and lower abdominal GI symptoms, thus suggesting a potential causal link.

Obesity is a major risk factor for a range of serious medical conditions, including cardiovascular disease, pancreatitis, and liver disease, among many other conditions. All medical practitioners, including gastroenterologists, must remain aggressive about addressing and treating obesity in their patients. Although it may be premature to claim that weight loss can alleviate the symptoms of FGIDs, it is unlikely that weight loss will exacerbate these symptoms. Given the strength of the available evidence, it seems reasonable to tell patients that weight loss may modestly improve GERD and other symptoms, particularly diarrhea, and that this benefit is one of many that weight loss can provide. Although the pathophysiology linking obesity to FGID-related symptoms is evolving, patients may benefit from a high-level understanding that weight loss may improve a range of abnormal eating behaviors, positively improve GI hormone levels, and potentially help regulate GI motility. Finally, physicians should always remain wary of PPI use that is not otherwise indicated and should discontinue PPIs in patients with chronic GI complaints who may not otherwise benefit from the antisecretory properties of these medicines.

The opinions and assertions contained herein are the sole views of the authors and are not to be construed as

official or as reflecting the views of the Department of Veterans Affairs.

References

Go to:

1. Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. JAMA. 2006;295:1549–1555. [PubMed]

2. Saito YA, Talley NJ, Melton L, Fett S, Zinmeister AR, Locke GR. The effect of new diagnostic criteria for irritable bowel syndrome on community prevalence estimates. Neurogastroenterol Motil. 2003;15:687–694. [PubMed]

3. Andrews EB, Eaton SC, Hollis KA, Hopkins JS, Ameen V, et al. Prevalence and demographics of irritable bowel syndrome: results from a large web-based survey. Aliment Pharmacol Ther. 2005;22:935–942. [PubMed]

4. Hungin AP, Chang L, Locke GR, Dennis EH, Barghout V. Irritable bowel syndrome in the United States: prevalence, symptom patterns and impact. Aliment Pharmacol Ther. 2005;21:1365–1375. [PubMed]

5. Minocha A, Johnson WD, Abell TL, Wiginton WC. Prevalence, sociodemography, and quality of life of older versus younger patients with irritable bowel syndrome: a population-based study. Dig Dis Sci. 2006;51:446–453. [PubMed]

6. van Oijen MG, Josemanders DF, Laheij RJ, van Rossum LG, Tan AC, Jansen JB. Gastrointestinal disorders and symptoms: does body mass index matter? Neth J Med. 2006;64:45–49. [PubMed]

7. Delgado-Aros S, Locke GR, 3rd, Camilleri M, Talley NJ, Fett S, et al. Obesity is associated with increased risk of gastrointestinal symptoms: a population-based study. Am J Gastroenterool. 2004;99:1801–1806. [PubMed]

8. Talley NJ, Quan C, Jones MP, Horowitz M. Association of upper and lower gastrointestinal tract symptoms with body mass index in an Australian cohort. Neurogastroenterol Motil. 2004;4:413–419. [PubMed]

9. Talley NJ, Howell S, Poulton R. Obesity and chronic gastrointestinal tract symptoms in young adults: a birth cohort study. Am J Gastroenterol. 2004;99:1807–1814. [PubMed]

10. Svedberg P, Johansson S, Wallander MA, Hamelin B, Pedersen NL. Extraintestinal manifestations associated with irritable bowel syndrome: a twin study. Aliment Pharmacol Ther. 2002;16:975–983. [PubMed]

11. Aro P, Ronkainen J, Talley NJ, Storskrubb T, Bolling-Sternevald E, Agréus L. Body mass index and chronic unexplained gastrointestinal symptoms: an adult endoscopic population based study. Gut. 2005;54:1377–1383. [PMC free article] [PubMed]

12. Nocon M, Labenz J, Jaspersen D, Meyer-Sabellek W, Stolte M, et al. Association of body mass index with heartburn, regurgitation and esophagitis: results of the Progression of Gastroesophageal Reflux Disease study. J Gastroenterol Hepatol. 2007;11:1728–1731. [PubMed]

13. Thorens J, Froehlich F, Schwizer W, Saraga E, Bille J, et al. Bacterial overgrowth during treatment with omeprazole compared with cimetidine: a prospective randomised double blind study. Gut. 1996;39:54–59. [PMC free article] [PubMed]

14. Fried M, Siegrist H, Frei R, Froehlich F, Duroux P, et al. Duodenal bacterial overgrowth during treatment in outpatients with omeprazole. Gut. 1994;35:23–26. [PMC free article] [PubMed]

15. Theisen J, Nehra D, Citron D, Johansson J, Hagen JA, et al. Suppression of gastric acid secretion in patients with GERD results in gastric bacterial overgrowth and deconjugation of bile acids. J Gastrointest Surg. 2000;4:50–54. [PubMed]

16. Lewis SJ, Franco S, Young G, O'Keefe SJ. Altered bowel function and duodenal bacterial overgrowth in patients treated with omeprazole. Aliment Pharmacol Ther. 1996;10:557–561. [PubMed]

17. Crowell MD, Cheskin LJ, Musial F. Prevalence of gastrointestinal symptoms in obese and normal weight binge eaters. Am J Gastroenterol. 1994;89:387–391. [PubMed]

18. Geliebter A, Schachter S, Lohmann-Walter C, Feldman H, Hashim SA. Reduced stomach capacity in obese subjects after dieting. Am J Clin Nutr. 1996;63:170–173. [PubMed]

19. Geliebter A, Hashim SA. Gastric capacity in normal, obese, and bulimic women. Physiol Behav. 2001;74:743–746. [PubMed]

20. Granstrom L, Backman L. Stomach distension in extremely obese and normal subjects. Acta ChirScand. 1985;151:367–370. [PubMed]

21. Chiloiro M, Caroli M, Guerra V, Lodadea Piepoli A, Riezzo G. Gastric emptying in normal weight and obese children: an ultrasound study. Int J Obes Relat Metab Disord. 1999;23:1303–1306. [PubMed]

22. Kim DY, Camilleri M, Murray JA, Stephens DA, Levine JA, Burton DD. Is there a role for gastric accommodation and satiety in asymptomatic obese people? Obes Res. 2001;9:655–661. [PubMed]

23. Tosetti C, Corinaldesi R, Stanghellini V, Pasquali R, Corbelli C, et al. Gastric emptying of solids in morbid obesity. Int J Obes Relat Metab Disord. 1996;20:200–205. [PubMed]

24. Wright RA, Krinsky S, Fleeman C, Trujillo J, Teague E. Gastric emptying and obesity. Gastroenterology. 1983;84:747–751. [PubMed]

25. Cardoso-Junior A, Coelho LG, Savassi-Rocha PR, Vignolo MC, Abrantes MM, et al. Gastric emptying of solids and semi-solids in morbidly obese and non-obese subjects: an assessment using the 13C-octanoic acid and 13C-acetic acid breath tests. Obes Surg. 2007;17:236–241. [PubMed]

26. Verdich C, Madsen JL, Toubro S, Buemann B, Holst JJ, Astrup A. Effect of obesity and major weight reduction on gastric emptying. Int J Obes Relat Metab Disord. 2000;24:899–905. [PubMed]

27. Hellmig S, Von Schoning F, Gadow C, Katsoulis S, Hedderich J, et al. Gastric emptying time of fluids and solids in healthy subjects determined by 13C breath tests: influence of age, sex and body mass index. J Gastroenterol Hepatol. 2006;21:1832–1838. [PubMed]

28. Hutson WR, Wald A. Obesity and weight reduction do not influence gastric emptying and antral motility. Am J Gastroenterol. 1993;9:1405–1409. [PubMed]

29. Jackson SJ, Leahy FE, McGowan AA, Bluck LJ, Coward WA, Jebb SA. Delayed gastric emptying in the obese: an assessment using the non-invasive 13C acid breath test. Diabetes Obes Metab. 2004;6:264–270. [PubMed]

30. Crowell MD, Decker GA, Levy R, Jeffrey R, Talley NJ. Gut-brain neuropeptides in the regulation of ingestive behaviors and obesity. Am J Gastroenterol. 2006;101:2848–2856. [PubMed]

31. Horvath TL, Diano S, Sotonyi P, Heiman M, Tschop M. Minireview: ghrelin and the regulation of energy balance—a hypothalamic perspective. Endocrinology. 2001;142:4163–4169. [PubMed]

32. Tschop M, Weyer C, Tataranni PA, Devanarayan V, Ravussin E, Heiman ML. Circulating ghrelin levels are decreased in human obesity. Diabetes. 2001;50:707–709. [PubMed]

33. Cummings DE, Weigle DS, Frayo RS, Breen PA, Ma MK, et al. Plasma ghrelin levels after diet-induced weight loss or gastric bypass surgery. N Engl J Med. 2002;346:1623–1630. [PubMed]

34. Hansen TK, Dall R, Hosoda H. Weight loss increases circulating levels of ghrelin in human obesity. Clin Endocrinol. 2002;56:203–206. [PubMed]

35. Nishizawa T, Suzuki H, Nomoto Y, Masaoka T, Hosoda H, et al. Enhanced plasma ghrelin levels in patients

with functional dyspepsia. Aliment Pharmacol Ther Sym Ser. 2006;2:104–110.

36. Shinomiya T, Fukunaga M, Akamizu T, Irako T, Yokode M, et al. Plasma acylated ghrelin levels correlate with subjective symptoms of functional dyspepsia in female patients. Scand J Gastroenterol. 2005;40:648–653. [PubMed]

37. Rey E, Moreno-Elola-Olaso C, Artalejo FR, Locke GR, III, Diaz-Rubio M. Association between weight gain and symptoms of gastroesophageal reflux in the general population. Am J Gastroenterol. 2006;101:229–233. [PubMed]

38. Fraer-Moodie CA, Norton B, Gornall C, Magnago S, Weale AR, Holmes GK. Weight loss has an independent beneficial effect on symptoms of gastrooesophageal reflux in patients who are overweight. Scand J Gastroenterol. 1999;34:337–340. [PubMed]

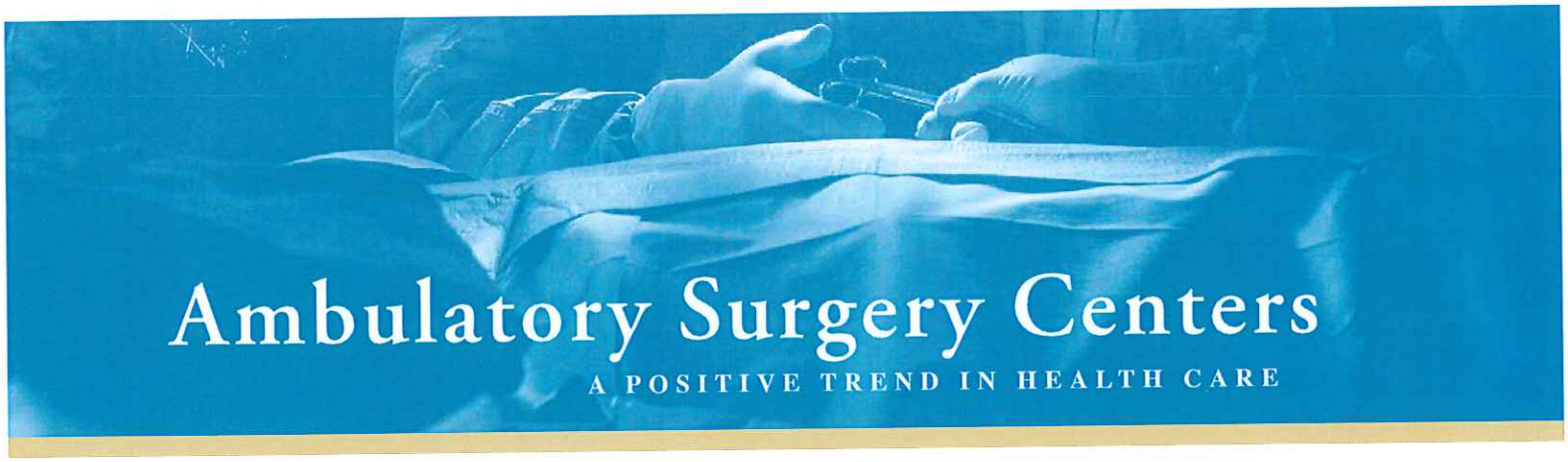
39. Jacobson BC, Sommers SC, Fuchs CS, Kelly CP, Camargo CA., Jr. Body-mass index and symptoms of gastroesophageal reflux in women. N Engl J Med. 2006;355:2340–2348. [PMC free article] [PubMed]

40. Kjellin A, Ramel S, Rossner S, Thor K. Gastroesophageal reflux in obese patients is not reduced by weight reduction. Scand J Gastroenterol. 1996;31:1047–1051. [PubMed]

41. Cremonini F, Locke GR, III, Schleck CD, Zinsmeister AR, Talley NJ. Relationship between upper gastrointestinal symptoms and changes in body weight in a population-based cohort. NeurogastroenterolMootil. 2006;18:987–994. [PubMed]

42. Poves I, Cabrera M, Maristany C, Coma A. Ballesta-López C. Gastrointestinal quality of life after laparoscopic Roux-en-Y gastric bypass. Obes Surg. 2006;16:19–23. [PubMed]

43. Foster A, Laws HL, Gonzalez QH, Clements RH. Gastrointestinal symptomatic outcome after laparoscopic Roux-en-Y gastric bypass. J Gastrointest Surg. 2003;7:750–753. [PubMed]



Ambulatory Surgery Centers

A POSITIVE TREND IN HEALTH CARE

Ambulatory surgery centers (ASCs) are health care facilities which offer patients the opportunity to have selected surgical and procedural services performed outside the hospital setting. Since their inception more than three decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A PROGRESSIVE MODEL FOR SURGICAL SERVICES

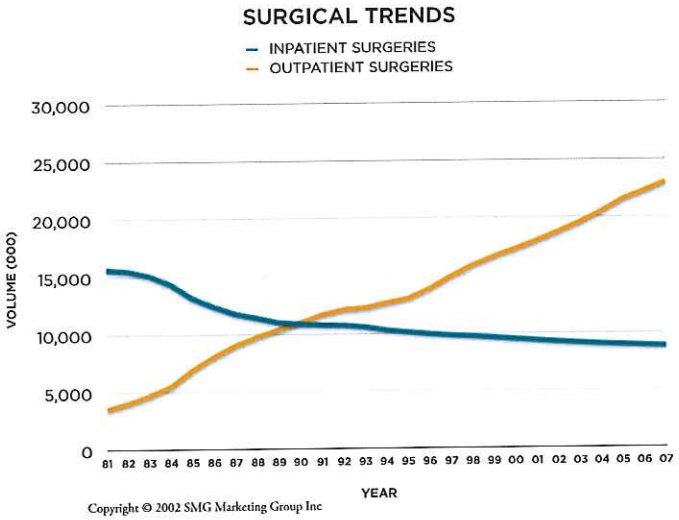
As our nation struggles with how to improve a troubled health care system, the experience of ASCs is a rare example of a successful transformation in health care delivery.

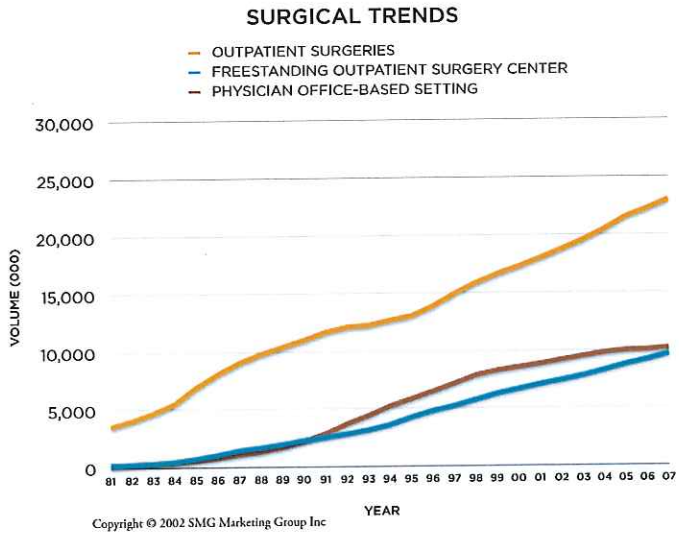
Thirty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still like this today, but not in the United States.

Physicians have led the development of ASCs. The first facility was opened in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way - and developed it in ASCs.

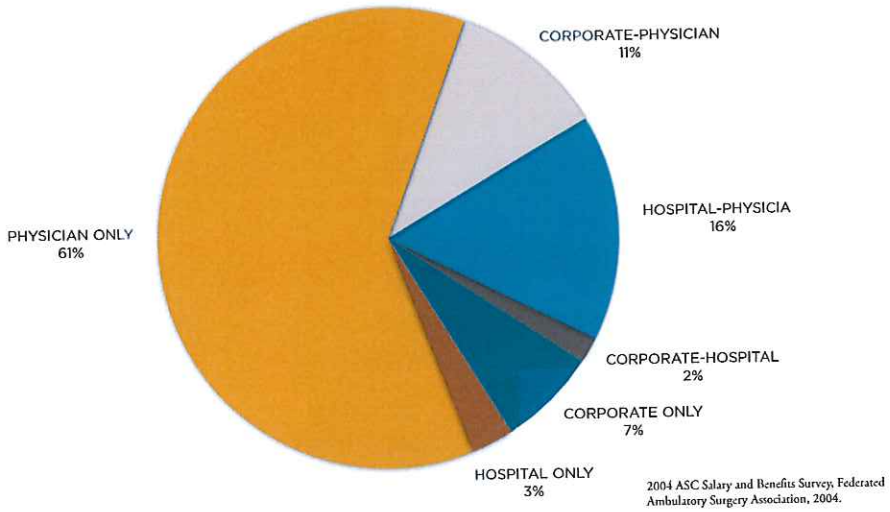
Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices.[1] In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially-trained and highly skilled staff, ensure the equipment and supplies being used are best suited to their technique, and design facilities tailored to their specialties. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Given the history of their involvement with making ASCs a reality, it is not surprising physicians continue to have ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs; 3% are owned entirely by hospitals.[2]





ASC OWNERSHIP STRUCTURE



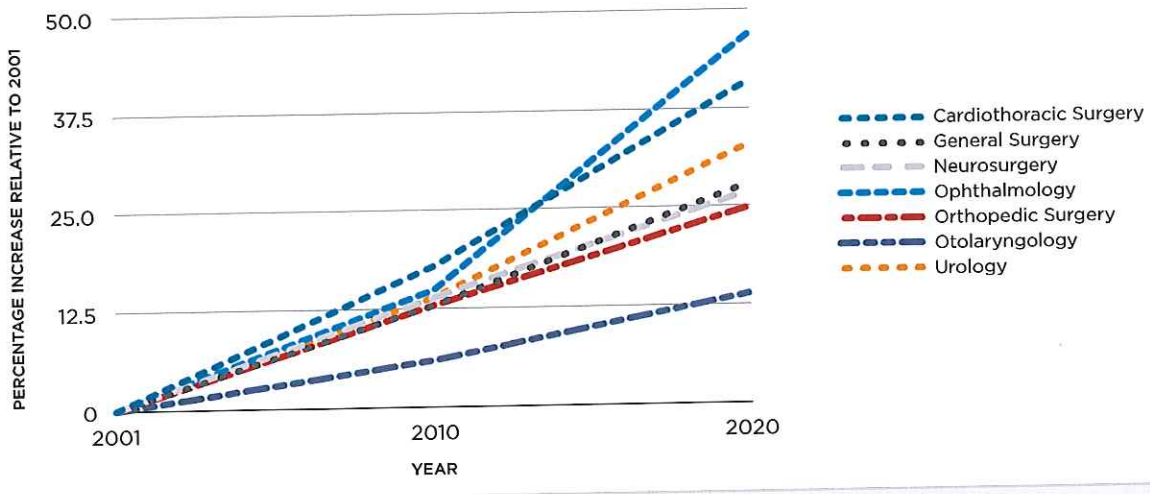
2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

ASCs ALLOW PHYSICIANS TO WORK EFFICIENTLY

A recent analysis examined the impact of the aging population on the demand for surgical procedures and attendant need for surgical subspecialists. This study concluded that the aging population would be a major force in driving significant growth in the demand for surgical services. The forecasted growth in work by the year 2020 varied from 14 percent to 47 percent, depending on specialty.[3] Meeting these surgical needs will be a challenge. Solutions include increasing the number of surgical residency positions, increasing the workloads of surgeons in the workforce, and improving the efficiency of surgeons.

Utilizing settings that allow physicians to practice efficiently will help mitigate the impact of the aging population on the anticipated shortage in the surgery workforce. ASCs offer physicians the ability to work more efficiently and are therefore uniquely positioned to play an important role in managing the increased need for surgical services as it arises in the years ahead.

FORECASTED DEMAND GROWTH IN THE NUMBER OF PROCEDURES BY SPECIALTY



Etzioni DA, Liu JH, Maggard MA, Ko CY. The aging population and its impact on the surgery workforce. Ann Surg. 2003 Aug;238(2):170-7.

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

Health care facilities in the United States are highly regulated by federal and state entities. ASCs are not excluded from this oversight.

The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Most states require ASCs to be licensed in order to operate. Each state determines the specific requirements ASCs must meet for licensure. Most state licensure programs require rigorous initial and ongoing inspection and reporting.

All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC. The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

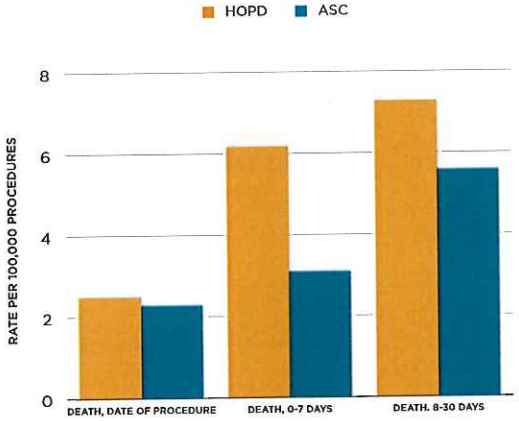
In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs.[5] Generally, services are limited to elective procedures with short anesthesia and operating times not requiring an overnight stay. These limitations do not apply to hospital outpatient departments (HOPDs).[6]

The federal government views ASCs and HOPDs as distinct types of providers. As a result, the federal regulations governing HOPDs and ASCs differ. Another reason for differing regulations is that, in a hospital, the same operating room may be used interchangeably to provide services to both inpatients and outpatients. For example, a procedure room in the HOPD may be used to perform a service for an inpatient and then used to perform the same procedure for an ambulatory patient who is discharged home immediately thereafter. In other words, ambulatory patients seen on an outpatient basis in an HOPD may utilize exactly the same facilities used to provide services to patients who have been admitted to the hospital. Consequently, the inpatient standards for hospitals are applied to HOPDs.[7]

On the other hand, ASCs provide services in facilities specifically designed to perform selected outpatient surgical services. The different requirements developed by the federal government appropriately reflect the fundamental differences in the hospital setting versus the ASC.[8]

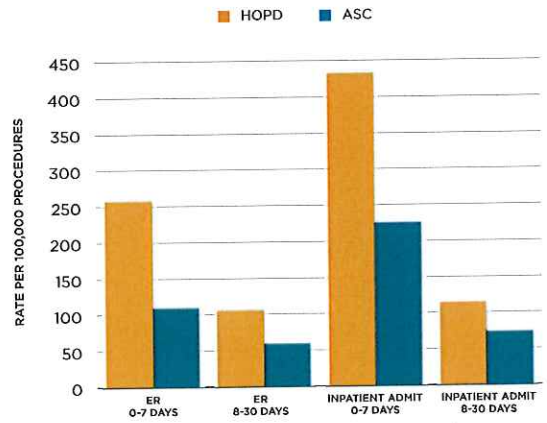
ASCs consistently perform as well as, if not better than, HOPDs when quality and safety is examined. A recent study[9] included an examination of the rates of inpatient hospital admission and death in elderly patients following common outpatient surgical procedures in HOPDs and ASCs. Rates of inpatient hospital admission and death were lower in freestanding ASCs as compared to HOPDs. Even after controlling for factors associated with higher-risk patients, ASCs had low adverse outcome rates.

RATE OF ADVERSE EVENTS: DEATH



Fleisher LA, Pasternak LR, Herbert R, Anderson GF. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. Arch Surg. 2004 Jan;139(1):67-72.

RATE OF ADVERSE EVENTS: ER VISIT OR INPATIENT ADMISSION



Fleisher LA, Pasternak LR, Herbert R, Anderson GF. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. Arch Surg. 2004 Jan;139(1):67-72.

SPECIFIC FEDERAL REQUIREMENTS GOVERNING ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government designed to ensure the facility is operated in a manner that ensures the safety of patients and the quality of services. Some of these requirements are highlighted in more detail below.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to ensure patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control, and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control. In fact, ASCs have historically had very low infection rates.[10]

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event an emergency occurs. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.[9,11]

Continuous quality improvement is an important means of assuring patients are receiving the best care possible. ASCs are required to implement and monitor policies that ensure the facility provides quality health care in a safe environment. An ASC, with the active participation of the medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Requirements for ASCs and Hospitals Are The Same Where Services are Comparable

Required Standards	ASC	Hospital
Compliance with state licensure law	r	r
Governing body	r	r
Surgical services	r	r
Evaluation of quality	r	r
Environment	r	r
Medical staff	r	r
Nursing services	r	r
Medical records	r	r
Pharmaceutical services	r	r
Laboratory services	r	r
Radiologic services	r	r

Source: 42 CFR 416, 42 CFR 482

THE ASC INDUSTRY IS COMMITTED TO REPORTING QUALITY MEASURES

A fundamental change in the way the government assures the quality of health care services is well underway. The Department of Health and Human Services has launched its Quality Initiative to assure quality health care through accountability and public disclosure.

The ASC industry is excited to have the opportunity to make its excellent outcomes more widely known to the public through this initiative. Leaders from the ASC industry, along with associations and related organizations with a focus on health care quality and safety, have come together in a collaborative effort to identify specific measures for quality appropriate to ASCs. This group, the ASC Quality Collaboration, strongly endorses the vision that measures of quality which are appropriate to ASCs should be congruent with measures utilized for other outpatient surgery settings. The continued development of these measures will involve a number of different stakeholders including ASC clinical and administrative leaders, health policy researchers, CMS and other key federal and state governmental agencies. The group will also work with the National Quality Forum to achieve consensus on the proposed quality measures.

PATIENT SATISFACTION

Patient satisfaction is a hallmark of the ASC industry. This year, more than eight million Americans will undergo surgery in an ASC. Virtually all of those patients will return home the same day and will resume most normal activities within a matter of days. Talk to these patients and you will hear how overwhelmingly satisfied they are with their ASC experience. Recent surveys show average patient satisfaction levels in ASCs exceeding 90 percent.[4] Safe and high quality services, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs as a place for having surgery.

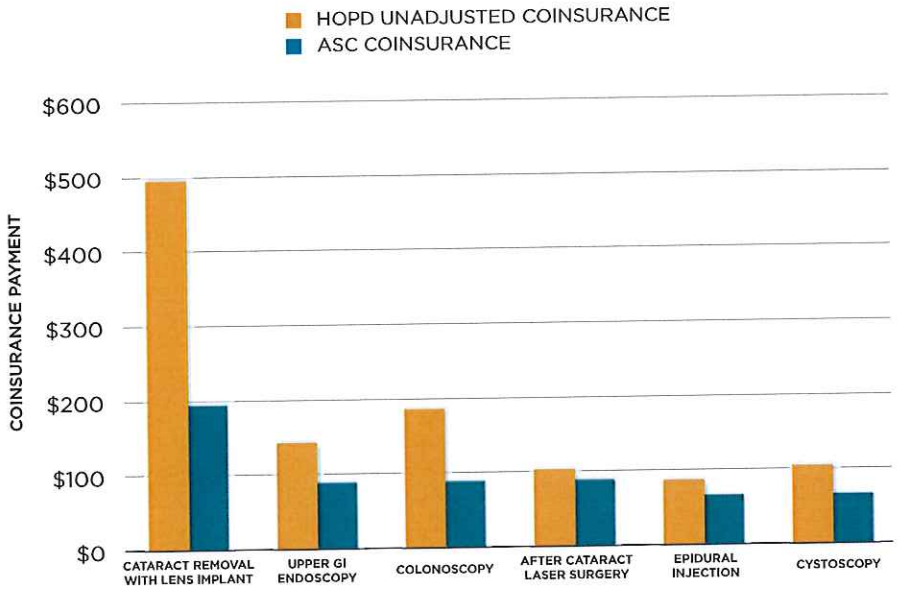
ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring patients have the best surgical experience possible, the care they provide is also more affordable. One of the reasons ASCs have been so successful is they offer valuable surgical and procedural services at a lower cost when compared to hospital charges for the same services. Beginning in 2007, Medicare payments to ASCs will be lower than or equal to Medicare payments to HOPDs for comparable services for 100 percent of procedures.[12]

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as $496 in coinsurance for a cataract extraction procedure performed in a HOPD, whereas that same beneficiary's copayment in the ASC would be only $195; a Medicare beneficiary could pay as much as $186 in coinsurance for a colonoscopy performed in a HOPD, whereas that same beneficiary's copayment for the same procedure performed in an ASC would be only $89. By having surgery in the ASC the patient may save as much as 61%, or more than $300, compared to their out-of-pocket coinsurance for the same procedure in the hospital.

Without the emergence of ASCs as an option for care, health care expenditures would have been billions of dollars higher over the past three decades. Studies have shown the Medicare program would pay approximately $464 million more per year if all procedures performed in an ASC were instead furnished at a hospital.[13] Private insurance companies tend to save similarly, which means employers also incur lower health care costs by utilizing ASC services. Employers and insurers, particularly managed care entities, are driving ASC growth in many areas, because they recognize ASCs are able to deliver consistent, high quality outcomes at a significant savings. As the number of surgical procedures performed in ASCs grows, the Medicare program may realize even greater savings - and of course Medicare beneficiaries will realize additional out-of-pocket savings as well.[13]

MEDICARE COINSURANCE RATES ARE LOWER IN ASCs



MedPAC, Report to the Congress: Medicare Payment Policy, March 2004.

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

It is the general practice of ASCs to make pricing information available to the patient in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

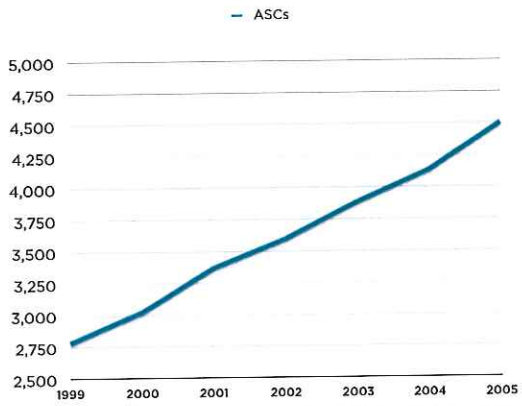
ASCs IMPROVE PATIENT CHOICE, DEMAND FOR ASCS GROWS

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis. Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

The number of ASCs continues to grow in response to demand from the key participants in surgical care – patients, physicians and insurers. This demand has been made possible by technology, but has been driven by high levels of patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all. The number of Medicare certified ASCs has grown from 2786 in 1999 to 4506 in 2005, with an average annual growth rate of 8.3%.[14]

Further impetus to future ASC growth has been given by MedPAC, which has recommended that the CMS list of approved ASC procedures be expanded. This would allow a broader range of choice for patients and surgeons. Specifically, MedPAC has recommended the procedures approved for the ASC setting be revised so that ASCs can receive payment for any surgical procedure, with the exception of those surgeries requiring an overnight stay or which pose a significant safety risk when furnished in an ASC.8 Adoption of these recommendations would allow Medicare beneficiaries to access an extended range of surgical services – a range of surgical services which is already available to patients with private insurance.[15]

NUMBER OF MEDICARE-CERTIFIED ASCs



MedPAC, Data Book, June 2006.

ASCs WILL CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As leaders of the revolution in surgical care who led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in stakeholder satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that promote the utilization of sites of service providing more affordable care while maintaining high quality and safety standards. In light of the many benefits ASCs have brought to the nation's health care system, it will be important for future payment and coverage policies to continue to strengthen access to and utilization of ASCs.

ENDNOTES

1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

3 Etzioni DA, Liu JH, Maggard MA, Ko CY. The aging population and its impact on the surgery workforce. Ann Surg. 2003 Aug;238(2):170-7.

4 Press Ganey Associates, 2004.

5 Centers for Medicare and Medicaid Services ASC Website, http://www.cms.hhs.gov/center/asc.asp

6 70 Fed. Reg. pp.68916-68964, November 10, 2005.

7 42 C.F.R. §482

8 42 C.F.R. §416

9 Fleisher LA, Pasternak LR, Herbert R, Anderson GF. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. Arch Surg. 2004 Jan;139(1):67-72.

10 FASA, FASA Outcomes Monitoring Project, 4th Quarter 2005

11 Natof HE. Complications associated with ambulatory surgery. JAMA. 1980 Sep 5;244(10):1116-8.

12 Deficit Reduction Act of 2005.

13 MedPAC, Report to the Congress: Medicare Payment Policy, March 2004.

14 MedPAC, Data Book, June 2006.

15 Thomson Medstat, MarketScan® Outpatient Claims Data, 2005.

This report was prepared by the ASC Coalition and is further supported by the following organizations:

Alabama Ambulatory Surgery Association
American Association of Ambulatory Surgery Centers
AmSurg
Arizona Ambulatory Surgery Center Association
Arkansas Ambulatory Surgery Association
California Ambulatory Surgery Association
Colorado Ambulatory Surgery Center Association
FASA
Florida Society of Ambulatory Surgical Centers
Foundation for Ambulatory Surgery in America
Freestanding Ambulatory Surgery Center Association of Tennessee
Georgia Society of Ambulatory Surgery Centers
Healthmark Industries Co
HealthSouth
Idaho Ambulatory Surgery Center Association
Illinois Freestanding Surgery Center Association
Indiana Federation of Ambulatory Surgical Centers
Kansas Association of Ambulatory Surgery Centers

Kentucky Ambulatory Surgery Center Association
Maine Ambulatory Surgery Center Coalition
Maryland Ambulatory Surgical Association
Mississippi Ambulatory Surgery Association
Missouri Ambulatory Surgery Center Association
National Surgical Care
Nevada Ambulatory Surgery Association
New Hampshire Ambulatory Surgical Association
NovaMed
Ohio Association of Ambulatory Surgery Centers
Pennsylvania Ambulatory Surgery Association
South Carolina Ambulatory Surgery Center Association
South Dakota Association of Specialty Care Providers
Symbion Healthcare
Texas Ambulatory Surgery Center Society
United Surgical Partners International
Utah Ambulatory Surgery Center Association
Washington Ambulatory Surgery Center Association

Provided to You Courtesy of

The American Society for Gastrointestinal Endoscopy
For information, call Randy Fenninger at 202.833.0007

Clin Colon Rectal Surg. 2005 Nov; 18(4): 261–266.
PMCID: PMC2780082
doi: 10.1055/s-2005-922849
Office Management

Guest Editors David E. Beck M.D. Dennis E. Choat M.D.

Endoscopic Ambulatory Surgery Centers

Kiran Kanji, M.D.[1]

[1]Gastroenterology, Digestive Healthcare of Georgia, Fayetteville, Georgia
Address for correspondence and reprint requests: Kiran Kanji M.D. Gastroenterology, Digestive Healthcare of Georgia, 1265 West Hwy. 54, Ste. 409, Fayetteville, GA 30214, Email: Mukiran01@yahoo.com

ABSTRACT

Go to:

Endoscopic ambulatory surgery centers are more efficient than hospital-based procedures, they are less costly to payers than hospital-based procedures, and they provide an additional source of revenue to healthcare providers. Physicians interested in establishing endoscopic ambulatory surgery centers must be aware of advantages and disadvantages of such units as well as optimal financing and equipment and personnel utilization.

Keywords: Endoscopy, ambulatory surgery center, endo-center, management, office

There are many reasons why endoscopic ambulatory surgery centers (EASCs) are thriving in the United States. We have an aging population and a shortage of physicians and healthcare costs are rising. As our population grows and grows older, there are increasing demands on physicians to become more efficient to keep up with the numbers. This is happening in a time when reimbursements are decreasing. Physicians are now at the point of having realized that they can increase efficiency only so far before they end up sacrificing good patient care and their own sense of well-being. EASCs fit well for everyone in this healthcare scenario. They are more efficient than hospital-based procedures, they are less costly to payers than hospital-based procedures, and they provide an additional source of revenue to healthcare providers.[1]

In comparison with hospital-based procedures, EASCs are advantageous to all parties involved. A low-risk patient is provided with a pleasant, convenient, and less intimidating atmosphere. The EASC is also more economical for the patient, which adds to his or her positive view of the experience. The insurance provider/payer is assured that the patient is receiving quality care in an accessible environment. In addition, the payer pays less for the EASC procedure than he or she would with a hospital-based procedure.

The physician also benefits from the EASC environment. When a group of physicians establishes an EASC, they are given control that they do not have in the hospital environment. This management aspect of the business allows the doctors to ensure that quality personnel are hired and trained to give both the patient and the physician the necessary services in a timely fashion. The physician is better able to control turn-around time and scheduling of procedures. Doctors are also able to incorporate their daily tasks, such as clinics and hospital rounds, with their time at the EASC because of their control over scheduling and the efficiency of the operation.

One major disadvantage of the EASC is the strain it often puts on the relationship between the physician and his/her affiliated hospital. A physician affiliated with an EASC who previously did all procedures in the hospital

may now find it more difficult to schedule hospital-based procedures. This is probably due to a combination of factors: lack of resources, other physicians now using the hospital's allotted procedure times, and the hospital staff feeling lack of loyalty from the EASC-affiliated physician. Another issue that affects the hospital-physician relationship is the loss of revenue the hospital experiences when lucrative services such as endoscopy are moved from the hospital setting to an EASC.

Establishing an EASC means physicians must delve into the business aspect of medicine. The process means getting state licensure, becoming certified by payer groups, and accreditation by JACHO. Once these are approved, the decision-making process begins.

Many factors are involved in deciding how to run an EASC:

1. What services will be provided? The physicians have to decide which patients will be eligible to have a colonoscopy or endoscopy in this setting according to their risk factors.
2. Which physicians will be allowed to work in the EASC? Are only partners of a group or physicians who have a financial stake in the EASC be offered use of the facility, or will there be open access? The number of physicians and the size of the unit will affect these decisions. Gastroenterologists usually attend clinic or perform endoscopy while colorectal surgeons divide their time between the operating room, clinic, and the endoscopy unit. A facility that is not maximally utilized will be less efficient.
3. Which equipment will be used? There are many options to choose from when deciding on the type of equipment that will make the most physicians comfortable with their procedures. Of course, cost and which company is willing to provide the best deal to the EASC play a role as well. Will the equipment be leased or bought?
4. How will the facility be designed? The way in which an EASC is physically set up can be a great factor in how efficiently it is able to run and how the patient feels about the environment.
5. What criteria will be used to hire personnel? Hiring personnel means putting together an efficient and competent group of staff members. Issues to be considered include requirements for nursing degrees (what combination of RNs and LPNs one desires), medical assistants, front office/medical records staff, and billing staff. Along with hiring staff come decisions on appropriate salary compensation and benefits. Personnel will be the EASC's largest overhead expense.
6. How will quality of care be attained? All prior decisions impact the quality of care one will provide at the EASC. The services provided, the equipment used, the facility design will all factor into the quality of care provided. Personnel is the most costly aspect of the EASC, but it is also the most important and the most influential on quality of care provided.[2]

EASC DEVELOPMENT

Go to:

Is It Necessary?

"If you build it, they will come." Does this adage really apply to EASCs? Every year there is an 8% increase in the number of EASCs. In 2003 there were 432. However, every year a small number of EASCs close or are bought up by hospitals or corporations. Limitations to success include the location of an EASC. Will the patient come to an area where real estate is more competitive, but is "on the other side of the track"? Is there a closer facility, specifically the hospital or another ambulatory surgery center (multiple versus single specialty)? Is transportation a limiting factor? All these questions should be considered from the patient's perspective.

Another barrier to setting up a viable EASC may be exclusive contracts that managed care companies have with hospitals. Most insurance companies will not contract with a facility until it is JACHO accredited.

In terms of viability, the revenue potential must be calculated. The number of cases multiplied by the base rate equals the potential gross revenue. An average of 1000 cases per physician per year at $450 base rate would generate a gross revenue of $900,000 for two physicians. One can expect the number of procedures to increase 5

to 10% per year and the revenue to grow 3.5% per year for all payers except Medicare. Medicare has frozen rates until 2009.[3]

The risk involved in setting up an EASC can limit physicians from undertaking this step. There are alternate setups, specifically corporate partners and hospital ventures. Is it worth it? It depends. Half of something is better than all of nothing. A corporate partner (hospital or third party) can help with planning and development, financing, negotiating contracts, staffing, marketing, and policy and procedures. In the end, physician-owners will have to share that revenue. Ultimately, it depends on the specific relationship between the physician and third party and if that relationship is necessary to get the ambulatory surgery center developed.[4]

Room Utilization

Before a decision is made to set up an EASC, it is crucial to determine the number of procedure rooms. That decision is based on the number of physicians participating in the EASC. If one calculates a capacity of 1000 procedures per room per year, it is possible to determine the number of endoscopy rooms that are necessary. The average EASC in the United States. has between two to three procedure rooms. By calculating the average time a patient spends in an EASC from admission to discharge, one can determine the efficiency of the setup and the number of preop and recovery beds that would be needed. In general, allocating 20 minutes for preop, 30 minutes per procedure (including turn-around time), and 40 minutes for recovery is adequate. With this allocation, one to two preop beds and two to three recovery beds per procedure room seem to be necessary for adequate flow of patients.[5] A sample flow pattern is described in Table 1.

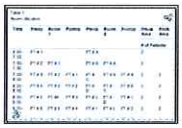


Table 1
Room Utilization

If the endoscopists' procedure time is equal to or less than the room turnover time (end of one procedure to start of next procedure), the best physician efficiency is obtained if each endoscopist has at least two procedure rooms assigned.[6] This allows the endoscopist to continue scoping in one room while "turnover" is occurring in the second room.

Physical Plant

Once you have determined that developing an EASC is a worthwhile undertaking and you are willing to invest the time and energy to set one up, you must determine the amount of space that will be necessary. Should you rent or build a free-standing EASC? The advantages to renting or leasing a space are decreased financial risk and location closer to a hospital. You can also offset tension with the hospital by leasing a space in the hospital office building. The advantages to building a free-standing EASC are freedom of design and little need for space or expansion reconstruction.

Marasco and Associates, Inc, a healthcare consulting firm, has developed a formula to help determine the square footage necessary for an EASC (Table 2).

Table 2
Endoscopic Ambulatory Surgery Center Space Requirements

Equipment

Deciding on the type of equipment and the number of endoscopes can be the most difficult part of the planning process. In general, five scopes (three lower and two upper) per room is a good rule. However, if you have an

excess of scopes, you are wasting money on leasing or buying expensive equipment. On the other hand, if there are not enough scopes, you may be waiting around to do procedures, resulting in reduced physician efficiency.

One must also consider what type of equipment is necessary for keeping the EASC running efficiently: what type of software will you use? Do you want to use electronic medical records (EMR) to keep records? The different vendors (such as Olympus, Pentex, and Fuji) each have their unique advantages and disadvantages. One must consider scopes, software, long-term service, and cost before making a decision.

According to Gastrointestinal Associates, P.C., one can estimate equipment costs at $500,000 for the first procedure room and $150,000 for each additional procedure room.[6] The types of equipment required for an EASC are listed in Table 3.

Table 3

Equipment Necessary for an Endoscopic Ambulatory Surgery Center

If capital is available and the equipment will be efficiently used, purchase of the equipment is the best financial option. If startup capital is limited, most of the major equipment companies have lease options available. With leasing, the unit is charged a fixed amount for each procedure performed. The amount of the charge is contractual, based on the cost of the equipment and its utilization (number of procedures performed per month or year). A typical lease agreement may charge $35 to $50 per colonoscopy.

Anesthesia and Sedation

Sedation for procedures can vary from moderate sedation (pain and sedative medication such as fentanyl, meperidine, and/or midazolam) administered by RNs to deep sedation (propofol) which is administered by certified RN anesthetists or anesthesiologists. Unless specific reimbursement is available to support the additional charge for anesthesia personnel, nurse-administered sedation is the most cost-effective and safe option. Physical control of the anesthesia medications must also be considered.

Staffing Cost

Once the physical plant and equipment are in place, the largest recurrent expense for the EASC will be staffing costs.[6] Again, a good balance must be achieved in which staff members are utilized to their maximum efficiency without being over- or underworked. Too few staff members or staff that is improperly matched to a job (e.g., an RN assigned to a tech job) can result in higher turnover and ultimately higher staffing costs. It is essential to establish a hardworking and motivated staff that is determined to make the EASC a success. Profit-sharing plans and/or financial bonus structures can give staff a sense of ownership and spark efficiency and the necessary work drive. The quality of service depends critically on the staff and affects not only the participating doctor, but also the patient and referring physicians. This will also be reflected by customer loyalty.

There are certain fundamentals to consider before making staffing decisions. One must consider the number of procedures, the number of rooms, the number of staff members who will be part- or full-time, and the qualifications of the staff (i.e., nurse versus tech for a particular position). Generally, one can use the formula below to decide on the appropriate number of staff members.

$$\text{Time per procedure} \times \text{number of procedures per day} = \frac{\text{hours required}}{8} = \text{FTE}$$

$$\text{FTE} = \text{full-time employee}(40\text{hours/week})$$

Gastrointestinal Associates, P.C., has provided estimates on numbers for staffing as well as salaries (Tables 4 and

5).

Table 4
Staffing Needs for an Endoscopic Ambulatory Surgery Center

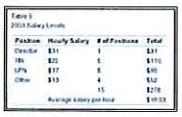


Table 5
2003 Salary Levels

Maximizing efficiency without affecting the morale of staff members is one way to control staff cost. Efficiency is based on the time from admission to discharge. Patient flow management can help increase efficiency and decrease costs. Time studies can help identify where problems lie. Studies of issues listed in column A of Table 6 can help identify delay reasons listed in column B and can ultimately help increase efficiency.

Table 6
Efficiency Issues

CONCLUSION

Go to:

EASCs are not only a profitable addition to a gastrointestinal or colorectal practice, but they are also a means of controlling efficiency and quality of the care provided. It is difficult to predict the future and how favorable or unfavorable the climate will be for EASCs. There are many factors that could hurt EASC development including lack of EASC set referral, expanded certificate of need review, and more rigorous licensure requirements.

If you can't have an EASC, office endoscopy is a good alternative. This type of service mainly exists in states with certificate of need requirements. The advantages are lower cost setup compared with an EASC, seemingly fewer hassles, and optional accreditation in many states. The disadvantage is lower profit margins. Medicare reimbursement does have a site of service differential (Table 7).[7]

Table 7
Medicare Reimbursement Model for Gastrointestinal Endoscopy

EASCs provide control over the quality of care one provides, control over the efficiency with which one provides that care, and an alternate source of revenue. The average EASC is small, independently owned, successful, and growing.

REFERENCES

Go to:

1. Ganz R A. The Future of Gastroenterology: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

2. Frakes J T. The Endoscopic Ambulatory Surgery Center: Its Importance to Your Practice: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

3. Zamojski D, Marasco J, Mahan G. Developing an Endoscopic ASC: AMSURG America's Single Specialty Surgery Center Leader: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

4. Deas T A. Corporate Partner: A Relationship That Works: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

5. Zamojski D, Marasco J, Mahan G. Developing an Endoscopic ASC: Marasco & Associates, Inc. Healthcare Architects and Consultants: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

6. Zamojski D, Marasco J, Mahan G. Developing an Endoscopic ASC: Gastrointestinal Associates, P.C.: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

7. Romansky M. Washington/Legislative Update, Endosopic ASCs: Creating Success: McDermott, Will & Emery: Gastroenterology Practice and Endoscopic ASCs—Creating Success. Knoxville, TN: 2004.

Exhibit 2: MidState Medical Center Department of Public Health Hospital License.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0070

General Hospital

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

Midstate Medical Center of Meriden, CT d/b/a Midstate Medical Center is hereby licensed to maintain and operate a General Hospital.

Midstate Medical Center is located at 435 Lewis Avenue, Meriden, CT 06451-2101.

The maximum number of beds shall not exceed at any time:

12 Bassinets
144 General Hospital Beds

This license expires **June 30, 2018** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, July 1, 2016. RENEWAL.

Satellites:
MMC Outpatient Clinic, 61 Pomeroy Avenue, Meriden, CT
MMC Outpatient Clinic, 680 South Main Street, Cheshire, CT

Raul Pino, MD, MPH
Commissioner

Exhibit 3: Curriculum vitae for key personnel.

LUCILLE ANDOLINA JANATKA, FACHE

PROFESSIONAL EXPERIENCE:

2013 – Present **Senior Vice President and President, Central Region**
Hartford HealthCare
Hartford, Connecticut 06013

Responsible for two hospitals and healthcare services serving Central Connecticut. The Hospital of Central Connecticut in New Britain, Connecticut is a 414-bed teaching hospital and MidState Medical Center in Meriden, Connecticut is a 156-bed acute care hospital. Along with Senior Services and Behavioral Health Services, the Central Region is now focused on the integration of population health services.

2009 – 2013 **Senior Vice President**
Hartford HealthCare
Hartford, Connecticut 06103

In addition to MidState Medical Center, Executive Sponsor for the development of Hartford HealthCare Cancer Institute, a system-wide Cancer Service Line integrating five hospital cancer programs which average over 5,000 new cancer cases annually.

Hartford HealthCare is a charter member of the Memorial Sloan Kettering Cancer Alliance.

- Responsible for statewide VNA Healthcare with operating revenue of $44 million;
- Responsible for Central Connecticut Senior Health Services. This organization includes five facilities offering assisted living, memory care, and skilled nursing care.

1999 – Present **President/Chief Executive Officer**
MidState Medical Center
Meriden, Connecticut 06451

Responsible for executive leadership of MidState Medical Center, a 156-bed acute care hospital with net revenue of $233 million.

- Consistently achieved 3-5% operating margin for 12 years;
- Recognized by Press Ganey for top scores in patient satisfaction, physician satisfaction, and employee satisfaction over many years;
- Recognized with top awards for quality throughout State of Connecticut and Massachusetts Baldrige process;
- Developed multi-specialty medical foundation consisting of 40 physicians, now merged system-wide with 500 providers;
- Oversight of new construction totaling $60 million and adding 30% more capacity on current campus.

Lucille Janatka, FACHE
203-405.3452

P. O. Box 940
Woodbury, Connecticut 06798

1995 - 1999

Chief Operating Officer
Waterbury Hospital
Waterbury, Connecticut 06708

Responsible for all hospital operations at this 360-bed acute care teaching facility; implemented a redesign plan that achieved $10 million savings in operating expenses; negotiated sale of dialysis business for $2 million above offering price; developed joint venture with rehabilitation agency, increasing net revenues by $500,000; participated in planning stages of merging outpatient cancer services operating at two hospitals, into new independent LLC.

1992 - 1995

Vice President, Operations
Hospital of St. Raphael
New Haven, Connecticut 06511

Accountable for all Clinical and Support Services in 500-bed teaching tertiary care hospital; hospital-wide program coordination for cancer services, JCAHO requirements, union negotiations, and Engineering/Maintenance, Construction Management, Environmental Health and Safety departments.

1990 - 1992

Vice President, Administration
Greenwich Hospital
Greenwich, Connecticut 06830

Responsible for operation of all clinical departments, Environmental Services, Engineering, construction programs, Materials Management, Laundry, Safety and Security; directed construction of 600-car ($6.8 million) parking garage; coordinated plan, design, and construction of cancer center and medical offices ($15 million); participated in development of master plan for renovation and expansion of entire hospital.

1986 - 1990

Senior Vice President
Meriden-Wallingford Hospital
Meriden, Connecticut 06450

Responsible for operation of both clinical and non-clinical departments; coordinated purchase and operation of walk-in center, industrial medicine services program, physical therapy services; changed physician referral patterns, increased market share with $1 million new revenue to hospital; developed new Women's Health Center; physician recruitment; participated in planning, strategy, and implementation of merger with competitor hospital.

1982 - 1986

Vice President for Patient Care Services
Meriden-Wallingford Hospital
Meriden, Connecticut 06450

Areas of responsibility included Division of Nursing, Anesthesia, Operating Room, Emergency Department, Continuing Care/Social

Services, OB clinics, Hospice, Infection Control, SurgiCenter, and labor relations; decentralized Nursing Division; instituted walk-in program for non-emergent care through the Emergency Department; key member of negotiating team for all union contracts.

EDUCATION:

MSN Degree, Boston College, School of Arts and Sciences, Chestnut Hill, Boston, Massachusetts

BSN Degree, St. Anselm College
Manchester, New Hampshire

PROFESSIONAL ASSOCIATIONS:

- Fellow of the American College of Health Care Executives 1987-present.

BOARD and COMMITTEE MEMBERSHIPS:

Professional:

- Numerous Board and Community memberships

PERSONAL AWARDS:

- 2011 Women in Business Award - Hartford Business Journal, Hartford, CT
- 2009 Top 25 Women in Healthcare - Modern Healthcare Magazine
- 2009 CT Women's Hall of Fame
- 2008 Athena Award - Quinnipiac Chamber of Commerce, Wallingford, CT 2003 Strong, Smart & Bold Award - Girls, Inc., Meriden, CT
- 2006 Women in Leadership - Women & Families Center, Meriden, CT
- 2005 Regent's Award - American College of Healthcare Executives
- 2003 Strong, Smart & Bold Award - Girls Inc., Meriden, CT

Garrett C. Havican, MBA, FACHE

PROFESSIONAL EXPERIENCE

MIDDLESEX HOSPITAL

(7/15-Present)-Vice President Strategic Planning & Ambulatory Operations

Middlesex Hospital is a not for profit, acute care community teaching hospital located in Middletown, CT. It provides health care services to a large geographic area covering the 24 towns in Middlesex County and the lower Connecticut River Valley, with a combined population of over 265,000 persons. The hospital is the only Connecticut member of the Mayo Clinic Care Network (MCCN) and the only acute care hospital located in its service area. It offers its residents a myriad of services including: two 24-hour emergency clinics, a comprehensive Cancer Center; out-patient Surgical Center, Laboratory, Radiology, Physical Therapy and Behavioral Health Services; a Family Practice Residency Program, Middlesex Primary Care Group and Middlesex Hospital Multi-specialty and Surgical Alliance Clinics. The hospital is licensed for 275 beds and 22 bassinets.

- *Executive oversight*: Health System Strategic Planning, MAYO Clinic Partnership, Ambulatory Operations &Business Development. *Departments include*: Radiology, Laboratory, Physical Medicine & Rehabilitation, Radiation Oncology, Surgical Alliance (multi-specialty surgical group), Radiation Safety, Cancer Center, Institutional Review Board, Out-patient services, Physician/Practice Relations, Internal Logistics and Patient Transport. *Initiatives include*: LEAN/ Six Sigma operational process improvement and the Health Systems Administrative Fellowship Program.
- Oversees all Certificate of Need applications and business development activities.
- Chairs patient throughput/length of stay initiative for MHS Performance Improvement Project. $4.3M expense reduction
- Negotiates multi-million dollar contracts for major medical equipment for Radiation Therapy, Radiology, Laboratory, Pulmonary Dept.
- Managed clinical practice transitions/acquisitions including Shoreline Medical Center in Westbrook, ASAP Urgent Care acquisition in Madison, East Haddam Family Medicine, Pro Physical Therapy/Rehab, Middletown Surgical Group and several Ambulatory Surgery Center joint ventures.
- Developed the following: Middlesex Medical Group(MMG) Surgical Alliance, MMG Dermatology Clinic, LEAN Six Sigma Leadership team, Physician/Practice Relations Department, Centralized Transportation Department and internal logistics team, new business acquisition teams and "No Lift Hospital" Committee.

(1/12-7/15)-*Promotion* -Vice President, Operations

(1/10-1/12)-*Promotion* -Director, Cancer Center & Oncology Services

(1/08-1/10)-Administrative Director

- Operational Oversight: Cancer Center, Comprehensive Breast Center, Radiation Oncology, Physics, & Surgical Sub-specialty Clinic
- Manages all financial aspects of six specific cost centers including budgeting, revenue and expense reporting and forecasting.
- 32 reports include: Physician Medical Directors, All Clinical, administrative and ancillary staff.
- Developed multi-disciplinary programs in breast, lung, colo-rectal, prostate, kidney, bladder, GYN Onc & IM/Survivorship.
- Facilitated inter-facility teams to justify, submit CON and acquire new technology including: Linear Accelerator, DaVinci Robotic Surgery, EBUS, 3.0 Tesla MRI's, etc.
- Developed comprehensive Multi-disciplinary surgical sub-specialty Clinic offering Thoracic Surgery, Gynecologic Oncology and Neurosurgical services. (2011)
- Led the Cancer Center to receive the American College of Surgeon's "Outstanding Achievement Award" (3/10 & 5/15))
- Developed the Middlesex Hospital Comprehensive Breast Center and the Center for Survivorship and Integrative Medicine. (2009)
- Secured in excess of $1Million in philanthropic donations for programmatic expansion.
- Developed a marketing platform including: a new web site, electronic & print media, Annual Report, Video and TV commercial.
- Received re-Accreditation with Commendation from the American College of Surgeon's Commission on Cancer (5-2009).
- Received re-Accreditation through the CALGB and the CTSU for clinical trial regulatory compliance (6/2009)
- Led the Comprehensive Breast Center through its inaugural site visit and achieved Accreditation through the American College of Surgeon's National Accreditation Program for Breast Centers (NAPBC) (7/2009) and re-accreditation (7-2012)

UNIVERSITY OF CONNECTICUT HEALTH CENTER; The Carole & Ray Neag Comprehensive Cancer Center

(1/06-1/08)-Administrative Manager; Signature Programs (Strategic Planning)

Neag Comprehensive Cancer Center Administrative Offices

The UConn Health Center is a vibrant, integrated academic medical center that is entering an era of unprecedented growth in all three areas of its mission: academics, research, and clinical care. Based in Farmington, Connecticut – a popular suburb of the state's capitol of Hartford – the UConn Health Center is home to the School of Medicine, School of Dental Medicine, John Dempsey Hospital, UConn Medical Group, UConn Health Partners, University Dentists and a thriving research enterprise. With approximately 5,000 employees, the UConn Health Center is a major economic driver in the region, generating nearly $1 billion annually in gross state product. It is closely linked with the University of Connecticut's main campus in Storrs through multiple, cross-campus academic projects.

- Direct oversight of the Academic Offices and its employees answering to the Chief Operating Officer of the Cancer Center.
- Oversight of all financial aspects of the $16 million budget including revenue/expenses, marketing, philanthropic giving & grant funding.
- Development of annual operational and research strategic plan in conjunction with the Cancer Center's Executive Committee.
- Develop org. infrastructure and policy to prepare the Cancer Center for subsequent National Cancer Institute (NCI) designation
- Direct supervision of Clinical Trials Office including employee supervision, recruitment, budgets and industry negotiations.
- Responsible for contractual review, financial planning, regulatory compliance and IRB submissions for over 76 active clinical trials.
- Led strategic planning efforts for the new Colon Cancer Prevention Program to develop "Prevention" translational medicine programs in colon, ovarian and breast cancer.
- New business development initiatives for health center trends in bench research, clinical treatment and translational activities.

HARTFORD HOSPITAL; Department of Trauma & Emergency Medicine. (Hartford, CT)
(3/04-1/06)-Strategic Planning Coordinator/ Regional Unit Leader
- Responsibilities included: Strategic organizational emergency response planning for the healthcare system in the Northern half of CT.
- Liaison to the CT. DPH, CT. Hospital Assoc., Dept. of Emergency Mgt. and Homeland Security and other planning partners.
- Directed project development including Surge Capacity planning, Web application project management, Behavioral Health Response, inter-regional Hospital resource utilization and Drill and Exercise Coordination.

GREENWICH EMERGENCY MEDICAL SERVICES; Administration. (Greenwich, CT)
(10/02-3/04)-Operations Manager
- Responsibilities included: Directing daily operations of citywide ambulance service managing over 80 employees.
- Head of strategy and planning and budgets for organization including identifying trends and forecasting growth opportunities.
- Increased staff by over 60% through successful recruitment campaign and establishment of successful employee retention programs.

UNIVERSITY OF CONNECTICUT HEALTH CENTER/ CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
(4/01- 10/02)-State of Connecticut Clinical Coordinator-Connecticut DPH
- Responsibilities included: consultation with State agencies regarding pre-hospital advanced medical practices.
- Reviewed and revised current regulations and statutes for the Ct. DPH Office of Emergency Medical Service.
- Manage the process for advanced level practice to grant and/or revoke authorization as necessary.
- Implement performance indicators used to track and trend statewide data and apply results to "Best-Practices" model.

(4/2001-10/2002)-Mobile Intensive Care Coordinator-UCHC Dept. of Traumatology and Emergency Medicine
- Responsibilities included: providing consultative services to the State of Connecticut Department of Public Health.
- Clinical Direction of 15 volunteer/municipal/Industrial/State EMS providers in 10 surrounding communities.
- Strategy, planning and new business development initiatives for UCHC Emergency Department and Regional Paramedic program
- Developed, published and implemented Standard Operating Guidelines for the sponsored EMS providers..

WATERBURY HOSPITAL HEALTH CENTER; Department of Emergency Medicine (Waterbury, CT.)
(9/97 - 4/01)-Emergency Medical Services Coordinator
- Responsibilities included: coordinating Emergency Medical Services for the Greater Waterbury area and the six contiguous communities (estimated population in excess of 85K).
- Strategy, planning and new business development initiatives for WHHC Emergency Department and Regional EMS program
- Coordinated a number of quality based projects including pharmaceutical research studies, analysis of concurrent and retrospective patient review, JCAHO preparatory teams and the implementation of HCFA (CMS) mandates.

EDUCATION/CREDENTIALS

Academic Degrees

1994: Western Connecticut State University, Danbury, Ct.
Bachelor of Arts, History.

2004 University of New Haven, New Haven, Ct.
Master's in Business Administration, (4.0 GPA)

Professional Certifications

2010: American College of Healthcare Executives, Chicago, IL.
Board Certification in Healthcare Management
Fellow, American College of Healthcare Executives

2011: Central Connecticut State University, New Britain, Ct.
Green Belt Certificate-Six Sigma

2012: Villanova University, Villanova, PA
Certified Six Sigma Black Belt

ADDITIONAL EXPERIENCE

Train the Trainer/ Health System Roll out: Level 3 High Reliability Organization
Renovation Project Leadership:

- Middlesex Health Systems Shoreline Medical Center Linear Accelerator/ Comprehensive Cancer Program $8M
- Middlesex Hospital Cancer Center Radiation Therapy Linear Accelerator acquisition/ vault construction $4M
- Middlesex Hospital Cancer Center Administrative/Clinical Office renovation $1M
- Middlesex Surgical Alliance office renovations $2M
- Middlesex Health Systems Shoreline Medical Center $34M
- Middlesex Health Systems Pro Physical Therapy acquisition/renovation (under development) appx $2.4M
- Neag Comprehensive Cancer Center Prevention Center $10M

State of Connecticut License: (1994-Present) Licensed Paramedic.
Coach: Little League Baseball, Youth Soccer
Certified: ACLS, PALS, BLS, HEICS
Operating system competencies in MS Word, Excel, Power Point, Access, Outlook, Publisher, Visio, MS Project, Google, Cerner

APPOINTMENTS AND INSTRUCTORSHIPS

Appointed Member: State of Connecticut; Governor's Certificate of Need Task Force
President: Connecticut Chapter of the American College of Healthcare Executives (CTAHE)
Board Member: Connecticut Chapter of the American College of Healthcare Executives
Member, Regents Advisory Council: Connecticut Chapter of the American College of Healthcare Executives
Member, Presidents Club: MARC: Community Resources (A local organization managing the needs of the developmentally disabled)
Member: University of New Haven Masters in Healthcare Administration Advisory Committee
Board Member: Middlesex United Way; Corporate Development Committee
Board Member: East Haddam Moodus Little League
Member: (2005-Present) Association of Community Cancer Centers (ACCC), Association of Cancer Executives (ACE)
Director/Instructor: (1995-2012) AHA Advanced Cardiac Life Support, Pediatric Advanced Life Support, BLS
Chair: 2010: Middlesex Health Systems United Way Campaign. (2009, Co-chair)
Chair: 2005-2009 American Heart Association, Emergency Cardiovascular Care Committee (New England Region)
President/CEO: (2004-2008) Corporation, Board of Directors, East Haddam Volunteer Ambulance Association, Inc.
Chairperson/Chief: Capitol Region Emergency Planning Committee Hospital Support Function (ESF8)
Chairperson (finr): Environment of Care Committee-Hazardous Materials and Emergency Preparedness-Waterbury Hospital
Instructor: Hospital Emergency Incident Command System (HEICS).

AWARDS AND ACCOMPLISHMENTS

2016 Appointed Member: State of Connecticut; Governor's Certificate of Need Task Force
2015 Promoted: Vice President Strategic Planning & Ambulatory Operations
2012 Awarded "ACHE" Regents Award for outstanding leadership/ healthcare management excellence
2012 Promoted: Vice President, Operations. Middlesex Health System
2011 Awarded "Heart of Hospice, Pulse of Palliative" Recognition Award
2011 Awarded "Corporate Achievement Award" and "Top 10" for leadership in the Middlesex County United Way Campaign.
2011 Named "Hometown Hero" by the Hartford Courant for community leadership and philanthropic initiatives.
2010 Promoted: Director, Cancer Center & Oncology Services; Middlesex Health System
2010 Awarded "Volunteer Leadership Award" by the American Heart Association Emergency Cardiovascular Care Committee
2007 Published: Hospital Preparation for Bioterror: A Medical and Biomedical Systems Approach; "Hospital Large Scale Drills"
2006 Lecture: "Top Off III: A Hospital Response". National Environmental Health Conference; San Antonio, Tx.
2005 Lecture: "Marketing your Community Training Center". American Heart Association Northeast affiliate; Worcester, MA.
2005 Awarded a "Public Service Award" by Secretary of State Susan Bysiewicz for Community Service in the State of Connecticut.
2004 Chosen as UNH EMBA "Success Story" by Dr. Parbadyul Singh, PhD; Associate Dean , UNH School of Business
2004 Awarded "Outstanding Service Award" Hartford Hospital Lead Planner for the Federal Top Officials Exercise, April 2004
2003 Awarded the "First Selectman's Award" Town of Greenwich for incident mitigation and control during the Black Outs of 2003.
1996 Awarded the "Member of the Year" (1996) for Wolcott Volunteer Ambulance.
1994 Award for Excellence in Field Internship for Yale Sponsored Hospital Paramedic Program.
1992-1993 Served as President and Alumni Chapter Advisor, Sigma Chi International Fraternity

REFERENCES AVAILABLE UPON REQUEST

Carolyn M. Freiheit

Summary & Overview

Versatile, highly accomplished, results driven leader who leads through change. Hands on leader with extensive background in healthcare finance and establishing cross functional partnerships to deliver results. Strong qualifications in developing and implementing financial controls and processes in addition to productivity improvements, and change management. Possesses solid leadership, communication and interpersonal skills to establish rapport with all levels of staff and management.

Professional Experience

2013-Present Hartford Healthcare, Inc.

Regional Vice President, Finance (2 acute care hospitals $600M Revenue)

Areas of Responsibility: Patient Financial Services, Admitting, General Accounting, Reimbursement, Decision Support Analytics, Budget and Accounts Payable for both Hospital of Central Connecticut and Midstate Medical Center with 5 direct reports and 100 divisional employees.

Key Accomplishments: transitioned revenue cycle to shared service organization model with standardization, regionalized departmental leadership, integrated system decision support and general accounting system,

2003- 2013 The Hospital of Central Connecticut, New Britain, CT

Director of Finance 2006 – Present

Areas of Responsibility: General Accounting, Reimbursement and Chargemaster Maintenance, Decision Support Analytics, Budget, Managed Annual Financial and Grant Audits, Accounts Payable with 14 direct staff members

Key Accomplishments: integrated fixed assets into general accounting with bar coding, implemented invoice scanning, electronic invoicing, reimbursement improvements with cost report preparation and compliance, implemented labor productivity monitoring system

Director of Budget 2003- 2006

Areas of Responsibility: budget & decision support system maintenance and reportingwith 2 direct staff members

Key Accomplishments: automated budget preparation, designed and implemented management training, managed variance reporting, selected and implemented new budget system with increased reporting efficiencies

1997-2003 Waterbury Hospital, Waterbury CT
Assistant Director of Finance 1999 – 2003
Reimbursement Analyst 1997- 1999

1994-1997 Milford Hospital, Milford CT
Reimbursement Analyst
1990-1994 Griffin Hospital, Derby CT
Senior Accountant

Professional Organizations & Community Leadership

CenConn Services	2013 - present
Hospital of Central Connecticut	2013 - present
Midstate Medical Center	2013 - present
Meriden Imaging Center	2013 - present
Corperator of Hospital of Central Connecticut	2009 - present
HealthCare Financial Management	2003 - present
Naugatuck Congregational Church	Finance Committee & Stewardship Committee

Education

Sacred Heart University and University of Connecticut MBA
Western CT State University Bachelors of Science; Major in Accounting
Bay Path College Associates of Science; Major in Accounting

CURRICULUM VITAE

DOUGLAS T. MILLER, MD

Education

Lafayette College, Easton, PA – BA Biology, Magna Cum Laude	1977
New York Medical College, Valhalla, NY, MD	1981
University of Connecticut, Storrs, CT – MBA	1998

Post Graduate Training

Straight Medical Intern, St. Vincent's Hospital & Medical Center of NY	1981-1982
Resident in Medicine – J.A.R., St. Vincent's Hospital & Medical Center of NY	1982-1983
Resident in Medicine – S.A.R., St. Vincent's Hospital & Medical Center of NY	1983-1984
Fellow in Gastroenterology, Albany Medical Center, Albany, NY	1986-1988

Medical Societies

American College of Physician Executives, Member
American Gastroenterological Association, Member
Connecticut State Medical Society, Member
New Haven County Medical Society, Member

Committees, Honors and Appointment

Recipient, National Health Service Corps Scholarship	1978-1980
Attending Physician, Department of Medicine, Oneida City Hospital, Oneida, NY	1984-1986
Clinical Instructor, Department of Medicine, State University of NY at Upstate, Syracuse, NY	1984-1986
Attending Physician, Department of Medicine, Mid State Medical Center, Meriden, CT	1988-Present
Member, Planning Committee, Mid State Medical Center, Meriden, CT	1994-Present
Member, Board of Directors, MWH Corporation, Meriden, CT	1994-1997
Assistant Professor, Dept of Med, Yale University School of Medicine, New Haven, CT	1995-Present
Member, PHO Steering Committee, MW-PHO Meriden, CT	1995
Secretary, MW Medical Service, PC Meriden, CT	1996-1997
Member, Physician Needs Task Force, Mid State Medical Center, Meriden, CT	1996-Present
Member, Project Design Committee, Mid State Medical Center, Meriden, CT	1996-1998
Member-at-Large, Medical Board, Mid State Medical Center, Meriden, CT	1996-Present
Co-Chairman, Physician Peer Review Action Group	2000
Chief of Staff Elect, Mid State Medical Center, Meriden, CT	2001-2003
Chief of Staff, Mid State Medical Center, Meriden, CT	2003-Present

Experience

Private Practice –General Internal Medicine, Camden, NY	1994-1986
Group Practice – Gastroenterology & Internal Med Assoc, PC, Meriden CT	09/1988–06/2011
Group Practice – Connecticut GI, PC, Meriden & Wallingford, CT	07/2011–Present

Credentials

Board Certified in Internal Medicine	1985
Board Certified in Gastroenterology	1989

Licensed to practice in CT (#028917) and NY (not active)

HOUSEIN WAZAZ, M.D.

PRIVATE PRACTICE July 2000 Present	MidState Gastroenterology Specialists 455 Lewis Ave. Suite 105 Meriden, CT 06451
FELLOWSHIP: July 1999-2000	Fellowship,Gastroenterology Nassau County Medical Center East Meadow, New York
July 1998-June 1999	Fellowship,Hepatology/Liver Transplants The UMDNJ New Jersey Meducak Newark, New Jersey
July 1997-June 1998	Fellowship, Gastroenterology Mount Sinai Medical Center New York, New York
RESIDENCY;	
June 1995-June 1997	Resident, Internal Medicine St.Barnabas Hospital Cornell Med. Ctr. Bronx, New York
INTERNSHIP;	
June 1994-June 1995	Internship, Internal Medicine St.Barnabas Hospital Cornell Med. Ctr. Bronx, New York
1993-1994	Internship, Internal Medicine Aleppo University Hospital Aleppo, Syria
MEDIAL SCHOOL: 1987-1993	M.D. Degree, Doctor of Medicine Aleppo University School of Medicine Aleppo, Syria

LICENSURE & CERTIFICATION:

2000 Board Certified Gastroenterology
1999 Board Certified Internal Medicine
1996 ACLS
1995 USMLE, step III
1994 ECFMG
1993 USMLE, step II
1993 USMLE, step I
2007 Recertification Internal Medicine and Gastroenterology

MEMBERSHIPS:

American College of Physicians
American Gastroenterology Association
American College of Gastroenterology

HONORS & AWARDS:

1997 94% SCORE ON THE In-Training Exam
1993 Top 4 among 120 graduates
1993 Scholarship in Medical School
1987 Ranked sixth in High School
1987 Scholarship in High School

PUBLICATIONS:

Carnitine & Cardiovascular Disease, Frishman/Sonnenblick
Cardiovascular Therapeutics, Innovative Pharmacological approaches for The treatment of myocardial ischemia, 1997, Chapter 37; pp 14-20

Therapeutic Expressions for smoking and addiction to nicotine under Professor Ali Haddad, Aleppo Medical, August 1993

The utility of side viewing scope to push entrescopy in the diagnosis and Management of obscure GI bleeding. DDW, New Orleans, LA 5/1998

Monitorin treatment of Viral Hepatitis C with Indocyanine green (JCG) Clearance, AASLD, Dallas, TX 11/99

RESEARCH:

The use of low molecular heparin in the treatment of unstable angina.
ALLHAT and CARS studies
The use of IV Cyclosporine in the treatment of severe Ulcerative Colitis, and the utility of colonoscopy in patients with fecal occult blood test positive and no evidence of iron deficiency anemia.

Exhibit 4: Letters of support related to this proposal.

OFFICE OF THE MAYOR

TOWN OF WALLINGFORD
CONNECTICUT

WILLIAM W. DICKINSON, JR.
MAYOR

45 SOUTH MAIN STREET
WALLINGFORD, CT 06492
TELEPHONE 203 294-2070
FAX 203 294-2073

November 15, 2016

Commissioner Raul Pino, MD, MPH
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Pino:

In a healthcare climate where integration, coordination and increased access are all of the utmost importance, I am writing today in support of the proposed plans for MidState Medical Center and a select group affiliated physicians to establish a jointly owned outpatient surgery facility center dedicated to gastroenterology.

The creation of a dedicated outpatient surgery facility will benefit the greater Meriden and Wallingford communities by increasing access to a lower cost alternative for GI procedures, enhancing care coordination for patients through the alignment of physicians and the Hospital, and expanding access to critical screening procedures for cancer and other GI diseases. In addition, the jointly owned facility will help retain and attract top clinical talent within the greater Meriden – Wallingford area in order to ensure the continued provision of health services necessary to improve the health status of our residents.

This project is simply another example of how the Hartford HealthCare system and its members are deploying their resources and enhancing their ability to truly coordinate care. Creating a dedicated center is an innovative approach that exemplifies the benefits of working collaboratively as a system and exhibits flexibility and commitment to providing quality services in an ever-changing environment.

Leaders at MidState Medical Center have always done a superb job of identifying and meeting the healthcare needs of the community. Their proven track record of financial success, high patient satisfaction and excellent outcomes are a testament to the great work they do – and the creation of this center is another step in the right director for our community.

Sincerely,

William W. Dickinson, Jr.
Mayor

jms

ProHealth PHYSICIANS

Cheshire Family Medicine

Michael M. Olsen, MD
Kathleen A. Viereg, MD
Richard G. Williams, MD
Joanne Priolo, APRN

July 28, 2016

Deputy Commissioner Jeannette Brankafort
Department of Public Health
Office of Health Care Access
410 Capital Avenue
Hartford, CT

Dear Deputy Commissioner Brankafort:

I am a family practioner practicing with ProHealth Physicians in Cheshire. It is with great pleasure that I write this letter to support the Midstate GI Endoscopy joint venture in Wallingford. ProHealth has been a leader in providing cost effective, high quality care in Connecticut for many years and I strongly believe that this GI Endoscopy Center would be aligned with our mission. GI endoscopy care in our area has been traditionally provided at MidState Medical Center which, although a high quality provider, is also a high cost center. The new endoscopy center promises to substantially decrease costs to our patients and provide services in a modern, pleasant environment.

I whole-heartedly support the development of this center and look forward to my patients having their GI endoscopic services delivered there.

Sincerely,

Michael Olsen, M.D.

335 Highland Avenue
Cheshire, CT 06410
Phone: (203) 271-3063
Fax: (203) 272-1365

www.ProHealthMD.com

Exhibit 5: Draft Operating Agreement.

OPERATING AGREEMENT

OF

WALLINGFORD ENDOSCOPY CENTER, LLC

A CONNECTICUT LIMITED LIABILITY COMPANY

DATED AS OF [ ], 2016

OPERATING AGREEMENT
OF
WALLINGFORD ENDOSCOPY CENTER, LLC

This Operating Agreement (this "Agreement") is entered into as of this [ ] day of [ ], 2016 ("Effective Date"), by and among the signatories hereto.

EXPLANATORY STATEMENT

WHEREAS, the parties have agreed to organize and operate a limited liability company in accordance with the terms of, and subject to the conditions set forth in, this Agreement; and

WHEREAS, the parties wish to establish a facility for the provision of outpatient G.I. endoscopy surgery and related care services as contemplated by the vision of the Members, including, without limitation, creating a facility focused on providing services which are high quality, cost efficient, coordinated and collaborative, and patient centric, and as to the extent compatible with and in furtherance of the charitable purposes of the Class A Member; and

WHEREAS, the parties have agreed to own and operate a limited liability company pursuant to Internal Revenue Service Revenue Ruling 2004-51, 2004-22 C.B. 974, in such a manner as to neither (i) jeopardize the status of the Class A Member as an organization exempt from federal income taxation pursuant to Code Section 501(a) as an organization described in Code Section 501(c)(3), nor (ii) generate any "unrelated business taxable income" for the Class A Member as such term is used in Code Section 512(a);

NOW, THEREFORE, for good and valuable consideration, the sufficiency of which is hereby acknowledged, the parties, intending legally to be bound, agree as follows:

ARTICLE I
ORGANIZATION OF THE COMPANY

1.01 Organization.

On [ ], 2016, the Company was organized as a Connecticut limited liability company by the execution and delivery of Articles of Organization to the Connecticut Secretary of the State in accordance with and pursuant to the Act.

1.02 Name of the Company.

The name of the Company is **WALLINGFORD ENDOSCOPY CENTER, LLC.** The Company may do business under that name and under any other name or names that the Management Committee may select. If the Company does business under a name other than that set forth in its Articles of Organization, then the Company shall amend its Articles of Organization or file a trade name certificate as required by Applicable Law.

1.03 Principal Place of Business.

The principal place of business and the office of the Company shall be located at, and the Company's business shall be conducted from 455 Lewis Avenue, Meriden, CT 06451. The Company may locate its place of business at any other place or places as the Management Committee may deem advisable.

1.04 Statutory Agent.

The name of the statutory agent of the Company for service of process on the Company in the State of Connecticut shall be [ ], whose address is [ ]. The Company may change its statutory agent if it is deemed advisable by the Management Committee. If the Company changes its statutory agent, the Company shall file the name and address of the new statutory agent with the Connecticut Secretary of the State as required by the Act.

1.05 Term.

The existence of the Company shall be perpetual and shall continue unless and until the Company is dissolved, wound up and terminated in accordance with this Agreement.

1.06 Purpose.

Subject to Section 1.07(a), the purposes to be promoted or carried out by the Company shall be as follows:

(a) The Company shall be organized, operated and managed in a manner that is exclusively in furtherance of the Class A Member's tax-exempt charitable purposes under Section 501(c)(3) of the Code, including, without limitation, promoting health and providing or expanding access to healthcare services for a broad cross section of the community in a manner that complies with and is in furtherance of the community benefit standard in Revenue Ruling 69-545. Specifically, and without limiting the generality of the foregoing, the Company shall ensure that it is operated and managed in a manner that: (i) provides access to patient care services based on medical necessity, without regard to characteristics such as a person's race, creed, national origin, gender, age, sexual orientation, physical or mental disability, payor source or ability to pay; (ii) provides access to patient care services to individuals covered by Medicare and other Government Health Care Programs in which the Class A Member participates; and (iii) will not cause the Company to be operated in a manner that is not exclusively in furtherance of the Class A Member's tax exempt purposes.

(b) The Company shall operate a fully licensed, certified and accredited endoscopy center applying best practice principles envisioned by the Class B Member, all in furtherance of the charitable purposes of the Class A Member by promoting health for a broad section of the community as further described in Section 1.07 and including, without limitation, a facility focused on providing services which are high quality, cost efficient, coordinated and collaborative, and patient centric; and

(c) The Members understand that the Company's and the Center's operations are subject to various state and federal laws regulating permissible relationships between the Members and entities such as the Company, including 42 U.S.C. § 1320a-7b(b) (the "Fraud and Abuse Statute"), and 42 U.S.C. § 1395nn (the "Stark Act"). It is the intent of the parties that the Company operate in a manner consistent with the foregoing statutes. The Members also acknowledge that the Stark Act, the regulations promulgated thereunder and similar Connecticut laws and regulations may restrict the Center (as presently formed) from providing "designated health services" (as defined by the Stark Act) or other services to patients referred by the Members or physician with an direct or indirect ownership or financial arrangement with the Company. The Center shall not provide "designated health services." If, in the future, any of the services that the Center provides are deemed to be "designated health services," such services shall be provided by the Center only if such services may be provided in compliance with one or more exceptions to the ban on self-referrals set forth in the Stark Act, the regulations promulgated thereunder, or any successor statutes and/or regulations thereto.

(d) To engage in any other lawful act or activity for which limited liability companies may be formed under the Act consistent with the foregoing.

1.07 Tax-Exempt Organization Limitations; No Referral Obligation.

Notwithstanding any other provision of this Agreement:

(a) Notwithstanding anything to the contrary contained in this Agreement [Redacted], so long as MidState Medical Center (or an entity owned by Hartford HealthCare Corporation which is exempt from taxation pursuant to Section 501(c)(3) of the Code) remains a Member of the Company all acts, activities, and business carried on by the Company shall be consistent with, and exclusively in furtherance of, the charitable health care and community benefit missions and tax-exempt status under Section 501(c)(3) of the Code, of Hartford HealthCare Corporation, or its tax exempt successor (the "Charitable Purposes"). The Members hereby agree and acknowledge that the foregoing duty of the Company to operate consistent with, and in furtherance of, the Charitable Purposes shall override any duty that the Company or its Member(s) may have to operate the Company for the financial benefit of any individual or for-profit Member. Accordingly, in the event of a conflict between the operation of the Company in accordance with the Charitable Purposes, on the one hand, and any duty to maximize the Company's profits, on the other hand, the Company, its Members and the Management Committee shall satisfy the Charitable Purposes without regard to the consequences for maximizing the Company's profitability.

(b) The Company shall not carry on propaganda or attempt to influence legislation, and shall not participate or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

1.08 Independent Medical Judgment.

No provision of this Agreement shall limit the independent medical judgment of any participating physician with Medical Staff privileges at the Center with regard to the provision of patient care.

ARTICLE II
MEMBERS AND MEMBER REPRESENTATIVES

2.01 Members.

The name, present mailing address, Capital Contributions, Class of Membership Interest and Percentage Interest of each Member are set forth on Exhibit A, attached hereto, as such Exhibit may be amended from time to time.

2.02 Membership Classes.

The Company shall have two Classes of Membership Interests: Class A Membership Interests and Class B Membership Interests. The two Classes of Membership Interest shall be identical in all respects except as otherwise provided in this Agreement. [Redacted].

2.03 Member Representations.

(a) Each Member represents and warrants that neither it, he or she, nor any owners of the Member (i) has received loans for the purpose of investing in the Company from the Company, a Member or their Affiliates, or from any direct or indirect investor in the Company; (ii) has offered (and will not offer) terms for investment in the Member based upon previous, actual or expected referrals, services furnished or the amount of business otherwise generated from that owner to the Center; (iii) has or will make payment to an owner in return for the owner's investment in the Member that is not directly proportional to the owner's capital investment in the Member; and (iv) has made (and will not make) any other payments, direct or indirect, to an owner that are based, in any manner, upon the volume or value of referrals the owner has made or directed to the Center (or is expected to refer to the Center).

(b) No Person shall be eligible to become a physician owner, directly or indirectly, of the Class B Member (or remain an owner of a Class B Member) (collectively, the "Physician Member") unless the following eligibility requirements are satisfied: (i) each Physician Member shall be a physician, licensed and registered, in good standing, to practice medicine in the State of Connecticut; (ii) each Physician Member has not been barred or suspended from participation in any governmental program, including, but not limited to, Medicare and/or Medicaid programs; (iii) each Physician Member shall derive at least one-third (1/3) of his or her medical practice income from all sources for the previous fiscal year or previous twelve (12)-month period from his or her own performance of procedures that are ambulatory surgical procedures (or procedures that are required to be provided in an inpatient or outpatient hospital operating room); (iv) each Physician Member shall fully inform each patient, prior to referring patients to the Center, of his or her investment interest in the Center; (v) each Physician Member shall treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner; (vi) if the Physician Member refers patients to the Center, such Physician Member shall maintain active privileges at the Center (and any

physician subject to a Management Committee action under the Medical Staff Bylaws that results in probation or suspended privileges may be deemed, at the Management Committees sole discretion, ineligible to remain a Physician Member); and (vii) under Applicable Law, such Physician Member's ownership shall not disqualify (and, without further action, would not disqualify) the Company or the Center from engaging in operations as a Medicare-certified ambulatory surgery center for any reason, or from having such Physician Member perform cases at the Center. A physician who meets such requirements may be referred to herein as an "Eligible Physician Investor". Notwithstanding any other provision of this Agreement to the contrary, in no event may a physician, other than an Eligible Physician Investor hold, directly or indirectly, a Membership Interest or Economic Interest.

(c) [Redacted] any Person which is an owner of the Class B Member shall either be (i) and Eligible Physician Investor, (ii) a "group practice" as defined 42 CFR 1001.952(r)(5) consisting exclusively of Eligible Physician Investors or (iii) a Person established for the sole purposes of investing in the Class B Member and all owners shall be Eligible Physician Investors as defined Section 2.03(b), above. Such Class B Member owners shall also comply with Section 2.03(a) and (b) above.

(d) The Class A Member further represents and warrants that (i) it will not require or encourage employed or affiliated physicians to refer patients to the Center or any Physician Member (or physician on staff at the Center); (ii) it will not track referrals made by its employed or affiliated physicians to the Center, directly or indirectly; (iii) any compensation paid to employed or affiliated physicians will be at fair market value and will not take into account, in any manner, the volume or value of referrals to the Center or physicians on staff at the Center; (iv) it will annually inform its employed and affiliated physicians of these requirements; (v) it will treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner; and (vi) it will not include any payment or cost associated with the Center on its cost report unless such costs are required to be included by a Federal health care program**.**

2.04 Member Representatives.

Each Member of the Company shall designate in writing one Member Representative who shall be entitled to exercise all of the rights of such Member, including voting rights, set forth in this Agreement. Such Member Representative shall have the authority to act on behalf of such Member unless the Management Committee receives written notice from the applicable Member of the replacement of such Member Representative. The initial Member Representative of each Class A Member and Class B Member is set forth in Exhibit B hereto. A Member Representative may be removed or replaced at any time, with or without cause or notice, by the Member which designated such Member Representative.

ARTICLE III
CONTRIBUTIONS AND CAPITAL ACCOUNTS

3.01 Initial Capital Contributions.

At the time of admission of any new Member to the Company, the new Member shall be

required to make a Capital Contribution to the Company in an amount determined by the Members.

3.02 Additional Capital Contributions.

(a) If the Member Representatives of the Class A Member and the Class B Member at any time, or from time to time, determine by unanimous written consent that the Company requires additional capital, then the Management Committee shall give written notice to each Member of (i) the aggregate amount of additional Capital Contribution required, (ii) the reason the additional Capital Contribution is required, (iii) each Member's proportionate share of the aggregate additional Capital Contribution (determined in accordance with this Section), and (iv) the date each Member's additional Capital Contribution is due and payable, which date shall be no sooner than thirty (30) days after the notice has been given. A Member's proportionate share of the total additional Capital Contribution shall be equal to the product obtained by multiplying the Member's Percentage Interest and the aggregate additional Capital Contribution required. A Member's proportionate share shall be payable in cash, by certified check or by wire transfer.

(b) Except as provided in this Article III, no Member shall be required to contribute any additional capital to the Company, and no Member shall have any personal liability for any obligation of the Company.

3.03 Capital Contribution Defaults.

(a) If a Member (the "Defaulting Member") does not make a Capital Contribution required pursuant to Section 3.01 or Section 3.02(a) on or before the date such Capital Contribution is due, such failure shall be grounds for the removal of such Member from the Company by the Management Committee, acting by majority vote of the disinterested members of the Management Committee within sixty (60) days after such failure. If the Management Committee does not remove the Defaulting Member, (i) the Defaulting Member's Membership Interest shall be converted to an Economic Interest until such time (the "Cure Date") that the Defaulting Member has made the delinquent Capital Contribution, plus interest, at a variable annual rate equal to the Prime Rate as in effect from time to time plus two percent (2%), from the date such Capital Contribution was due to the date of payment, (ii) the Defaulting Member shall automatically forfeit until the Cure Date its voting rights hereunder, if any, and its right, if any, to designate a Member Representative or any representative on the Management Committee, (iii) the Managers designated by the Defaulting Member to the Management Committee, if any, shall automatically be removed from the Management Committee, and (iv) the Company shall be entitled to set off against any Cash Flow or other amounts due to such Defaulting Member hereunder any amounts due to the Company attributable to such Capital Contribution and the interest thereon.

(b) As used in Section 3.03(a), "Prime Rate" means the Prime Rate as published from time to time in the "Money Rates" section of The Wall Street Journal or any successor publication, or in the event that such rate is no longer published in The

Wall Street Journal or such successor journal, a comparable index or reference as may be selected by a majority of the Members which are not at such time Defaulting Members.

3.04 Interest on and Return of Capital Contributions.

No Member shall be entitled to interest on such Member's Capital Contribution or to a return of such Member's Capital Contribution, unless otherwise provided herein.

3.05 Form of Return of Capital Contributions.

If a Member is entitled to receive a return of a Capital Contribution, the Member shall not have the right to receive anything but cash in return of the Member's Capital Contribution.

3.06 Capital Accounts.

A separate Capital Account shall be maintained for each Member and Economic Interest Owner.

3.07 Loans to the Company.

Any Member may at any time, with the consent of the Management Committee, make or cause a loan to be made to the Company in any amount and on those terms upon which: (i) the Company and the Member agree; and (ii) are in compliance with all Applicable Law, including, but not limited to, the Fraud and Abuse Statute and Stark Act.

ARTICLE IV
MEMBER REPRESENTATIVE MEETINGS

4.01 Meetings.

Meetings of the Member Representatives, for any valid purpose or purposes, may be called by the Management Committee or by any Member Representative.

4.02 Place of Meetings.

The Member Representatives may designate any place, either within or outside the State of Connecticut, as the place of meeting for any meeting of the Member Representatives. If no designation is made, the place of meeting shall be the principal place of business of the Company. One or more Member Representatives may participate in a meeting of the Member Representatives by use of a conference telephone or similar communications equipment that allows all persons participating in the meeting to communicate with one another.

4.03 Notice of Meetings.

Except as provided in Section 4.04, written notice stating the place, day and hour of a meeting of the Member Representatives and the purpose or purposes for which the meeting is

called shall be delivered not less than five (5) nor more than thirty (30) days before the date of the meeting either personally or by mail, by or at the direction of the Management Committee or Member Representative calling the meeting, to each Member Representative entitled to vote at such meeting.

4.04 Meeting of All Member Representatives.

If all of the Member Representatives shall meet at any time and place, either within or outside of the State of Connecticut, and consent to the holding of a meeting at such time and place, such meeting shall be valid without call or notice, and at such meeting lawful action may be taken.

4.05 Record Date.

For the purpose of determining the Member Representatives entitled to notice of or to vote at any meeting of the Member Representatives or any adjournment thereof, the date on which notice of the meeting is mailed shall be the record date for such determination. When a determination of the Member Representatives entitled to vote at any meeting of the Member Representatives has been made as provided in this Section, such determination shall apply to any adjournment thereof.

4.06 Manner of Acting.

(a) The Supermajority Vote of the Member Representatives shall be required to take or approve any matter coming before the Member Representatives, unless the vote of a lesser or greater proportion or number is otherwise required by the Act, by the Articles of Organization, or by this Agreement. [Redacted].

4.07 Proxies.

At all meetings of the Member Representatives, a Member Representative may vote in person or by proxy executed in writing by the Member Representative or by a duly authorized attorney-in-fact. Such proxy shall be filed with the Company before or at the time of the meeting. No proxy shall be valid after eleven months from the date of its execution, unless otherwise provided in the proxy.

4.08 Action by Member Representatives Without a Meeting.

Any action required by this Agreement or the Act to be taken at a meeting of the Member Representatives, or any other action that may be taken at a meeting of the Member Representatives, may be taken without a meeting and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by at least the minimum number of Member Representatives who could approve such action at a meeting of the Members.

4.09 Waiver of Notice.

When any notice is required to be given to any Member Representative, a waiver thereof in writing signed by the person entitled to such notice, whether before, at, or after the time stated therein, shall be equivalent to the giving of such notice.

ARTICLE V
RIGHTS, DUTIES AND OBLIGATIONS OF MEMBERS

5.01 Limitation of Liability.

Each Member's liability shall be limited as set forth in this Agreement, the Act and other Applicable Law.

5.02 Liability for Company Debt.

A Member shall not be personally liable for the debts or losses of the Company except as otherwise required by Applicable Law.

5.03 Member Duties.

No Member shall be required to perform services for the Company solely by virtue of being a Member. Unless approved by the Management Committee, no Member shall perform services for the Company or be entitled to compensation for services performed for the Company.

5.04 Limitation on Authority of Members.

Except as otherwise set forth herein, the Members shall have no right to take any part in, or interfere in any manner with, the conduct, control or management of the Company's business and shall have no right or authority to act for or bind the Company, said powers being vested solely and exclusively in the Management Committee. Except as otherwise expressly provided herein, the Members shall have only those rights granted exclusively to members pursuant to the Act or under this Agreement. Any Member who takes any action or binds the Company in violation of this Agreement shall be solely responsible for any loss and expense incurred by the Company as a result of the unauthorized action and shall indemnify and hold the Company harmless with respect to the loss or expense.

5.05 Redacted.

5.06 Restrictive Covenants.

(a) **Redacted.**

(b) **Confidentiality**.

(i) Each Member hereby acknowledges that any disclosure of the Company's or another Member's Confidential Information, as defined below, even inadvertent disclosure, would cause irreparable and material damage to the Company or to the other Member. Each Member hereby agrees that it and each of its Affiliates shall (A) maintain as confidential all of the Company's and the other Members' Confidential Information made known to it; (B) protect the confidentiality thereof in the same manner in which it protects the confidentiality of similar Confidential Information of its own, at all times exercising at least a reasonable degree of care in the protection of the Confidential Information; and (C) not disclose such Confidential Information to any third party without the express written consent of the owner of the Confidential Information. Each Member agrees to transfer to the Company and the other Members, as applicable, upon the termination of its Membership Interest, the Confidential Information made known to it as a result of it being a Member and in its possession upon the termination and to continue to maintain the confidentiality of the Confidential Information as provided herein. The obligations of each Member under this Section shall survive the termination of the Member's Membership Interest and the termination of this Agreement.

(ii) "Confidential Information" includes, but is not limited to, all: (A) financial information; (B) products, and services and product and service information, including but not limited to product and service costs, prices, profits and sales; (C) new business ideas; (D) business strategies; (E) product and service plans; (F) marketing plans and studies; (G) forecasts and models; (H) all intellectual property, including but not limited to property or information (1) that is protected by copyright or is copyrightable, (2) that is protected by patent or that is patentable, or (3) that is valuable and not generally known in the trade, including trade secrets, financial data, business plans, and data, and any developments relating to foregoing, whether or not patentable or copyrightable; (I) databases (and the documentation and information contained therein); (J) research projects and all information connected with research and development efforts; (K) records (including the records of the Company and the medical records of patients); (L) business relationships, methods and recommendations; (M) patient lists (including the identities of patients and prospective patients); (N) contract termination and renewal dates; (O) personnel files; (P) competitive analyses; (Q) all information relating to the operation of the Company's business; and (R) other confidential, proprietary or trade secret information that has not been made available to the general public by the Company's management.

(c) ***Limitation of Covenants***. The restrictions in this Section 5.06:

(i) shall not prohibit any Member or its Affiliates from taking any action on behalf of the Company;

(ii) shall not apply to the activities of a Member, a former Member or its Affiliates if the Members by Supermajority Vote consent to allow the Member or former Member to undertake the prohibited activity after full disclosure of all

the relevant facts; or

(iii) [Redacted].

(d) ***Injunctive Relief.*** Each Member acknowledges that any violation of any provision of Section 5.06 will cause irreparable harm to the Company and the other Member, that damages for such harm will be incapable of precise measurement and that, as a result, the Company and/or the other Member(s) will not have an adequate remedy at law to redress the harm caused by such violation. Therefore, in the event of such a violation, the parties agree that, in addition to other remedies, the aggrieved party or parties shall be entitled, without the necessity of either proof of actual damage or the posting of a bond, to injunctive relief, including but not limited to an immediate temporary injunction, temporary restraining order and/or preliminary or permanent injunction to restrain or enjoin any such violation, and to reimbursement of any attorneys' fees incurred to enforce the provisions of this Section 5.06. Nothing in this Agreement shall be construed to prohibit the Company and/or an aggrieved Member from pursuing any other remedy, the parties having agreed that all remedies are cumulative and that the Member is liable for any and all acts or omissions of such Member [Redacted] that violate any provision of this Section 5.06. In addition, the Class B Member agrees to obtain an agreement from each Person who is a direct or indirect owner of a beneficial interest in the Class B Member to be bound by the provisions of this Section 5.06 and that the Company and the Class A Member shall be third party beneficiaries to such agreement with independent rights to enforce the non-compete provisions contained in that agreement

(e) ***Acknowledgment***. Each Member hereby acknowledges the reasonableness of the restrictions contained in this Section 5.06 in view of the purposes of the Company and the relationship of the Members. Each Member acknowledges that the restrictions contained in this Section 5.06 represent mandatory conditions precedent to the execution of this Agreement, and that in the absence of such restrictions, neither Member would have consented to, or entered into, this Agreement.

ARTICLE VI
RIGHTS AND DUTIES OF MANAGEMENT COMMITTEE

6.01 Management Committee.

(a) The management of the Company shall be vested in a Management Committee, which shall consist of six individuals (each individually referred to as a "Manager", and collectively as the "Managers"). The Class A Member shall be responsible for designating three of such six Managers (each of which shall be referred to individually as a "Class A Manager", and collectively as the "Class A Managers") to the Management Committee. The Class B Member shall be responsible for designating three of such six Managers (each of which shall be referred to individually as a "Class B Manager", and collectively as the "Class A Member and Class B Managers") to the Management Committee. The initial Managers designated by each of the Class A Member and the Class B Member are set forth on Exhibit B hereto.

(b) The annual meeting of the Management Committee shall be held on the second Monday of the month of December each year, or at such other time as is selected by the Management Committee. Regular meetings of the Management Committee may be held at such times and places as may be determined by the Management Committee, and once such determination has been made and notice given to each Manager, regular meetings may be held without any further notice. Special meetings of the Management Committee may be called by the Chairman, a Member Representative, or by two or more Managers upon at least forty-eight (48) hours' notice. Attendance at a meeting of the Management Committee, in person or as otherwise permitted under this Agreement or the Act, by a majority of the Class A Managers and a majority of the Class B Managers shall constitute a quorum.

(c) Action may be taken by the Management Committee without a meeting by consent, in writing, setting forth the action to be taken, signed by the number of Managers entitled to vote on such action as would be required to approve such action at a meeting at which all the Managers entitled to vote thereon were present. Such consent shall be filed with the records of the meetings of the Management Committee and shall be treated for all purposes as the act of the Management Committee.

(d) Managers may participate in a Management Committee meeting by means of conference telephone or similar communications equipment that enables all persons participating in the meeting to hear each other.

(e) The Management Committee may, from time to time, designate by resolution one or more subcommittees, with such powers and authority as may be prescribed in such resolution, to serve at the request of the Management Committee. Each subcommittee, which shall be comprised of an equal number of representatives of each of the Class A Member and the Class B Member, may determine the procedural rules for its meetings and conducting its business and shall act in accordance therewith. Adequate provision shall be made for notice to subcommittee members of all meetings; a majority of the subcommittee members shall constitute a quorum; and all matters shall be determined by the vote of a majority of the subcommittee members present at a meeting at which a quorum is present.

(f) [Redacted] it is the intention of the Members that this Agreement vest in the Class A Managers such control over Company operations as is necessary to permit the Class A Member to ensure that the Company's operations exclusively further the tax-exempt purposes of the Class A Member as set forth in Sections 1.06 and 1.07 of this Agreement.

6.02 Powers of Management Committee.

The Management Committee shall have full, exclusive, and complete discretion, power, and authority (subject in all cases to Section 4.06, Section 6.03, Section 6.04, [Redacted] the other provisions of this Agreement and the requirements of Applicable Law), to manage, control, administer, and operate the business and affairs of the Company so as to further the purpose of the Company as set forth in Sections 1.06 and 1.07, and to make all decisions affecting such

business and affairs [Redacted], including without limitation, for Company purposes, the power to:

(a) acquire by purchase, lease, or otherwise any real property or any personal property, tangible or intangible;

(b) construct, operate, maintain, finance, and improve any real property or any personal property;

(c) sell, convey, assign, or lease any real property or any personal property;

(d) open and use bank accounts in the Company's name and to withdraw funds or issue checks, drafts or orders for the payment of money from such accounts;

(e) enter into agreements and contracts and to give receipts, releases, and discharges;

(f) appoint, employ or otherwise contract with any Person to perform services for or on behalf of the Company, and to grant to any such Person such authority to act on behalf of the Company as the Management Committee may from time to time deem appropriate;

(g) purchase liability and other insurance to protect the Company's assets and business;

(h) execute any and all other instruments and documents that may be necessary or in the opinion of the Management Committee desirable to carry out the intent and purpose of this Agreement;

(i) make any and all expenditures that the Management Committee, in its sole discretion, deems necessary or appropriate in connection with the management of the affairs of the Company and the carrying out of its obligations and responsibilities under this Agreement, including, without limitation, all legal, accounting, and other related expenses incurred in connection with the organization, financing, and operation of the Company;

(j) invest and reinvest Company reserves in short-term instruments or money market funds;

(k) adopt and amend Medical Staff Bylaws and Medical Staff Rules and Regulations for the organization and operation of the Center (as provided further in Section 8.02 below);

(l) appoint and credential members of the Medical Staff and delineate their privileges at the Center, and otherwise discharge its responsibilities under the Medical Staff Bylaws and Rules and Regulations in effect from time to time;

(m) oversee quality assurance, quality improvement, and best practices

medicine;

(n) arrange for managed care contracting;

(o) control the proper and efficient use of operating room time;

(p) oversee the review peers using the Company's Center pursuant to procedures adopted by the Management Committee from time to time;

(q) take and approve all actions and matters required of a governing authority of an endoscopy center under Applicable Law; and

(r) enter into any activity necessary to, in connection with, or incidental to, the accomplishment of the purposes of the Company.

6.03 Management of Endoscopy Center.

The Management Committee shall oversee the management and administration of the business affairs of the Company's Center. It shall do so either through the employment or engagement of individuals with the necessary credentials to do so, or through contract with a third party engaged in the business of endoscopy center management. Any management agreement shall require the manager to operate the Company exclusively in furtherance of the charitable purposes of the Class A Member as set forth in this Agreement. The Medical Director and Associate Medical Director shall have responsibility for the day-to-day operations of the Center as provided in Section 7.07. The Members and the Management Committee hereby adopt and agree to comply with the Charity Care Policy. Notwithstanding the foregoing, the Class A Member shall have the exclusive right to amend the Charity Care Policy, provided that the Class B Member is given at least ten days' prior written notice of the proposed change and an opportunity to comment on the proposed change.

6.04 Extraordinary Transactions.

Notwithstanding anything herein to the contrary [Redacted] the Management Committee may not take action with regards to any of the following matters without the Supermajority Vote of the Member Representatives [Redacted]:

(a) sell all or substantially all of the assets of the Company;

(b) merge or consolidate the Company with any other Person;

(c) acquire all or substantially all the assets of, or ownership interests in, another Person;

(d) borrow money or incur any debt for, or on behalf of, the Company in excess of $250,000, other than in the ordinary course of business;

(e) execute for or on behalf of the Company any mortgage or deed of trust or prepay, in whole or in part, refinance, amend, modify, or extend any mortgage or deeds

of trust for or on behalf of the Company securing a debt in excess of $250,000;

(f) create a security interest in or cause a lien securing a debt in excess of $250,000 to be placed on any real property of the Company or, other than in the ordinary course of business, any personal property of the Company;

(g) acquire by purchase, lease or otherwise any real property;

(h) admit additional Members to the Company;

(i) enter into any management agreement relating to all or substantially all of the assets and/or operations of the Company, or any other contract or series of related contracts that (a) require aggregate expenditures by the Company, or will result in aggregate gross payments to the Company, in excess of $100,000 or (b) are with any entity that is, directly or indirectly, in a position to generate patient referrals to the Center;

(j) hire or fire key personnel;

(k) open additional offices; and

(l) terminate the Medical Director and Medico-Administrative Services Agreement.

6.05 Term of Managers.

Each Manager shall hold office until his or her death, resignation, incapacitation or removal as provided herein.

6.06 Resignation of Manager.

Any Manager of the Company may resign at any time by giving written notice to the Company and to the Member who designated such Manager. The resignation of any Manager shall take effect upon receipt by the Member and the Company of the notice thereof or at such later date specified in such notice, and unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

6.07 Removal of Manager.

A Manager may be removed at any time, with or without cause or notice, by the Member that originally designated such Manager or as described in Section 3.03(a)(iii).

6.08 Vacancies.

Manager vacancies shall be filled by the Member who originally designated such Manager.

6.09 Manner of Acting.

(a) Redacted.

(b) Redacted.

(c) Redacted.

(d) Compliance Plan and Conflict of Interest Policy. The Management Committee shall adopt, and the Company shall operate consistently with, a compliance plan that is complimentary to the compliance plan of the Class A Member and a conflict of interest policy that is substantially similar to the Class A Member's conflict of interest policy, provided that each such plan and policy shall not impair any of the rights of the Class B Managers [Redacted] and the Class B Members or Managers shall not have to recuse themselves from participating in any meeting or discussion relating to a Service Agreement or the Medical Director and Medico-Administrative Services Agreement. Furthermore, the Company's compliance plan must be approved by the Class A Member's Office of Compliance Audit and Privacy. Except as otherwise agreed upon by the Management Committee, the compliance plan operation shall be provided through a third party service. In furtherance of the foregoing, at its sole expense, the Class A Member may perform periodic audits of the Company's corporate compliance plan to provide recommendations to the Class A Managers regarding performance and, as needed, modifications of the compliance plan. In addition, the Management Committee shall adopt, and the Company shall operate consistently with, an antitrust protocol to assure the Company operates in a manner compliant with applicable antitrust laws.

(e) Medical Staff Credentialing. Except as otherwise determined by the Management Committee, medical staff credentialing for the Center shall be conducted using internal staff under the direction of the Company's Medical Director.

(f) Third Party Payer Contracting. The Class B Managers shall have the right to negotiate all contracts between the Company and third-party payers, which contracts shall be subject to the approval of the Management Committee. If the Management Committee fails to approve a payor contract recommended by the Class B Managers, the Class B Managers may contest the decision, in which case a valuation consultant mutually agreed to by the Members shall be engaged to evaluate the proposed payor contract. If the valuation consultant concludes the proposed payor contract is consistent with industry-standard terms and would result in fair market value compensation to the Center, the payor contract shall be approved, notwithstanding the prior disapproval of the Management Committee. In the event a payor contract involves a global payment for professional and facility services, the contract between the Company and Connecticut GI, P.C. or MidState Gastroenterology Specialists, P.C. for professional services shall be deemed to be, and shall be treated as, a Service Agreement [Redacted].

6.10 Duties of Managers.

Each Manager shall devote such time to the business and affairs of the Company as is necessary to carry out the duties set forth in this Agreement. The Management Committee shall

manage the Company so as to further the purpose of the Company as set forth in Section 1.06 without regard to maximizing profitability.

6.11 Liability of Managers.

In no event will any Manager be personally liable to the Company, the Members or any other Manager for the debts, obligations, or liabilities of the Company whether arising in contract, tort or otherwise, in acting on behalf of the Company or in his or her capacity as a Manager, except as otherwise required by Applicable Law, provided that his or her actions or omissions did not constitute fraud, bad faith, gross negligence, or willful misconduct. No Manager shall be personally liable for failure to perform in accordance with, or to comply with the terms and conditions of, this Agreement or for any other reason unless such failure to conform or to comply or such other reason constitutes fraud, bad faith, gross negligence, or willful misconduct by such Manager.

6.12 Indemnity of Managers.

The Company shall indemnify and hold harmless each Manager against any and all liability, loss, expense, or damage incurred or sustained by reason of any act or omission in the conduct of the business of the Company, except if such Manager shall have been guilty of fraud, bad faith, gross negligence or willful misconduct. Such indemnification shall include the reasonable expenses (including reasonable attorneys' fees and costs) incurred by a Manager in connection with the defense of any action to which he or she may be made a party by reason of his or her interest in or activities on behalf of the Company. Any indemnity under this Section shall be provided out of and to the extent of Company assets only and no Member shall have any personal liability on account thereof. Subject to the approval of the Management Committee, the Company may pay the expenses incurred by a Manager who is the subject of an action, suit or proceeding described to in this Section 6.12, in defending the action, suit, or proceeding, including attorney's fees, as they are incurred, in advance of the final disposition of the action, suit, or proceeding, upon receipt of an undertaking by or on behalf of the Manager to repay the amount if it is ultimately determined that the Manager is not entitled to be indemnified by the Company.

6.13 Reliance upon Third Parties.

The Management Committee and each Manager shall be fully protected in relying in good faith upon information, opinions, reports, or statements furnished by any Person as to matters the Management Committee or Manager reasonably believes are within such other Person's professional or expert competence and who has been selected with reasonable care.

6.14 Compensation.

The salary and/or other compensation of the Managers, if any, shall be fixed from time to time by the Supermajority Vote of the Member Representatives.

ARTICLE VII
OFFICERS OF THE COMPANY AND MEDICAL DIRECTORS

7.01 General.

The Management Committee annually at its annual meeting shall appoint a Chairman, and may elect such other officers of the Company, which may include a Treasurer, a Secretary and other officers and assistant officers, as the Management Committee may deem necessary or advisable for the efficient operation of the Company's affairs. Any two or more offices may be held by the same person. The Chairman shall be one of the six Managers, and such position shall be held for alternating one-year terms by a Class A Manager and a Class B Manager, such that the Chairman shall be designated by the Class A Managers during the annual meeting of the Management Committee held during an even-numbered year, and shall be designated by the Class B Managers during the annual meeting of the Management Committee held during an odd-numbered year.

7.02 Authority and Duties.

Officers of the Company, if any, shall have such authority and perform such duties in the management of the Company as may be provided in this Agreement or, to the extent not so provided, by resolution of the Management Committee.

7.03 Election and Term of Office.

Officers of the Company, if any, shall be elected annually by the Management Committee at the annual meeting of the Management Committee. Each officer shall hold office until his or her successor shall have been duly elected or until his or her prior death, resignation or removal.

7.04 Removal.

Any officer of the Company may be removed by the Management Committee whenever in its judgment the best interest of the Company would be served thereby; provided, however, (a) the removal of a Chairman can only be by vote of the Managers who designated such Chairman; and (b) the removal of any officer shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment shall not of itself create contract rights. [Redacted].

7.05 Resignations.

Any officer of the Company may resign his or her office at any time by giving written notice thereof to the Chairman of the Company, if any, or to the Management Committee. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

7.06 Vacancies.

A vacancy in any office shall be filled by the Management Committee for the unexpired portion of the term; provided, however, that any vacancy in the position of Chairman shall be filled by the Managers who designated the Chairman at the immediately preceding annual

meeting of the Management Committee.

7.07 Chairman.

The Chairman shall preside at all meetings of the Management Committee and the Members, and shall have such powers and duties as may from time to time be delegated or assigned to the Chairman by the Management Committee. The Chairman shall be required to place on the agenda for a meeting of the Management Committee any agenda item proposed by a Manager at least two (2) business days before such meeting.

7.08 Treasurer.

The Treasurer, if any, shall have charge and custody of and be responsible for all the funds and securities of the Company; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Company in books belonging to the Company; and he or she shall deposit all moneys and other valuable effects of the Company in the name of and to the credit of the Company in such banks or other depositories as may be designated by the Management Committee. The Treasurer shall disburse or oversee the disbursement of the funds of the Company as may be ordered by the Management Committee, taking proper vouchers for disbursements, and shall render to the Managers at the meetings of the Management Committee, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Company. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Management Committee.

7.09 Secretary.

The Secretary, if any, shall keep the minutes of the meetings of the Members and the Management Committee in one or more books provided for that purpose. In general, he or she shall perform all the duties incident to the office of Secretary and such other duties as may from time to time be assigned to the Secretary by the Management Committee.

7.10 Medical Director and Associate Medical Director.

As provided in the Medical Director and Medico-Administrative Services Agreement between the Company and MEC, the Class A Managers shall appoint the Medical Director and Associate Medical Director who shall be nominated by the Class B Managers and must at all times be on the active medical staff of MidState Medical Center and a physician employee of Connecticut GI, P.C. or MidState Gastroenterology Specialists, P.C. The Medical Director shall be the chief operating officer of the Company's Center, with such powers and duties, including without limitation responsibility for the day-to-day operations of the Center, as may be contemplated by Applicable Law, or as may be established by the Management Committee. The Medical Director shall be responsible for the implementation of the Company's Charity Care Policy. The Associate Medical Director shall perform the duties of the Medical Director in case of the absence, death or inability to act of such officer, with all the powers given to, and responsibilities imposed upon, such officer. The Associate Medical Director shall have such

other powers and duties as may be assigned to him or her from time to time by the Medical Director or the Management Committee. The Medical Director and the Associate Medical Director shall be invited to attend all meetings of the Management Committee, except as otherwise directed by the Management Committee; provided, however, that (a) the presence of neither the Medical Director nor the Associate Medical Director shall be required to conduct a meeting of the Management Committee; and (b) each of the Medical Director and the Associate Medical Director shall recuse himself or herself from any deliberations or votes of the Management Committee concerning the evaluation and/or compensation of the Medical Director or the Associate Medical Director.

The Medical Director shall be primarily responsible for monitoring the performance of all Contracted Service Providers under Service Agreements. The Medical Director shall notify the Class A Managers in the event that the Medical Director reasonably determines Connecticut GI, P.C. or MidState Gastroenterology Specialists, P.C. or its agent or subcontractor has failed to perform satisfactorily its material obligations under the applicable Service Agreement [Redacted].

As of the effective date of this Restated Operating Agreement, the Members acknowledge that: (i) the Medical Director shall be [ ], M.D.; and (ii) the Associate Medical Director shall be [ ], M.D.

7.11 Other Assistants and Acting Officers.

The Management Committee may from time to time appoint such other officers as the Management Committee may deem necessary or advisable, each of whom shall hold office for such period, have such authority and perform such duties as the Management Committee may from time to time determine.

ARTICLE VIII
MEDICAL STAFF

8.01 Medical Staff.

The Management Committee shall cause to be created and shall continue to provide for a medical staff organization known as the "Medical Staff of the Wallingford Endoscopy Center", which shall include all physicians and members of allied professions who are granted by the Management Committee the privilege of caring for or contributing to the care of patients at the Center (the "Medical Staff"). Membership on the Medical Staff shall be a prerequisite to the exercise of clinical privileges at the Center, except as otherwise may be provided in the Medical Staff Bylaws.

8.02 Medical Staff Bylaws.

The Management Committee shall adopt prior to the commencement of medical procedures at the Center, and may amend from time to time, the Medical Staff Bylaws and the

Medical Staff Rules and Regulations to govern the organization, appointment and removal of the Medical Staff. The Medical Staff Bylaws shall provide that it shall be the responsibility of any member of the Medical Staff to assist the Company to comply with the Charity Care Policy as established pursuant to this Agreement, amended from time to time and enforced by the Management Committee.

8.03 Staff Status; Privileges; Corrective Action.

The Medical Staff Bylaws shall provide for the procedure to be followed in matters relating to Medical Staff membership status, clinical privileges, and corrective action. Final action on all such matters shall be taken by the Management Committee. The terms and conditions of membership status on the Medical Staff, and of the exercise of clinical privileges, shall be as specified in the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or as more specifically defined in the notice of individual appointment to the Medical Staff.

8.04 Management Committee Exclusive Appointing Authority.

[Redacted] The Management Committee shall have the exclusive authority and responsibility to make appointments or reappointments to the Medical Staff, after considering the recommendations and reports of the Medical Staff.

ARTICLE IX
ALLOCATION OF PROFIT AND LOSS AND DISTRIBUTIONS

9.01 Distributions.

(a) ***General.*** Except as otherwise provided in Section 9.01(b), distributions of cash or other assets of the Company shall be made at such times and in such amounts as the Management Committee may determine. Distributions, other than tax distributions made in accordance with Section 9.01(b), special allocations made in accordance with Section 9.07, and liquidating distributions that shall be made in accordance with Section 15.03, shall be made to the Members and Economic Interest Owners in proportion to their Percentage Interests in the Company.

(b) ***Tax Distributions.*** With respect to each fiscal year of the Company, or part thereof, the Company shall distribute (the "Tax Distribution"), to the extent that it has cash or other liquid investments, to each Member and Economic Interest Owner (who is a Member or Economic Interest Owner as of the date of the distribution) an amount of cash equal to fifty (50%) percent of the net amount of Profit and Loss allocated to such Member or Economic Interest Owner for such year under this Article IX on a cumulative basis. Tax Distributions shall be made to the Members and Economic Interest Owner in proportion to their Percentage Interests on or before those dates upon which federal estimated tax payments or federal tax returns are required to be made or filed by the Members and Economic Interest Owners. The Tax Distributions shall be made without regard to the taxable or tax-exempt status of the Member or Economic Interest Owner.

(c) ***Authority to Withhold; Treatment of Withheld Tax***. Notwithstanding any other provision of this Agreement, each Member and Economic Interest Owner hereby authorizes the Company to withhold and to pay over, or otherwise to pay, any withholding or other taxes payable by the Company (pursuant to the Code or any provision of United States federal, state or local or foreign law) with respect to such Member or Economic Interest Owner or as a result of such Member's or Economic Interest Owner's participation in the Company; and if and to the extent that the Company shall be required to withhold or pay any such withholding or other taxes, such Member or Economic Interest Owner shall be deemed for all purposes of this Agreement to have received a payment from the Company as of the time such withholding or other tax is required to be paid, which payment shall be deemed to be a distribution with respect to such Member's or Economic Interest Owner's Interest in the Company. To the extent that the aggregate amount of such payments to a Member or Economic Interest Owner for any fiscal year exceeds the amount of distributions that such Member or Economic Interest Owner would have received for such fiscal year, the Company shall notify such Member or Economic Interest Owner as to the amount of such excess and such Member or Economic Interest Owner shall make a prompt payment to the Company of such amount by wire transfer. The Company shall promptly notify each Member or Economic Interest Owner of any withholding or other taxes payable by the Company with respect to such Member or Economic Interest Owner and, upon the request of such Member or Economic Interest Owner, shall use reasonable efforts to assist such Member or Economic Interest Owner to secure any available tax refunds, credits or exemptions (including exemptions from withholding) with respect to such withholding or other taxes.

9.02 Allocation of Profit and Loss.

After giving effect to the special allocations set forth in Section 9.03, for any taxable year of the Company, Profit or Loss shall be allocated to the Members and the Economic Interest Owners in proportion to their Percentage Interests, subject to any special allocation required by Section 9.06 or 9.07.

9.03 Regulatory Allocations.

(a) ***Qualified Income Offset***. No Member or Economic Interest Owner shall be allocated Loss or deductions if the allocation causes the Member or the Economic Interest Owner to have an Adjusted Capital Account Deficit, after the allocation of all Profit and gains. If a Member or an Economic Interest Owner receives (i) an allocation of Loss or deduction (or item thereof) or (ii) any distribution, that causes the Member or the Economic Interest Owner to have an Adjusted Capital Account Deficit at the end of any taxable year, then all items of income and gain of the Company (consisting of a *pro rata* portion of each item of Company income, including gross income and gain) for that taxable year shall be allocated to that Member or Economic Interest Owner, before any other allocation is made of Company items for that taxable year, in the amount and in proportions required to eliminate the excess as quickly as possible. This Section 9.03(a) is intended to comply with, and shall be interpreted consistently with, the "qualified income offset" provisions of the Regulations promulgated under Code Section 704(b). Any special allocations of items of Profit or Loss pursuant to this Section 9.03(a) shall be

taken into account in computing subsequent allocations of Profit and Loss pursuant to this Agreement, so that the net amount of any items so allocated and the Profit, Loss, and other items allocated to each Member and Economic Interest Owner shall, to the extent possible, be equal to the net amount that would have been allocated to each such Member or Economic Interest Owner pursuant to this Agreement if such special allocation had not occurred.

(b) ***Minimum Gain Chargeback***. Except as set forth in Regulation Sections 1.704-2(f)(2), (3) and (4), if during any taxable year, there is a net decrease in Minimum Gain, each Member and Economic Interest Owner, prior to any other allocation pursuant to this Article IX, shall be specially allocated items of gross income and gain for such taxable year (and if necessary, subsequent taxable years) in an amount equal to that Member's or Economic Interest Owner's share of the net decrease of Minimum Gain, computed in accordance with Regulation Section 1.704-2(g). Allocations of gross income and gain pursuant to this Section shall be made first from gain recognized from the disposition of Company assets subject to nonrecourse liabilities (within the meaning of the Regulations promulgated under Code Section 752), to the extent of the Minimum Gain attributable to those assets, and thereafter, from a *pro rata* portion of the Company's other items of income and gain for the taxable year. It is the intent of the parties hereto that any allocation pursuant to this Section 9.03(b) shall constitute a "minimum gain chargeback" under Regulation Section 1.704-2(f).

(c) ***Member Nonrecourse Debt Minimum Gain.*** Except as set forth in Regulation Section 1.704-2(i)(4), if during any taxable year, there is a net decrease in Member Nonrecourse Debt Minimum Gain, each Member and Economic Interest Owner, prior to any other allocation pursuant to this Article IX, shall be specially allocated items of gross income and gain for such taxable year (and if necessary, subsequent taxable years) in an amount equal to that Member's or Economic Interest Owner's share of the net decrease of Member Nonrecourse Debt Minimum Gain, computed in accordance with Regulation Section 1.704-2(i)(5). Allocations of gross income and gain pursuant to this Section shall be made first from gain recognized from the disposition of Company assets subject to nonrecourse liabilities (within the meaning of Regulation Section 1.704-2(b)(4)), to the extent of the Member Nonrecourse Debt Minimum Gain attributable to those assets, and thereafter, from a *pro rata* portion of the Company's other items of income and gain for the taxable year. It is the intent of the parties hereto that any allocation pursuant to this Section 9.03(c) shall constitute a "chargeback of partner nonrecourse debt minimum gain" under Regulation Section 1.704-2(i)(4).

(d) ***Code Section 754 Adjustment***. To the extent an adjustment to the tax basis of any Company asset pursuant to Code Section 734(b) or Code Section 743(b) is required, pursuant to Regulation Section 1.704-1(b)(2)(iv)(m), to be taken into account in determining Capital Accounts, the amount of the adjustment to the Capital Accounts shall be treated as an item of gain (if the adjustment increases the basis of the asset) or loss (if the adjustment decreases basis), and the gain or loss shall be specially allocated to the Members and the Economic Interest Owners in a manner consistent with the manner in which their Capital Accounts are required to be adjusted pursuant to that Section of the Regulations.

(e) ***Nonrecourse Deductions***. Nonrecourse Deductions for a taxable year or other period shall be specially allocated among the Members and the Economic Interest Owners in proportion to their Percentage Interests.

(f) ***Member Nonrecourse Deductions***. Any Member Nonrecourse Deduction for any taxable year or other period shall be specially allocated to the Member or the Economic Interest Owner who bears the risk of loss with respect to the loan to which the Member Nonrecourse Deduction is attributable in accordance with Regulation Section 1.704-2(i).

(g) ***Fractions Rule Adjustment***. Notwithstanding anything to the contrary in this Agreement, the Company shall (i) make allocations of Profit (or any item thereof) to the Class A Member only to the extent that the Class A Member have actually received a distribution under Section 9.01 attributable to such Profit, and (ii) make such special, curative, and/or offsetting allocations of Profit or Net Loss (or any item thereof) to the extent necessary to cause the allocations of Company income, gain, loss, and deduction to meet the requirements of Code Section 514(c)(9)(E) and the Treasury Regulations thereunder; provided, however, in the event any such allocation made under this subsection (g) would reduce the amounts distributable to any Member under this Agreement, the parties shall in good faith negotiate an amendment to the allocation provisions of this Agreement such that no such reduction occurs (unless the Class A Members waive such right with respect to a reduction in any amount distributable to it).

9.04 Contributed Property and Book-ups.

In accordance with Code Section 704(c) and the Regulations thereunder, as well as Regulation Section 1.704-1(b)(2)(iv)(d)(3), income, gain, loss, and deduction with respect to any property contributed (or deemed contributed) to the Company shall, solely for tax purposes, be allocated among the Members and the Economic Interest Owners so as to take account of any variation between the adjusted basis of the property to the Company for federal income tax purposes and its fair market value at the date of contribution (or deemed contribution). If the adjusted book value of any Company asset is adjusted as provided herein, subsequent allocations of income, gain, loss, and deduction with respect to the asset shall take account of any variation between the adjusted basis of the asset for federal income tax purposes and its adjusted book value in the manner required under Code Section 704(c) and the Regulations thereunder. Any elections or decisions relating to such allocations shall be made by the Management Committee in a manner that reasonably reflects the intent of this Agreement. Allocations pursuant to this Section 9.04 are solely for tax purposes and shall not affect any Member's or any Economic Interest Owner's Capital Account.

9.05 General.

(a) ***Distributions of Property.*** If any assets of the Company are distributed in kind to any Member or Economic Interest Owner, those assets shall be valued on the basis of their Agreed Value, and any Member or any Economic Interest Owner entitled to any interest in those assets shall receive that interest as a tenant-in-common with all other

Members and Economic Interest Owners so entitled. The Profit or Loss for each distributed asset shall be determined as if the asset had been sold at its Agreed Value, and the Profit or Loss shall be allocated as provided in Section 9.02 and shall be properly credited or charged to the Capital Accounts of the Members and the Economic Interest Owners prior to the distribution of the assets.

(b) ***Members of Record for Allocations.*** All Profit and Loss shall be allocated to the Persons shown on the records of the Company to have been Members or Economic Interest Owners during the year, as of the last day of the taxable year for which the allocation is to be made. Notwithstanding the foregoing, unless the Company elects to separate its taxable year into segments, if there is a Transfer or an Involuntary or Voluntary Withdrawal during the taxable year, the Profit and Loss shall be allocated between the original Member or Economic Interest Owner and his or her successor or, in the case of a Transfer to the Company or a Voluntary Withdrawal, among the remaining Members and Economic Interest Owners, on the basis of the number of days each was a Member or an Economic Interest Owner during the taxable year. However, the Company's taxable year shall be segregated into two or more segments in order to account for Profit, Loss, or proceeds attributable to any extraordinary non-recurring items of the Company.

(c) ***Members of Record for Distributions.*** All *pro rata* distributions shall be made to the Persons shown on the records of the Company to be Members or Economic Interest Owners as of the day of the distribution.

(d) ***Guaranteed Payments***. To the extent any compensation for goods or services, that is paid to a Member or an Economic Interest Owner by the Company, is determined by the Internal Revenue Service not to be a guaranteed payment under Code Section 707(c) or is not paid to the Member or the Economic Interest Owner other than in the Person's capacity as a Member or an Economic Interest Owner within the meaning of Code Section 707(a), the Member or the Economic Interest Owner shall be specially allocated gross income of the Company in an amount equal to the amount of that compensation, and the Member or the Economic Interest Owner's Capital Account shall be adjusted to reflect the payment of that compensation.

(e) ***Amendment of Regulatory Allocations.*** The Management Committee is hereby authorized, upon the advice of the Company's tax counsel, to amend this Article IX to comply with the Code and the Regulations promulgated under Code Section 704(b). However, no amendment shall materially affect distributions to a Member or an Economic Interest Owner without the Member's or Economic Interest Owner's prior written consent.

9.06 <u>Certain Special Allocations</u>.

Notwithstanding the other provisions of this Article IX, the Management Committee will make special allocations of certain items of gross income and expenses to one or more Members as set forth in this Section 9.06.

(a) The Members acknowledge and agree that as of the Effective Date, the Company shall convert from cash basis accounting to accrual basis accounting which conversion may result in the Company, for tax purposes, realizing additional taxable income. The Members agree that the Company will make an additional distribution to the Class B Member of the Company, equal to the following: fifty (50%) percent times the sum of (i) the expected collectable value of the Company's accounts receivable as of the end of its tax year; (ii) any expenses which would have been deductible under cash basis accounting but are not deductible under accrual basis accounting; less (iii) any expenses which are deductible under accrual basis accounting but not deductible under cash basis accounting. The calculation of this one time distribution will be made within thirty (30) days of the end of the Company's fiscal year and paid within thirty (30) days of the completion of the calculation. Upon payment of this distribution, the Class B Member's Capital Account shall be adjusted in accordance with this Agreement.

(b) In the event that the accreditation body of the Facility is changed from the Accreditation Association for Ambulatory Health Care, Inc. ("AAAHC") to the Joint Commission (the "Joint Commission"), all costs and expenses of the Company incurred to meet the accreditation standards of the Joint Commission that are different from those of AAAHC shall be accrued and allocated solely to the Class A Member for the determination of profits and losses and shall not be included in the determination of the profits and losses allocated to, or cash distributed to, the Class B Member pursuant to this Agreement.

ARTICLE X
BOOKS, RECORDS, ACCOUNTING AND TAX ELECTIONS

10.01 Bank Accounts.

All funds of the Company shall be deposited in a bank account or accounts maintained in the Company's name. The Management Committee shall determine the institution or institutions at which the accounts will be opened and maintained, the types of accounts, and the Persons who will have authority with respect to the accounts and the funds therein.

10.02 Books and Records.

(a) The Management Committee shall keep or cause to be kept complete and accurate books and records of the Company and supporting documentation of the transactions with respect to the conduct of the Company's business. At a minimum, the Company shall keep the following records:

(i) A current list of (1) the full name and last known address of each Member and Economic Interest Owner, Member Representative and Manager, (2) the amount of cash each Member and Economic Interest Owner has contributed, (3) a description and statement of the Agreed Value of the other property each Member and Economic Interest Owner has contributed or has agreed to contribute in the future, and (4) the date on which each became a Member and Economic Interest Owner;

(ii) A copy of the Articles of Organization of the Company and all amendments thereto, together with executed copies of any powers of attorney pursuant to which any amendment has been executed;

(iii) Copies of the Company's federal, state, and local income tax returns and reports (including information returns), if any, for the three most recent years;

(iv) Copies of the Company's currently effective Operating Agreement;

(v) Copies of the Company's financial statements for the three most recent years;

(vi) Minutes of every meeting of the Members;

(vii) Any written consents obtained from the Members for actions taken by the Members without a meeting;

(viii) A copy of the Company's Charity Care Policy; and

(ix) Copies of the quarterly reports of charity care provided by the Company and the charitable initiatives implemented or to be implemented by the Company (subject to any reasonable record retention policy adopted by the Management Committee).

(b) The books and records shall be maintained in accordance with sound accounting practices and shall be available at the Company's principal office for examination by any Member, or any former Member (but only those books and records pertaining to the period in which he or she was a Member), or the Member's duly authorized representative at any and all reasonable times during normal business hours.

(c) Each Member shall reimburse the Company for all costs and expenses incurred by the Company in connection with the Member's inspection or copying of the Company's books and records.

(d) At the request of any Member, and at the requesting Member's expense, the Management Committee shall cause an audit of the Company's books and records to be prepared by independent accountants for the period requested by that Member.

10.03 Annual Accounting Period.

The annual accounting period and the fiscal year of the Company shall be its taxable year. The Company's taxable year shall be the annual period ending on September 30.

10.04 Accounting.

The Company shall be an accrual basis taxpayer.

10.05 Returns and Other Elections.

The Management Committee shall (a) cause the preparation and timely filing of all tax returns required to be filed by the Company pursuant to the Code and all other tax returns deemed necessary and required in each jurisdiction in which the Company does business; (b) shall send a copy of Schedule K-1 or any successor or replacement form thereof to each Member and Economic Interest Owner as soon as the same is filed; and (c) shall cause the Company to file any other documents from time to time as may be required by any state or any subdivision thereof. All tax elections may be made by the Management Committee in its sole discretion, provided that the Management Committee shall make any tax election authorized by a unanimous vote of all of the Class A and Class B Members. However, the Management Committee may not make an election for the Company (i) to be excluded from the provisions of Subchapter K of the Code or (ii) to be treated as a corporation for federal income tax purposes, without the unanimous written consent of the Class A and Class B Members. The determination by the Management Committee with respect to the treatment of any item or its allocation for Federal, state or local tax purposes shall be binding so long as such determination will not be inconsistent with any provision of this Agreement.

10.06 Tax Matters Partner.

The Class A Member shall be and is designated the "Tax Matters Partner" (as defined in Code Section 6231) and is authorized and required (a) to represent the Company (at the Company's expense) in connection with all examinations of the Company's affairs by tax authorities, including, without limitation, administrative and judicial proceedings; (b) to expend Company funds for professional services and costs associated therewith; and (c) to keep all Members informed of all notices from government taxing authorities that may come to the attention of the Tax Matters Partner; provided, however, that: (i) upon written request by the Class B Member, the Class B Member and/or its representative may attend any particular examination or administrative or judicial proceeding; and (ii) the Class A Member shall not settle any tax examination or administrative or judicial proceeding without the prior written consent of the Class B Member if such settlement will have an adverse economic impact on the Class B Member. The Members agree to cooperate with each other and to do or refrain from doing any and all things reasonably required to conduct such proceedings. The Company shall indemnify and save harmless the Tax Matters Partner from and against any loss, damage, liability or expense incurred or sustained by it by reason of any act performed by it, or any failure by it to act, as the Tax Matters Partner, provided that any such act or failure to act shall not result from its willful misconduct, gross negligence or fraud.

10.07 Title to Company Property.

Except as provided in this Section, all real and personal property acquired by the Company shall be acquired and held by the Company in its name. The Management Committee may direct that legal title to all or any portion of the Company's property be acquired or held in a name other than the Company's name. Without limiting the foregoing, the Management Committee may cause title to be acquired and held in the names of trustees, nominees, or straw parties for the Company. It is expressly understood and agreed that the manner of holding title to the Company's property (or any part thereof) is solely for the convenience of the Company, and

all property shall be treated as Company property.

ARTICLE XI
ASSIGNMENTS

11.01 Transfers.

Except as otherwise provided in this Agreement, no Member may Transfer all, or any portion of, or any interest or rights in, its Membership Interest or Economic Interest, and no Economic Interest Owner may Transfer all, or any portion of, or any interest or rights in, its Economic Interest, including the assignment of the right to receive distributions. An Involuntary Withdrawal shall be governed by Article XIV of this Agreement.

11.02 Redacted.

11.03 Redacted.

11.04 Redacted.

11.05 Redacted.

11.06 Reasonableness of Restrictions.

Each Member hereby acknowledges the reasonableness of the restrictions contained in this Article in view of the purposes of the Company, the tax-exempt status of the Class A Member and the relationship of the Members. The Transfer of any Membership Interest or Economic Interest in violation of the restrictions contained in this Article shall be deemed invalid, null and void, and of no force or effect. Any Person to whom a Membership Interest or Economic Interest, or any portion thereof, is attempted to be transferred in violation of this Article shall not be entitled to vote on matters coming before the Members, participate in the management of the Company, act as an agent of the Company, receive distributions from the Company or have any other rights in or with respect to the Membership Interest or Economic Interest, or portion thereof.

ARTICLE XII
REDACTED

ARTICLE XIII
ADDITIONAL MEMBERS

13.01 Additional Members.

The Members, by Supermajority Vote, shall have the right to admit additional Members

upon such terms and conditions, at such time or times, and for such contributions as shall be determined by such Members, and in connection with any such admission, the Management Committee shall have the right to amend Exhibit A to reflect the name, address, contribution, taxpayer identification number and Percentage Interest of the admitted Member; provided, however, that the terms and conditions of any such admission and their impact on the Membership Interests of other Members must comply with the provisions of this Agreement. The admission of any Person as a substitute or additional Member shall be conditioned upon such Person's written acceptance and adoption of all the terms and provisions of this Agreement. Within a reasonable time period following the addition of a new Member(s), the Class A Member shall make such capital contributions as necessary, to maintain its Percentage Interest at fifty one (51%) percent. The Class A Member must notify the Management Committee of its intent to exercise its purchase option within ten (10) business days following the admission of a new Member. The Members otherwise specifically waive any preemptive rights.

13.02 Redacted.

ARTICLE XIV
WITHDRAWALS OF MEMBERS

14.01 Voluntary Withdrawal.

Except as otherwise provided herein, no Member or Economic Interest Owner shall have the right or power to Voluntarily Withdraw from the Company, except as otherwise provided by this Agreement.

The parties acknowledge and agree that in order for the Company to achieve its goal of creating a high quality, low cost provider for the community served by the Class A Member, the Center must have a critical mass of physicians actively engaged in the continuous improvement and provision of quality and efficient care at the Center including physician participation on the Board of Managers, Credentialing Committees and Quality Improvement Committees. Accordingly, if the Company has [ ] or fewer Eligible Physician Investors who are either direct or indirect owners in the Company, the Class A Member upon thirty (30) days' prior written notice to the Class B Member shall be entitled to withdraw and redeem its Class A Membership Interest in accordance with the terms of this Section 14.01 ("Withdrawal Notice Period"). Upon the withdrawal of the Class A Member pursuant to this Section 14.01, the Company shall purchase all, but not less than all, of the Class A Member's Membership Interest for the purchase price and on the payment terms as set forth herein.

(a) **Transfer Closing Date**. The Company shall fix a closing date (the "Transfer Closing Date") for the purchase, which shall not be more than ninety (90) days after the expiration of the Withdrawal Notice Period.

(b) **Purchase Price**. The Purchase Price for the Class A Member's Membership Interest shall be the Appraised Value as determined under Section 14.05.

(c) **Payments Terms**. The Company may elect to pay the purchase price on the Transfer Closing Date (i) in cash, (ii) in five equal annual installments, with the first installment to be paid on the Transfer Closing Date, together with interest calculated at a minimum rate per annum at which no interest will be imputed for federal income tax purposes, or (iii) upon any other terms mutually agreed to by the Class A and B Members.

(d) **Closing**. The sale and acquisition of the Class A Member's Membership Interest (the "Closing") shall occur on the Transfer Closing Date. At such Closing, the Class A Member shall convey and assign to the Company by assignment with warranty of title, free and clear of all liens, claims, and encumbrances arising through the assignor, the Class A Member's Membership Interest and shall execute and deliver to the Company all documents that are reasonably required to give effect to the sale and acquisition of such Membership Interest, provided that the Class A Member may retain a security interest in the Economic Interest of the Class A Member's Membership Interest if the Company elects to pay the Purchase Price in five equal annual installments as set forth in Section 14.01(c)(ii). The Class A Member and the Company shall take such other actions and execute such other documents as may be necessary or appropriate to give effect to any transaction contemplated by this Section 14.01.

14.02 Involuntary Withdrawal.

Immediately upon the occurrence of an Involuntary Withdrawal, the successor of the withdrawn Member or Economic Interest Owner shall thereupon become an Economic Interest Owner but shall not become a Member without the Supermajority Vote of the remaining Members. The successor Economic Interest Owner shall have all the rights of an Economic Interest Owner, subject to the provisions of this Agreement, including the obligation to sell its Economic Interest under Section 14.03. However, neither the withdrawn Member or Economic Interest Owner nor the successor Economic Interest Owner shall be entitled to receive, in liquidation of the withdrawn Member's Membership Interest or Economic Interest Owner's Economic Interest, the fair market value of the withdrawn Member's Membership Interest or Economic Interest Owner's Economic Interest as of the date the Member or Economic Interest Owner Involuntarily Withdrew from the Company, except as otherwise provided by this Agreement.

14.03 Right to Buy Interest.

Upon the Involuntary Withdrawal of a Member or an Economic Interest Owner, the Company and the Class A and Class B Members (the "Purchasing Members"), other than the Withdrawn Member (as defined below), shall have the right to purchase all, but not less than all, of a Withdrawn Member's Economic Interest, who shall be obligated to sell, upon the receipt of an Election Notice and for the Purchase Price and on the Payment Terms as set forth herein.

(a) ***"Withdrawn Member"*** means a Member or an Economic Interest Owner who has suffered an Involuntary Withdrawal and its successors or assigns.

(b) ***Transfer Period***. Upon the occurrence of the Involuntary Withdrawal, the Withdrawn Member shall be and remain obligated to sell its Economic Interest for a period (the "Transfer Period") ending at 11:59 p.m. local time at the Company's principal office on the sixtieth (60^{th}) day following the day the Members, other than the Withdrawn Member, receive actual written notice of the Involuntary Withdrawal.

(c) ***Purchaser***. The Withdrawn Member's Economic Interest shall be purchased by the Company if the Management Committee consents to the purchase of the Economic Interest by the Company. Otherwise, the Purchasing Members shall have the right to purchase the Withdrawn Member's Economic Interest. In the event that more than one Member elects to purchase the Withdrawn Member's Economic Interest, each Member shall have the right to purchase the Withdrawn Member's Economic Interest in the same proportion as that Member's Percentage Interest bears to the total Percentage Interest of all Members who have elected to purchase the Withdrawn Member's Economic Interest.

(d) ***Manner of Election***. At any time during the Transfer Period, the Company or a Class A or Class B Member may elect to purchase the Withdrawn Member's Economic Interest by giving written notice of its election to the Withdrawn Member (the "Election Notice"). If such election is not made within the Transfer Period, any right to purchase the Withdrawn Member's Economic Interest shall be waived except as provided in any other Section of this Agreement.

(e) ***Transfer Closing Date.*** If the Company or a Class A or Class B Member elects to purchase the Withdrawn Member's Economic Interest, the Company's or the Class A or Class B Member's notice shall fix a closing date (the "Transfer Closing Date") for the purchase, which shall not be earlier than five (5) days after the expiration of the Transfer Period, nor more than sixty (60) days after the expiration of the Transfer Period.

(f) ***Purchase Price***. The Purchase Price for the Withdrawn Member's Economic Interest shall be the Appraised Value of the Withdrawn Member's Economic Interest, as determined under Section 14.05.

(g) ***Payments Terms.*** In the event that a Class A or Class B Member or the Company (the "Purchaser") exercises its right to purchase the Withdrawn Member's Economic Interest, the Purchaser may elect to pay the purchase price on the Transfer Closing Date (i) in cash, (ii) in five equal annual installments, with the first installment to be paid on the Transfer Closing Date, together with interest calculated at a minimum rate per annum at which no interest will be imputed for federal income tax purposes, or (iii) on any other terms mutually agreed to by the Withdrawn Member and the Purchaser.

(h) ***Closing.*** The sale and acquisition of the Withdrawn Member's Economic Interest (the "Closing") shall occur on the Transfer Closing Date. At such Closing, the Withdrawn Member shall convey and assign to the Purchaser by assignment with warranty of title, free and clear of all liens, claims, and encumbrances arising through the assignor, the Economic Interest of the Withdrawn Member and shall execute and deliver

to the Purchaser all documents that are reasonably required to give effect to the sale and acquisition of such Economic Interest, provided that the Withdrawn Member may retain a security interest in the Economic Interest if the Purchaser elects to pay the Purchase Price in five equal annual installments as set forth in Section 14.03(g)(ii). The Withdrawn Member and the Purchaser shall take such other actions and execute such other documents as may be necessary or appropriate to give effect to any transaction contemplated by this Section.

14.04 Dissolution Upon Involuntary Withdrawal.

Unless the Company and the Members, other than the Withdrawn Member, unanimously agree otherwise, if both the Company and the remaining Members fail to exercise their option to buy the Withdrawn Member's Economic Interest under Section 14.03, the Company shall be dissolved and liquidated pursuant to Article XV of this Agreement.

14.05 Appraised Value.

(a) The term "Appraised Value" means the appraised fair market value of an Economic Interest in the Company as hereinafter provided. The Company and the Withdrawn Member, under Section 14.03, shall each appoint, by written notice to the other within ten days of the date of the Election Notice, an appraiser to determine the fair market value of the Economic Interest (without any discount for lack of voting rights, marketability or control) being sold as of the date of the Involuntary Withdrawal. If the two appraisers agree upon the value of the Economic Interest, they shall jointly render a single written report stating that value. If the two appraisers cannot agree upon the value of the Economic Interest, they shall each render a separate written report and shall appoint a third appraiser within thirty (30) days of their appointment. The third appraiser shall determine the value of the Economic Interest being sold and shall render a written report of his or her opinion thereon. The value contained in the aforesaid joint written report or written report of the third appraiser, as the case may be, shall be the Appraised Value. However, if the value of the Economic Interest contained in the appraisal report of the third appraiser is more than the higher of the first two appraisals, the higher of the first two appraisals shall be the Appraised Value and if the value of the Economic Interest contained in the appraisal report of the third appraiser is less than the lower of the first two appraisals, the lower of the first two appraisals shall be the Appraised Value. (If either party fails to timely appoint an appraiser, or either appraiser fails to timely render a report, the value contained in the timely-rendered report of the timely-appointed appraiser shall be the Appraised Value and there shall be no need to appoint a third appraiser.) Each party shall pay the fees and costs of the appraiser appointed by that party, and the fees and other costs of the third appraiser shall be shared equally by both parties.

ARTICLE XV
DISSOLUTION AND TERMINATION

15.01 Dissolution.

The Company shall be dissolved and subsequently terminated upon:

(a) the unanimous vote or written consent of the Class A Member and the Class B Member to dissolve the Company, or as set forth in Section 14.04; or

(b) the written consent of the Class A Member to dissolve the Company, provided that: (i) the Class A Member has determined that that the continued existence and/or operation of the Company could jeopardize the status of the Class A Member as a tax-exempt organization under Code Section 501(a) as an organization described in Code section 501(c)(3); or (ii) the Company has been sanctioned or excluded from participation in any federal health care program; provided, however, that the Class B Member shall have the right to continue the business by purchasing the Class A Member's Membership Interest, within ninety (90) days of the date of the written consent, for an amount equal to the greater of the amount which the Class A Member would otherwise have received for such Membership Interest under Section 14.03 or Section 15.03.

15.02 Winding Up and Liquidation.

When the Company is dissolved, the business and property of the Company shall be wound up and liquidated by the Management Committee or a liquidator designated by the Members (the "Liquidating Trustee"). The Management Committee or the Liquidating Trustee shall use his or her or its best efforts to reduce to cash and cash equivalent items, such assets of the Company as the Management Committee or the Liquidating Trustee shall deem it advisable to sell, with consideration to obtaining fair value for such assets, and any tax or other legal considerations.

15.03 Distributions.

On winding up of the Company, the assets of the Company shall be distributed, first to creditors of the Company, including Members and Economic Interest Owners who are creditors, in satisfaction of the liabilities of the Company, and then to the Members and Economic Interest Owners in accordance with the balances in their respective Capital Accounts, after taking into account all contributions, distributions, and allocations for all periods.

15.04 Negative Capital Accounts.

Except as otherwise provided in this Agreement, no Member or Economic Interest Owner shall be obligated to restore a Negative Capital Account to the Company, and such deficit shall not be considered a debt owed to the Company or any other person for any purpose whatsoever.

ARTICLE XVI
DEFINITIONS

The following capitalized terms shall have the meanings specified in this Article XVI. Other terms are defined in the text of this Agreement, and throughout this Agreement, those terms shall have the meanings respectively ascribed to them.

Act.

"Act" shall mean the Connecticut Limited Liability Company Act, as amended from time to time.

Adjusted Capital Account Deficit.

"Adjusted Capital Account Deficit" means, with respect to any Member or Economic Interest Owner, the deficit balance, if any, in the Member's or Economic Interest Owner's Capital Account as of the end of the relevant taxable year, after giving effect to the following adjustments:

(i) the Member's or Economic Interest Owner's Capital Account shall be increased by the amount that the Member or the Economic Interest Owner is obligated to restore, or is deemed obligated to restore pursuant to Regulation Section 1.704-1(b)(2)(ii)(c) and the penultimate sentences of Regulation Sections 1.704-2(g)(1) and 1.704-2(i)(5); and

(ii) the Member's or Economic Interest Owner's Capital Account shall be decreased by the items described in Regulation Sections 1.704-1(b)(2)(ii)(d)(4), (5), and (6).

The foregoing definition of Adjusted Capital Account Deficit is intended to comply with the provisions of Section 1.704-1(b)(2)(ii)(d) of the Regulations and shall be interpreted consistently therewith.

Affiliate.

"Affiliate" shall mean, with respect to a Member or Connecticut GI, P.C. or MidState Gastroenterology Specialists, P.C., any other Person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the Member or Connecticut GI, P.C. or MidState Gastroenterology Specialists, P.C. All Physician Members, and any Person directly or indirectly owned by a Physician Member, shall be deemed to be Affiliates of the Class B Member. Notwithstanding any other provision of this Agreement to the contrary, for purpose of Article XI only, "Affiliate", in the case of the Class B Member, shall mean exclusively a Person owned exclusively by the Physician Owners of the Class B Member immediately prior to the subject Transfer.

Agreed Value.

"Agreed Value" shall mean the fair market value of an asset as of the date of valuation, which shall be determined by the Supermajority Vote of the Members or, if they cannot so agree, by an independent appraiser selected by the Management Committee.

Applicable Law.

"Applicable Law" shall mean each and every applicable federal, state or local law, statute, charter, ordinance, rule, regulation, order, license certification and accreditation standard of any governmental, regulatory or administrative agency or authority or court or other tribunal,

including but not limited to the Connecticut Public Health Code and any decision issued by the Connecticut Office of Health Care Access with regard to the application for a certificate of need to be filed with respect to the Center.

Arbitrable Issue.

"Arbitrable Issue" shall mean any one or more of the following: (i) an alleged breach of this Agreement; (ii) a dispute regarding the interpretation or implementation of this Agreement, including without limitation the Company's Charity Care Policy; (iii) [Redacted].

Articles of Organization.

"Articles of Organization" shall mean the Articles of Organization of the Company as filed with the Connecticut Secretary of the State, as amended from time to time.

Capital Account.

"Capital Account" shall mean the account maintained by the Company for each Member and Economic Interest Owner in accordance with the following provisions:

> (iii) a Member's or Economic Interest Owner's Capital Account shall be credited with the Member's or Economic Interest Owner's Capital Contributions, the amount of any Company liabilities assumed by the Member or the Economic Interest Owner (or that are secured by Company property distributed to the Member or the Economic Interest Owner), the Member's or Economic Interest Owner's distributive share of Profit, and any item in the nature of income or gain specially allocated to such Member or Economic Interest Owner pursuant to the provisions of Article IX (other than Section 9.04); and
>
> (iv) a Member's or Economic Interest Owner's Capital Account shall be debited with the amount of money and the fair market value of any Company property distributed to the Member or the Economic Interest Owner, the amount of any liabilities of the Member or the Economic Interest Owner assumed by the Company (or that are secured by property contributed by the Member or the Economic Interest Owner to the Company), the Member's or Economic Interest Owner's distributive share of Loss, and any item in the nature of expenses or loss specially allocated to the Member or the Economic Interest Owner pursuant to the provisions of Article IX (other than Section 9.04).

If any Economic Interest is transferred pursuant to the terms of this Agreement, the transferee shall succeed to the Capital Account of the transferor to the extent the Capital Account is attributable to the transferred Economic Interest. If the book value of Company property is adjusted pursuant to Section 9.03(d), the Capital Account of each Member and Economic Interest Owner shall be adjusted to reflect the aggregate adjustment in the same manner as if the Company had recognized gain or loss equal to the amount of such aggregate adjustment.

In connection with a Capital Contribution of money or other property (other than a de

minimis amount) by a new or existing Member or Economic Interest Owner as consideration for an Economic Interest or Membership Interest, or in connection with the liquidation of the Company or a distribution of money or other property (other than a de minimis amount) by the Company to a retiring Member or Economic Interest Owner (as consideration for an Economic Interest or Membership Interest), the Capital Accounts of the Members shall be adjusted to reflect a revaluation of Company property (including intangible assets) to its Agreed Value in accordance with Regulation Section 1.704-l(b)(2)(iv)(f). Any differences in the adjusted tax basis of Company property and the Agreed Value hereunder shall be accounted for under the principles set forth in Section 9.04.

It is intended that the Capital Accounts of all Members and Economic Interest Owners shall be maintained in compliance with the provisions of Regulation Section 1.704-1(b), and all provisions of this Agreement relating to the maintenance of Capital Accounts shall be interpreted and applied in a manner consistent with that Regulation.

Capital Contribution.

"Capital Contribution" shall mean any contribution to the capital of the Company in cash or property by a Member or Economic Interest Owner whenever made.

Center.

"Center" shall mean the endoscopy center to be operated by the Company in Wallingford, Connecticut.

Change in Control.

"Change in Control" means:

(b) With respect to the Class B Member, less than fifty percent (50%) of the ownership interests in the Class B Member that are owned by physicians on the active medical staff of a hospital are owned by licensed gastroenterologists who are then on the active medical staff of MidState Medical Center; and

(c) With respect to the Class A Member, if, within one year after a merger or other reorganization involving Persons other than only then Affiliates of the Class A Member, more than fifty percent (50%) of the Persons electing the Board of Directors of the Class A Member are different than the Persons electing the Board of Directors of the Class A Member immediately prior to such reorganization.

Charity Care Policy.

"Charity Care Policy" shall mean the charity care policy of the Class A Member attached as Exhibit E to this Agreement and the Financial Assistance Policy available at https://hartfordhealthcare.org/patients-visitors/patients/billing-insurance/financial-assistance as amended from time to time by Class A Member and adopted by the Management Committee or as provided in this Agreement [Redacted].

Claim.

"Claim" shall mean an action, suit, audit, proceeding, hearing, investigation, litigation, charge, complaint, claim, assessment or demand.

Class A Managers.

"Class A Managers" shall mean the individual Managers designated by the Class A Member pursuant to Section 6.01(a) hereof.

Class A Member.

"Class A Member" means MidState Medical Center and its successors and assigns to the Class A Membership Interest and has been duly admitted as a Class A Member of the Company in accordance with the terms and conditions of this Agreement.

Class A Membership Interest.

"Class A Membership Interest" means a Membership Interest in the Company described in Section 2.02 hereof that is not a Class B Membership Interest. Each Member's Percentage Interest in the Class A Membership Interests are initially set forth in Section 2.02 and on Exhibit A.

Class B Managers.

"Class B Managers" shall mean the individual Managers designated by the Class B Member pursuant to Section 6.01(a) hereof.

Class B Member.

"Class B Member" means MEC and its successors and assigns to the Class B Membership Interest and has been duly admitted as a Class B Member of the Company in accordance with the terms and conditions of this Agreement.

Class B Membership Interest.

"Class B Membership Interest" means a Membership Interest in the Company described in Section 2.02 hereof that is not a Class A Membership Interest. Each Member's Percentage Interest in the Class B Membership Interests are set forth on Exhibit A.

[Redacted].

Code.

"Code" shall mean the Internal Revenue Code of 1986, as amended, or the corresponding provisions of subsequent and superseding federal revenue laws.

Company.

"Company" shall mean Wallingford Endoscopy Center, LLC.

[Redacted].

Connecticut GI, P.C.

"Connecticut GI, P.C." shall mean Connecticut GI, P.C., a Connecticut professional service corporation, with an address at 85 Seymour Street, #1000, Hartford, Connecticut 06106, and its successors.

Costs.

"Costs" shall mean any and all liabilities, losses, damages, Claims, sanctions, exclusions, taxes, interest, penalties, fines, costs and expenses (including without limitation, reasonable expenses of investigation and court costs, reasonable attorneys' fees and disbursements and the reasonable fees and disbursements of other professionals).

Economic Interest.

"Economic Interest" shall mean a Member's or Economic Interest Owner's share of the Profit and Loss of and the right to receive distributions from the Company pursuant to this Agreement and the Act, but shall not include any right to participate in the management or affairs of the Company, including the right to vote on, consent to, or otherwise participate in any decision of the Members.

Economic Interest Owner.

"Economic Interest Owner" shall mean the owner of an Economic Interest who is not a Member.

[Redacted].

[Redacted].

[Redacted].

Majority in Interest.

"Majority in Interest" means the Members holding a majority of the Percentage Interests then held by the Members.

Manager.

"Manager" shall mean the Person or Persons designated to manage the business and affairs of the Company pursuant to Article VI hereof.

Management Committee.

"Management Committee" shall mean the Managers designated to manage the business and affairs of the Company pursuant to Article VI hereof.

[Redacted].

Medical Staff.

"Medical Staff" shall have the meaning set forth in Section 8.01 hereof.

Member.

"Member" shall mean each of the parties who executes a counterpart of this Agreement as a Member and each of the parties who may hereafter become a Member in accordance with the terms hereof. If a Person is a Member immediately prior to the purchase or other acquisition by such Person of a Membership Interest or an Economic Interest, such Person shall have all the rights of a Member with respect to such purchased or otherwise acquired Membership Interest or Economic Interest, as the case may be. A Member shall cease to be a Member upon the sale or other transfer of his or her entire Economic Interest in the Company and shall not be deemed a Member with respect to any Percentage Interest in which he or she has sold or otherwise transferred his or her entire Economic Interest.

Member Nonrecourse Debt Minimum Gain.

"Member Nonrecourse Debt Minimum Gain" has the meaning set forth in Regulation Section 1.704-2(i)(3). Member Nonrecourse Debt Minimum Gain shall be computed separately for each Member and Economic Interest Owner in a manner consistent with the Regulations under Code Section 704(b).

Member Nonrecourse Deductions.

"Member Nonrecourse Deductions" means any Company deductions that would be Nonrecourse Deductions, if they were not attributable to a loan made or guaranteed by a Member or Economic Interest Owner within the meaning of Regulation Section 1.704-2(b)(4).

Member Representatives.

"Member Representatives" shall mean those individuals designated by the Members pursuant to Article II hereof.

Membership Interest.

"Membership Interest" shall mean a Member's entire interest in the Company including such Member's Economic Interest and the right to participate in the management of the business and affairs of the Company, including the right to vote on, consent to, or otherwise participate in any decision or action of or by the Members granted pursuant to this Agreement and the Act.

MidState Gastroenterology Specialists, P.C.

"MidState Gastroenterology Specialists, P.C." shall mean MidState Gastroenterology Specialists, P.C., a Connecticut professional services corporation with an address at 455 Lewis Avenue, #105, Meriden, CT 06451, and its successors.

MidState Medical Center.

"MidState Medical Center" shall mean MidState Medical Center or any Affiliate of MidState Medical Center [Redacted].

Minimum Gain.

"Minimum Gain" has the meaning set forth in Regulation Sections 1.704-2(b)(2) and 1.704-2(d). Minimum Gain shall be computed separately for each Member and Economic Interest Owner in a manner consistent with the Regulations under Code Section 704(b).

Negative Capital Account.

"Negative Capital Account" means a Capital Account with a balance of less than zero.

Nonrecourse Deductions.

"Nonrecourse Deductions" has the meaning set forth in Regulation Section 1.704-2(b)(1). The amount of Nonrecourse Deductions for a taxable year of the Company equals the net increase, if any, in the amount of Minimum Gain during that taxable year, determined according to the provisions of Regulation Section 1.704-2(c).

Nonrecourse Liability.

"Nonrecourse Liability" means any liability of the Company with respect to which no Member or Economic Interest Owner has personal liability determined in accordance with Regulation Section 1.752-1(a)(2).

Percentage Interest.

"Percentage Interest" shall mean, as to a Member, the percentage set forth after the Member's name on Exhibit A, as amended from time to time, and as to an Economic Interest Owner who is not a Member, the Percentage Interest of the Member whose Economic Interest has been acquired by such Economic Interest Owner, to the extent the Economic Interest Owner has succeeded to that Member's Economic Interest.

Person.

"Person" shall mean any individual, general partnership, limited partnership, limited liability company, corporation, joint venture, trust, business trust, cooperative, association, foreign trust or foreign business organization and the heirs, executors, administrators, legal representatives, successors, and assigns of such "Person" where the context so permits.

Profit and Loss.

"Profit" and "Loss" shall mean, for each taxable year of the Company (or other period for which Profit or Loss must be computed) the Company's taxable income or loss determined in accordance with Code Section 703(a), with the following adjustments:

(i) all items of income, gain, loss, deduction, or credit required to be stated separately pursuant to Code Section 703(a)(1) shall be included in computing taxable income or loss;

(ii) any tax-exempt income of the Company, not otherwise taken into account in computing taxable income or loss, shall be included in computing Profit or Loss;

(iii) any expenditures of the Company described in Code Section 705(a)(2)(B) (or treated as such pursuant to Regulation Section 1.704-1(b)(2)(iv)(i)) and not otherwise taken into account in computing taxable income or loss, shall be subtracted from Profit or Loss;

(iv) gain or loss resulting from any taxable disposition of Company property shall be computed by reference to the adjusted book value of the property disposed of, notwithstanding the fact that the adjusted book value differs from the adjusted basis of the property for federal income tax purposes; and

(v) in lieu of the depreciation, amortization, or cost recovery deductions allowable in computing taxable income or loss, there shall be taken into account the depreciation computed based upon the adjusted book value of the asset.

Regulation(s).

"Regulation" or "Regulations" shall mean the income tax regulations promulgated under the Code by the United States Department of the Treasury, including proposed, temporary and final regulations.

Shortfall.

"Shortfall" shall have the meaning set forth in Section 9.06(d) hereof.

[Redacted].

Supermajority Vote.

"Supermajority Vote" means (a) the vote of the Members holding at least seventy six (76%) percent of the Percentage Interests of the Company or (b) the vote of Member Representatives whose Member's hold at least seventy six (76%) percent of the Percentage Interests in the Company.

Transfer.

"Transfer" means, when used as a noun, any sale, hypothecation, pledge, assignment, attachment, gift, bequest, exchange, conveyance, encumbrance or any other form of disposition, whether voluntary or involuntary, by direct or indirect means, or by merger, consolidation or otherwise, and, when used as a verb, means, to sell, hypothecate, pledge, assign, gift, bequeath, exchange, convey, encumber or otherwise dispose of, whether voluntary or involuntary, by direct or indirect means, or by merger, consolidation or otherwise; provided, however, that "Transfer" shall not include a Transfer by the Class A Member or the Class B Member to an Affiliate of the transferor.

Voluntary Withdrawal.

"Voluntary Withdrawal" means the disassociation of a Member or an Economic Interest Owner from the Company by means other than by a Transfer or an Involuntary Withdrawal.

MEC.

"MEC" shall mean MidState Endoscopy Center Holdings, LLC, a Connecticut limited liability company, all of the beneficial interests of which are owned by stockholders of Connecticut GI, P.C. and MidState Gastroenterology Specialists, P.C., with an address at [85 Seymour Street, #1000, Hartford, Connecticut 06106], or any Affiliate of MEC [Redacted].

ARTICLE XVII
MISCELLANEOUS PROVISIONS

17.01 [Redacted].

17.02 Power of Attorney.

(a) Each Member constitutes and appoints each Manager as the Member's true and lawful attorney-in-fact ("Attorney-In-Fact"), and in the Member's name, place and stead, to make, execute, sign, acknowledge, and file or cause to be made, executed, signed, acknowledged and filed:

(i) all documents (including amendments to the Articles of Organization) that the Attorney-In-Fact deems appropriate to reflect any amendment, change, or modification of this Agreement;

(ii) any and all other certificates or other instruments required to be filed by the Company under the laws of the State of Connecticut or of any other state or jurisdiction, including, without limitation, any certificate or other instruments necessary in order for the Company to continue to qualify as a limited liability company under the laws of the State of Connecticut;

(iii) one or more applications to use an assumed name; and

(iv) all documents that may be required to dissolve and terminate the Company and to cancel its Articles of Organization.

(b) The foregoing power of attorney is irrevocable and is coupled with an interest, and to the extent permitted by Applicable Law, shall survive the death, disability or dissolution of a Member. It also shall survive the transfer of a Membership Interest or an Economic Interest, except that if the transferee is approved for admission as a Member, this power of attorney shall survive the delivery of the assignment for the sole purpose of enabling the Attorney-in-Fact to execute, acknowledge, and file any documents needed to effectuate the substitution. Each Member shall be bound by any representations made by the Attorney-in-Fact acting in good faith pursuant to this power of attorney, and each Member hereby waives any and all defenses that may be available to contest, negate, or disaffirm the action of the Attorney-in-Fact taken in good faith under this power of attorney.

17.03 Notices.

Any notice, demand, consent, approval, communication or other document required or permitted to be given hereunder shall be in writing and delivered personally or sent by registered or certified mail, postage prepaid, or a nationally recognized overnight delivery service (receipt requested), to the Member's or the Company's address, as appropriate, which is set forth in this Agreement, or to such other address for the party as shall be specified by like notice. Any notice that is delivered personally in the manner provided herein shall be deemed to have been duly given to the party to whom it is directed upon actual receipt by such party. Any notice that is addressed and mailed or delivered overnight in the manner herein provided shall be duly given when received by the addressee.

17.04 Application of Connecticut Law.

This Agreement and its interpretation shall be governed exclusively by its terms and by the laws of the State of Connecticut (without regard to principles of conflicts of law), and specifically the Act.

17.05 Jurisdiction and Venue.

Any suit involving any dispute or matter arising under this Agreement may only be brought in the United States District Court for the District of Connecticut or any Connecticut State Court having jurisdiction over the subject matter of the dispute or matter. All Members and Economic Interest Owners hereby consent to the exercise of personal jurisdiction by any

such court with respect to any such proceeding.

17.06 Amendments.

(a) This Agreement and the Articles of Organization may be amended upon a Supermajority Vote of the Member Representatives or by a written consent signed by all the Member Representatives.

(b) [Redacted] this Agreement and the Articles of Organization may be amended upon a unanimous vote of the Class A Managers, provided that the Class A Managers have reasonably determined, based on the written advice of counsel, that such amendment or amendments are necessary to prevent the Class A Member from losing its status as a tax-exempt organization under Code Section 501(a) as an organization described in Code Section 501(c)(3).

17.07 Execution of Additional Instruments.

Each Member hereby agrees to execute such other and further statements of interest and holdings, designations and other instruments necessary to comply with any Applicable Law, rules or regulations.

17.08 Construction.

When required by the context, the singular number whenever used in this Agreement shall include the plural and vice-versa, and the masculine gender whenever used in this Agreement shall include the feminine and neuter genders and vice-versa.

17.09 Headings.

The headings in this Agreement are inserted for convenience only and are in no way intended to describe, interpret, define, or limit the scope, extent or intent of this Agreement or any provision hereof.

17.10 Waivers.

The failure of any party to seek redress for default of or to insist upon the strict performance of any covenant or condition of this Agreement shall not prevent a subsequent act, that would have originally constituted a default, from having the effect of an original default.

17.11 Rights and Remedies Cumulative.

The rights and remedies provided by this Agreement are cumulative and the use of any one right or remedy by any party shall not preclude or waive the right to use any other remedy. The rights and remedies provided by this Agreement are given in addition to any other legal rights the parties may have.

17.12 Severability.

If any provision of this Agreement or the application thereof to any person or circumstance shall be invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

17.13 Specific Performance.

The parties recognize that irreparable injury will result from a breach of any provision of this Agreement and that money damages will be inadequate to fully remedy the injury. Accordingly, in the event of a breach or threatened breach of one or more of the provisions of this Agreement, any party who may be injured (in addition to any other remedies that may be available to that party) shall be entitled to one or more preliminary or permanent orders (i) restraining and enjoining any act that would constitute a breach or (ii) compelling the performance of any obligation that, if not performed, would constitute a breach.

17.14 Successors and Assigns.

The covenants, terms, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto and to the extent permitted by this Agreement, their respective successors and assigns.

17.15 Creditors.

None of the provisions of this Agreement shall be for the benefit of or enforceable by any creditors of the Company.

17.16 Dispute Resolution.

(a) [Redacted], all disputes, claims, controversies and differences arising out of or relating to this Agreement, or the termination, invalidity or breach hereof, including without limitation any deadlock in a vote of the Member Representatives, shall first be submitted by a party by written notice to, and for resolution by, the Management Committee. Within ten (10) days of receipt of such notice, the Management Committee shall meet and attempt to resolve such matter. If the Management Committee is unable to resolve the matter within such ten day-period (or the dispute originated with the Management Committee), the party may refer the matter by written notice to, and for resolution by, the chief executive officers of the Class A and Class B Members. Such chief executive officers shall meet at the principal office of the Company, or at such other location as they may agree, within fourteen (14) days of the notice from the party to negotiate in good faith a resolution of the matter. If within twenty-one (21) days of the written notice from the party the mater still has not been resolved, and such matter involves an Arbitrable Issue, the party may submit the dispute to arbitration pursuant to Section 17.16(b) of this Agreement.

(b)

(i) If an Arbitrable Issue has not been resolved pursuant to the

procedures provided for in Section 17.16(a), a party may, by written notice to the other Members, submit the Arbitrable Issue to be determined by arbitration in the City of Hartford, Connecticut, in accordance with the Commercial Arbitration Rules of the American Arbitration Association (except as otherwise specified in this Section 17.16). The dispute shall be determined by one (1) arbitrator acceptable to both parties who shall be selected within fourteen (14) days of receipt of notice of intention to arbitrate by the party receiving that notice. If the receiving party fails to respond to said notice in writing within said fourteen (14) days, then the party providing said notice shall select the arbitrator and the arbitrator selected by the party providing said notice shall be deemed to have been selected by the receiving party. If, by the end of said fourteen (14) day period the parties have not agreed upon one (1) arbitrator as acceptable, then the dispute shall be determined by a panel of three (3) arbitrators selected as follows: Within an additional seven (7) days, each party will appoint one (1) arbitrator. These two (2) arbitrators will then, within an additional seven (7) days, name a third arbitrator. If the two (2) arbitrators are unable to agree upon the choice of a third arbitrator within seven (7) days, either party may request the person or entity administering the arbitration, or, if none, the American Arbitration Association or any other arbitration administering person or entity, to appoint the necessary arbitrator pursuant to the Commercial Arbitration Rules.

(ii) As soon as the arbitrator has been chosen or if three are utilized, the panel has been convened, a hearing date shall be set within thirty (30) days thereafter. Such hearing date shall be subject to the mutual agreement of the parties and the arbitrator(s), but if such agreement cannot be reached, the arbitrator(s) shall have authority to establish such times for hearings as he, she or they deem appropriate. Written submissions shall be presented and exchanged by both parties fifteen (15) days before the hearing date, including reports prepared by any expert upon whom either party intends to rely. At such time the parties shall also exchange copies of all documentary evidence upon which they will rely at the arbitration hearing and a list of the witnesses whom they intend to call to testify at the hearing. Each party shall also make its respective experts available for deposition by the other party prior to the hearing date. The arbitrator(s) shall make his or her award as promptly as practicable after conclusion of the hearing. Arbitrators shall be compensated for their services at the standard hourly rate charged in their private professional activities.

(iii) The parties acknowledge that the United States District Court for the District of Connecticut has jurisdiction over the parties for the purpose of enforcing this Section 17.16. Connecticut rules of civil procedure and evidence shall apply with respect to any arbitration hereunder, including all rules pertaining to discovery and inspection. The award may be made solely on the default of a party. The arbitrator(s) shall follow substantive rules of law. The arbitrator(s) shall make the award in strict conformity with this Agreement and shall have no power to depart from or change any of the provisions hereof. If three arbitrators are used, a decision of any two of them shall be binding. At the request of either party at the start of the arbitration, the award of the arbitrator(s) shall be

accompanied by findings of fact and a written statement of reasons for the decision. The arbitrator(s) shall have the discretion to award the costs of arbitration, arbitrators' fees and the respective attorneys' fees of each party between the parties as they see fit. All parties agree to be bound by the results of this arbitration; judgment upon the award so rendered may be entered and enforced in any court of competent jurisdiction, including the power to require specific performance. To the extent reasonably practicable, both parties agree to continue performing their respective obligations under this Agreement while the dispute is being resolved. All matters relating to any arbitration hereunder shall be maintained in confidence.

(iv) Nothing contained in this Section 17.15 shall prohibit either party from seeking equitable relief without first resorting to arbitration under such circumstances as that party's interests hereunder and in its property will be otherwise compromised.

17.17 Indemnification for Violations of Law.

(a) Each Member and Economic Interest Owner (each, an "Indemnitor") shall indemnify, hold harmless and defend the Company and each other Member, Economic Interest Owner and their respective directors, officers, owners, employees, representatives and agents (each an "Indemnitee" and collectively, the "Indemnitees") from and against any Costs incurred by the Indemnitees that arise from or are related to: (i) a violation of the anti-kickback provisions of Applicable Law by the Indemnitor or any of its directors, officers, owners, employees, representatives or agents relating to the Company and/or the Center, and such violation of Applicable Law is not cured by the Indemnitor at its sole cost and expense within sixty (60) days of the notice provided for in the first sentence of Section 17.17(b); and/or (ii) the enforcement of this indemnity.

(b) If there occurs an event which a party asserts is an indemnifiable event pursuant to this Section 17.17, the parties seeking indemnification shall promptly notify the other parties obligated to provide indemnification (collectively, the "Indemnifying Party"). If such event involves (i) any Claim or (ii) the commencement of any action, suit or proceeding by a third person, the party seeking indemnification will give such Indemnifying Party prompt written notice of such Claim or the commencement of such action, suit or proceeding, provided, however, that the failure to provide prompt notice as provided herein will relieve the Indemnifying Party of its obligations hereunder only to the extent that such failure prejudices the Indemnifying Party hereunder. In case any such action, suit or proceeding shall be brought against any party seeking indemnification and it shall notify the Indemnifying Party of the commencement thereof, the Indemnifying Party shall be entitled to participate therein and, to the extent that it desires to do so, to assume the defense thereof, with counsel reasonably satisfactory to such party seeking indemnification and, after notice from the Indemnifying Party to such party seeking indemnification of such election so to assume the defense thereof, the Indemnifying Party shall not be liable to the party seeking indemnification hereunder for any attorneys' fees or any other expenses, in each case subsequently incurred by such party, in connection with the defense of such action, suit or proceeding. The party

seeking indemnification agrees to cooperate fully with the Indemnifying Party and its counsel in the defense against any such action, suit or proceeding. In any event, the party seeking indemnification shall have the right to participate at its own expense in the defense of such action, suit or proceeding. In no event shall an Indemnifying Party be liable for any settlement or compromise effected without its prior consent. If, however, the party seeking indemnification refuses its consent to a bona fide offer of settlement which the Indemnifying Party wishes to accept (which must include the unconditional release of the parties seeking indemnification from all liability with respect to the Claim at issue), the party seeking indemnification may continue to pursue such matter, free of any participation by the Indemnifying Party, at the sole expense of the party seeking indemnification. In such event, the obligation of the Indemnifying Party to the party seeking indemnification shall be equal to the lesser of (i) the amount of the offer or settlement which the party seeking indemnification refused to accept plus the costs and expenses of such party prior to the date the Indemnifying Party notifies the party seeking indemnification of the offer of settlement and (ii) the actual out-of-pocket amount the party seeking indemnification is obligated to pay as a result of such party's continuing to pursue such matter.

(c) The amount which an Indemnifying Party is required to pay to, for or on behalf of any other party (hereinafter referred to as an "Indemnitee") pursuant to this Section 17.17 shall be adjusted (including, without limitation, retroactively) by any insurance proceeds actually recovered by or on behalf of such Indemnitee in reduction of the related indemnifiable loss (the "Indemnifiable Loss"). Amounts required to be paid, as so reduced, are hereafter sometimes called an "Indemnity Payment." If an Indemnitee shall have received or shall have had paid on its behalf an Indemnity Payment in respect of an Indemnifiable Loss and shall subsequently receive insurance proceeds in respect of such Indemnifiable Loss, then the Indemnitee shall pay to the Indemnifying Party the amount of such insurance proceeds or, if less, the amount of the Indemnity Payment.

17.18 Counterparts.

This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

[The rest of this page is intentionally left blank.]

IN WITNESS WHEREOF, the parties hereto have caused their signatures, or the signatures of their duly authorized representatives, to be set forth below on the day and year first above written.

MEMBERS:

[SIGNATURE BLOCK]

EXHIBIT A

MEMBERS, MEMBER PERCENTAGE INTEREST AND CLASS OF MEMBERSHIP INTEREST

Name and Address	Percentage Interest	Class of Member-ship Interest
MidState Medical Center 435 Lewis Avenue Meriden, CT 06451	51%	A
Wallingford Endoscopy Center Physicians, LLC _____ _____	49%	B

EXHIBIT B

MEMBER REPRESENTATIVES
AND
MANAGEMENT COMMITTEE MEMBERS

MEMBER REPRESENTATIVES

MidState Medical Center Representative:

MidState Endoscopy Center Holdings, LLC Representative:

[ ], M.D.

MANAGEMENT COMMITTEE MEMBERS

MidState Medical Center (Class A) Managers:

MidState Endoscopy Center Holdings, LLC (Class B) Managers:

EXHIBIT C

CHARITY CARE POLICY

See attached Class A Member Charity Care Policy.

CHARITY CARE POLICY

This policy, as amended from time to time, shall apply to the Company's Glastonbury Surgery Center, LLC (the "Center") and shall be enforced by the Management Committee.

1. **Promotion of Health in the Community**. The Center shall be responsible for the holding annually of free health educational programs and seminars as determined by the Management Committee, and will otherwise promote the health of the community served by the Center.

2. **Medicare and Medicaid Patients**. The Center shall accept patients covered by Medicare and Medicaid.

3. **Charity Care**. In accordance with the Financial Assistance Policy attached hereto, the Center shall provide free or reduced charge health care services to the poor or indigent, based on ability to pay. Charity care for this purpose shall not include contractual allowances. Ability to pay shall be determined on the basis of the patient's income relative to the federal poverty level, his or her net assets, and any other hardship factors.

4. **Debt Collection**. While the Center may institute collection proceedings against those who appear able to pay, it shall not be the primary moving party to foreclose a security interest in a patient's primary residence in collection of the debt.

5. **Administration**. The Center shall assure that there are adequate notices on premises about the availability of charity care. Billing and admissions staff shall be trained in the application process and in the overall Charity Care Policy.

6. **Reports**. The Medical Director shall cause a report detailing compliance with this Charity Care Policy to be prepared and submitted for the review of the Management Committee of the Company each calendar quarter during the term of this Operating Agreement. The Management Committee shall cause the Medical Director to take prompt action to require compliance with this Charity Care Policy should the aforementioned reports evidence noncompliance, in whole or in part, with this policy.

Exhibit 6: Draft Transfer Agreement between MidState Medical Center and WEC.

TRANSFER AGREEMENT BETWEEN

MIDSTATE MEDICAL CENTER
435 LEWIS AVE
MERIDEN, CT 06451
("Hospital")

AND

WALLINGFORD ENDOSCOPY CENTER, LLC

Name of Facility

863 NORTH MAIN STREET EXTENSION

Street Address

WALLINGFORD, CT 06492

City, State, and ZIP Code
("Facility")

To facilitate continuity of care and the timely transfer of patients and records between the Hospital and the Facility, the parties named above agree as follows:

1. Both parties shall make their facilities available to receive and care for all patients who in the professional opinion of the patient's physician would receive more appropriate treatment or care in the receiving institution; provided that at the time of the proposed transfer, the receiving institution shall have the facilities available for the proper care for the transferring patient, in accordance with federal and state laws and regulations.

2. The transferring institution will send with each patient at the time of transfer and whenever possible with the driver of the vehicle which transports the patient, or in the case of emergency, as promptly as possible the completed transfer and referral forms mutually agreed upon to provide the medical and administrative information necessary to determine the appropriateness of the placement and to enable continuing care to the patient. The transfer and referral forms will include such information as current medical findings, diagnoses, a brief summary of the course of treatment followed in the transferring institution, nursing and dietary information, discharge medication list, ambulation status, and pertinent administrative and social information, as appropriate.

3. The Hospital shall make available its diagnostic and therapeutic services for emergency care, on an outpatient basis, as ordered or referred by the attending physician subject to federal and state laws and regulations and Hospital's policies and procedures.

4. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.

5. The transferring institution will be responsible for effecting the transfer of the patient, including arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations.

6. The receiving institution will have responsibility for the care of the patient upon acceptance of admission.

7. Each institution shall be solely responsible for billing and collecting charges which result from services it rendered to the patient. Charges for services performed by either facility shall be collected by the institution rendering such services, directly from the patient, third-party payer, or other sources normally billed by the institution. Neither facility shall have any liability to the other for such charges. However, each transferring institution will provide the receiving institution with appropriate information it possesses pertinent to the financial status of the patient, the responsible party for the patient and any applicable information on benefit or insurance coverage.

8. The governing body of each facility shall have exclusive control of policies, management, assets, and affairs of its respective institutions. Neither institution shall assume any liability by virtue of the agreement for any debts or other obligations of either a financial or legal nature incurred by the other party to this agreement.

9. Nothing in this agreement shall be construed as limiting the rights of either institution to contract with any other facility on a limited or general basis.

10. This agreement shall be in effect from the effective date identified below and shall remain in force unless terminated by (i) either facility providing thirty (30) days prior written notice; or (ii) immediately upon the revocation of either party's license to operate by the State of Connecticut or the failure of either party to be properly certified to participate in Medicare or Medicaid.

11. Any dispute arising under this agreement shall be discussed directly by the Administrator of the Facility and the director of Case Management at MidState Medical Center. If no agreement is reached, the Director of Case Management will bring the matter to the attention of the MidState Medical Center Administration.

12. This agreement may be modified or amended by mutual agreement of the parties in writing,

13. Nothing in this agreement shall be construed as allowing the use of the other party's name in any promotional or advertising material without the prior written approval of the institution whose name is to be used.

IN WITNESS THEREFORE, the parties hereto are duly authorized to execute this agreement to be effective on the __ day of _____, 2016.

MIDSTATE MEDICAL CENTER	**WALLINGFORD ENDOSCOPY CENTER, LLC**
By:_____	By: _____
Printed Name: _____	Printed Name: _____
Its: _____	Its: _____
Date: _____	Date: _____

Exhibit 7: Hartford Healthcare's Financial Assistance Policy.

Hartford HealthCare	**Subject:** **Financial Assistance Policy**	
Issuing Department: **Finance/Revenue Cycle Services** **Subject Matter Consultation:** Legal Services	**File Under:** _____ Section - _____	**Original Date:** 12/16/2010
Latest Revision Date: January 1, 2016 September 20, 2016	1) **Page 1 of 13**	**Approved By:** _____ Charles L. Johnson, III HHC Executive Vice President & Chief Financial Officer

Purpose: The purpose of this Policy is to set forth the Hartford HealthCare (HHC) policy for the provision of free or discounted Health Care Services to patients who meet the criteria for Financial Assistance. This Policy describes: (i) the eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted Health Care Services; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for Financial Assistance; (iv) the collection actions that may be initiated in the event of non-payment, including civil collections actions and reporting to consumer credit reporting agencies; and (v) the Hospital's approach to presumptive eligibility determinations and the types of information that the Hospital will use to assess presumptive eligibility.

This Policy is intended to comply with Section 501(r) of the Internal Revenue Code and the billing and collection requirements described in Chapter 368z of the Connecticut General Statutes and any regulations promulgated thereunder and must be interpreted and applied in accordance with those laws and regulations. This Policy will be adopted by the governing body of Hartford HealthCare on behalf of its affiliates.

Scope: This Policy applies to all Health Care Services provided by a Hartford HealthCare hospital facility. (Facilities listed in Appendix D)

Definitions:

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient qualifies for Financial Assistance for the Health Care Services provided.

"EMTALA" means the Emergency Medical Treatment and Labor Act, 42 USC 1395dd.

"Extraordinary Collection Activity"(ECA) means a collection action requiring a legal or judicial process, involving selling debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under HHC's Financial Assistance Policy. The actions that require legal or judicial process for this purpose include 1) placing a lien; 2) foreclosing on real property; 3) attaching or seizing of bank accounts or other personal property; 4) commencing a civil action against an individual; 5) taking actions that cause an individual's arrest; 6) taking actions that cause an individual to be subject to body attachment; and 7) garnishing wages.

"Family" means, pursuant to the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption. For purposes of this Policy, if the patient claims someone as a dependent on the patient's income tax return, that person may be considered a dependent for purposes of the provision of Financial Assistance.

"Family Income" means the following income when calculating Federal Poverty Level Guidelines of liquid assets: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, business income, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources of income. .

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services in effect on the date of the provision of the Health Care Service for awards of Financial Assistance under this Policy.

"Financial Assistance" means free or discounted Health Care Services provided to persons who, pursuant to the Eligibility Criteria, HHC has determined to be unable to pay for all or a portion of such Health Care Services and to be eligible for free or discounted Health Care Services under this Policy.

"Free Bed Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor to a HHC hospital facility for the purpose of establishing a fund to provide medical care to a patient.

"Health Care Services" means (i) emergency medical services as defined by EMTALA; (ii) services for a condition which, if not promptly treated, will result in adverse change in the health status of the individual; (iii) non-elective services provided in response to life-

threatening circumstances in a non-emergency department setting; and (iv) medically necessary services as determined by HHC on a case-by-case basis at the provider's discretion.

"Liquid Assets" refers to how easily an asset can be exchanged for cash on short notice, without losing value. Items such as cash, gold or marketable securities are examples. On the converse, nonliquid asset examples are real estate (land and housing) and automobiles.

"Medically Indigent" means a person who HHC has determined to be unable to pay some or all of his or her medical bills because the medical bills exceed a certain percentage of the person's Family Income or Family Assets even though they have income or assets that otherwise exceed the generally applicable eligibility criteria for free or discounted care under the policy. Refer to Appendix A.

"Patient" means person receiving or registered to receive medical treatment or in context of the policy refers to the person liable for payment.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for Health Care Services and is not covered by Medicare, Medicaid, Tricare, or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

"Underinsured" means the patient has some level of insurance or third-party assistance but still has out-of-pocket Health Care Service expenses such as high deductible plans that exceed the patient's level of financial resources.

Policy: Consistent with its mission, it is Hartford HealthCare's policy to provide Financial Assistance to all eligible individuals who are Uninsured or Underinsured, ineligible for a government payer program, and otherwise unable to pay for Health Care Services due to their limited financial resources. It is also HHC's policy to provide without discrimination care for emergency medical conditions (as defined by EMTALA) to individuals regardless of their eligibility for Financial Assistance under this Policy or for government assistance. Finally, it is the policy of HHC to prohibit any action that discourages individuals from seeking emergency medical care, such as by demanding that Emergency Department patients pay before receiving treatment for emergency medical conditions. Nothing in this Policy shall be deemed to limit the Hospital's obligations under EMTALA to treat patients with emergency medical conditions.

I. Determining Eligibility.

In determining eligibility for Financial Assistance, it is important that both HHC and the patient work collaboratively. Specifically, HHC will do its best to apply the Eligibility Criteria in a reasonable manner and the patient will do his or her best in responding to requests for information in a timely, complete, and accurate manner. If the documentation provided by the patient or his/her family is incomplete or inconsistent with the application we will request clarification to assist in making a decision about eligibility for financial assistance.

1. Eligibility for Financial Assistance. Individuals who are Uninsured or Underinsured, ineligible for any government health care benefit program and unable to pay for their Health Care Services may be eligible for Financial Assistance pursuant to this Policy. Financial Assistance also may be available for individuals who are Medically Indigent. The granting of Financial Assistance shall be based upon an individualized determination of financial need, and shall not take into account age, gender, race, color, national origin, marital status, social or immigrant status, sexual orientation or religious affiliation. The Financial Assistance Application outlines the documents required to verify family size and income.

Further, to be eligible for Financial Assistance, an individual must cooperate with HHC, provide the requested information and documentation in a timely manner, complete the required application form truthfully, and notify HHC promptly of any change in his or her financial situation so that HHC can assess the change's impact on the individual's eligibility for financial assistance.

2. Process for Determining Eligibility for Financial Assistance. In connection with determining eligibility for Financial Assistance, HHC (i) will require that the patient complete an application for Financial Assistance and provide other financial information and documentation relevant to making a determination of financial eligibility; (ii) may rely upon publicly available information and resources to verify the financial resources of the patient or a potential guarantor; (iii) may pursue alternative sources of payment from public and private payment benefit programs; and (iv) may review the patient's prior payment history.

3. Processing Requests. HHC will use its best efforts to facilitate the determination process before rendering services so long as the determination process does not interfere with the provision of emergency medical services as defined under federal law. However, eligibility determinations can be made at any time during the revenue cycle. During the eligibility determination process, HHC will at all times treat the patient or their authorized representative with dignity and respect and in accordance with all state and federal laws.

4. Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. Family size is determined based upon the number of dependents living in the household. Information collected will be used to corroborate information generated by predictive analytical software used in making a determination of financial assistance. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

(a) ***Uninsured Patients:***

(i) Published rates will be reduced by the percentage defined by the IRS as the amount generally billed using a "look back" retrospective calculation to calculate the amount allowed by governmental (Medicare and Medicaid) and commercially insured patients. This percentage will be updated on an annual basis. The annual calculation methodology and the percentages are located in Appendix A of this policy.

(ii) If Family Income is verified to be at or below 250% of the Federal Poverty Level Guidelines, the patient will qualify for a 100% discount of the amount generally billed.

(iii) If Family income is verified between 250% and 400% of the Federal Poverty Level Guidelines, the patient will qualify for a 25-75% discount of the amount generally billed.

(iv) A patient may also qualify for Free Bed Funds in accordance with the Hospital's Free Bed Funds criteria.

(vi) Payment plans will be extended for any patient liability identified in a manner consistent with the Hartford HealthCare's Payment Plan Policy, a copy of which is available from the Financial Assistance team as provided below and on the Hartford HealthCare and subsidiary websites.

(vii) Refunds will be issued for any payments of $5.00 or more that exceed the patient's personal liability.

(b) ***Underinsured Patients:***

(i) If Family Income is verified to be at or below 250% of the Federal Poverty Level Guidelines, the patient will qualify for a 100% discount against the patient's account balance after insurance payments from third-party payors are applied. Underinsured patients will not be billed more than amounts generally billed (AGB) to insured patients.

(ii) If Family Income is verified between 250% and 400% of the Federal Poverty Level Guidelines, the patient will qualify for a 25-75% discount against the patient's account balance after insurance payments from third-party payers are applied.

(iii) A patient also may qualify for Free Bed Funds in accordance with the Hospital's Free Bed Funds criteria.

(v) Payment plans will be extended for any patient liability identified in a manner consistent with HHC's Payment Plan Policy, a copy of which is available from the Financial Assistance team as provided below.

(vi) Refunds will be issued for any payments of $5.00 or more that exceed the patient's personal liability

(c) ***Medically Indigent****:*

A Patient will be required to submit a Financial Assistance Application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that Hartford Health Care can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities. This discount will be considered after other discounts have been applied and the patient is still unable pay for the Health Care Service provided. This discount will be applied as described in Appendix A.

(d) ***Presumptive Eligibility****:* Eligibility for Financial Assistance may be presumed based on the patient's life circumstances. The list below is representative of circumstances under which a patient is deemed to be eligible for a 100% discount without further need to complete a Financial Assistance Application:

1. The patient's receipt of state-funded prescription programs

2. Participation in Women, Infants and Children programs

3. Food stamp eligibility (SNAP)

4. Subsidized school lunch program eligibility

5. Subsidized housing or other public assistance eligibility

6. Patient states that he/she is homeless and additional due diligence on such status performed and documented

7. Patient is identified to have an income of 250% of the Federal Poverty Level or less, as verified by electronic industry standard software

II. Method for Applying for Financial Assistance. Copies of the Financial Assistance Application and instructions are available online at [www.HarfordHealthCare.org, or on each hospital facility's website], by requesting a copy in person at any of the HHC hospitals' patient admission or registration areas as identified in Appendix B, or by requesting a free copy by mail by contacting the HHC hospitals' Patient Access Services department. Additional contact information is provided in Appendix B of this policy. In addition, patients may ask any nurse, physician, chaplain, or staff member from Patient Registration, Patient Financial Services, Office of Professional Services, Case Coordination, or Social Services about initiating the Financial Assistance Application process.

To apply for Financial Assistance, a patient must complete HHC's Financial Assistance Application Form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income described below.

Patients may submit an application up to 240 days from the date on which HHC issues its first, post-discharge billing statement. If an individual has not submitted an application within the first 120 days from the date on which HHC issues its first, post-discharge billing statement, then HHC may begin engaging in the collection actions described below.

Before HHC initiates any collection actions, it will issue a written notice to the last known address of record for the patient (or his/her family) that describes the specific collection activities it intends to initiate (or resume), provides a deadline after which such action(s) will be initiated (or resumed), and includes a plain-language summary of this Policy. HHC may initiate collection activities no sooner than 30 days from the date on which it transmits this written initiation notice, either by mail or electronic mail.

If HHC receives an incomplete application form, it will provide the patient (or his or her legal representative) with a list of the missing information or documentation and give the patient 30 days to provide the missing information. Extraordinary collection activities (ECA's) will be suspended during this 30 day period. If the patient does not provide the missing information within this period, HHC may commence collection actions including ECA's (assuming it has provided the written notice described above).

If HHC receives a completed application form, it will make and document eligibility determinations in a timely manner. If an application is deemed complete HHC will provide to the patient or his or her legal representative, a written determination of financial eligibility within fifteen (15) business days. Decisions by HHC that the patient does not qualify for Financial Assistance may be appealed by the patient, or his or her legal representative, within fourteen (14) calendar days of the date of the written determination.

If the patient or his or her legal representative appeals the determination, the Director of Patient Access (or designee) will review the determination along with any new information and make a final decision within fifteen (15) business days. During this review and decision making period, Hartford Healthcare will suspend any ECA's. If financial assistance is not approved, Hartford Healthcare will resume its collection activities after the 14 calendar days afforded for appeal.

Signage and written information regarding how to apply for Financial Assistance will be available in the Hospital emergency service departments and patient registration areas.

Once a patient or his or her legal representative requests information about Financial Assistance, a financial counselor will provide the patient or his or her legal representative with the Financial Assistance Application along with a list of the required documents that must be provided to process the application.

Approved Financial Assistance Applications will be valid for six months from the date HHC's makes its eligibility determination.

Patients may apply for Financial Assistance at any time during the collection cycle process or within 240 days from the date of the first Self Pay notice.

III. Calculating Amounts Charged to Patients

Notwithstanding anything else in this Policy, no individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the amount generally billed to individuals who have insurance covering such care. The basis to which any discount is applied is equivalent to the billed charges posted to a patient account minus any prior insurance payments and adjustments from the patient's insurance (if applicable).

IV. Relationship to Hartford HealthCare's Collection Practices.

In the event a patient fails to qualify for Financial Assistance or fails to timely pay his or her portion of discounted charges pursuant to this Policy, HHC reserves the right to institute and pursue Extraordinary Collection Actions (ECA) and remedies such as imposing wage garnishments or filing liens on primary or secondary residences, bank or investment accounts, or other assets, instituting and prosecuting legal actions and reporting the matter to one or more credit rating agencies. For those patients who qualify for Financial Assistance and who, in HHC's sole determination, are cooperating in good faith to resolve the outstanding accounts, HHC may offer extended payment plans to eligible patients. For patients who meet the terms of the payment plan HHC will not impose wage garnishments or liens on primary residences, and will not send unpaid bills that are part of the payment plan to outside collection agencies.

No ECA will be initiated during the first 120 days following the first post-discharge billing statement to a valid address or during the time that the patient's Financial Assistance Application is processing. Before initiating any ECA, a notice will be provided to the patient 30 days prior to initiating such event.

If the patient applies for assistance within 240 days from the first notification of the self-pay balance, and is granted assistance, any ECA's such as negative reporting to a credit bureau or liens that have been filed will be removed.

V. Publication and Education. HHC will provide information about its Financial Assistance Policy as follows: (i) provide signs regarding this Policy and written plain language summary information describing the Policy along with Financial Assistance contact information in the Emergency Department, Labor and Delivery areas and other patient registration areas; (ii) provide to each patient written plain language summary information describing the Policy along with Financial Assistance contact information in admission, patient registration, discharge, billing and collection written communications; (iii) make paper copies of the Policy, financial assistance application, and plain language summary of the Policy available upon request and without charge, both by mail and in public locations in the hospital facility, including the emergency room (if any) and admissions areas; (iii) post the Policy, plain language summary and financial assistance application on the website with clear linkage to such documents on the HHC's home page; (iv) educate all admission and registration personnel regarding the Policy so that they can serve as an informational resource to patients regarding the Policy; and (v) include the tag line "Please ask about our Financial Assistance Policy" in HHC written publications.

VI. Covered/Non-Covered Provider List. Attached as Appendix C to this Policy is a list of providers independent of HHC that deliver emergency or other medically necessary care in HHC's facility and identifies whether the care they provide is (or is not) covered by this Policy. The Board of Directors of HHC delegates the authority to update Appendix C as needed to the Executive Vice President and Chief Financial Officer.

VII. Relation to Free Bed Funds. If a patient applies for Financial Assistance, the Hospital will determine his or her eligibility for Financial Assistance and or Free Bed Funds.

VIII. Regulatory Compliance. The Hospital will comply with all state and federal laws, rules and regulations applicable to the conduct described in this Policy.

APPENDIX A

Federal Poverty Guidelines Effective January 2015

		250%** FPG	275%** FPG	300%** FPG	325%** FPG	400%** FPG
Size of Famil	Poverty Guideline	100% Awarded	75% Awarded	50% Awarded	25% Awarded	25% Awarded
1	$11,770	$29,425	$32,368	$35,310	$38,253	$47,080
2	$15,930	$39,825	$43,808	$47,790	$51,773	$63,720
3	$20,090	$50,225	$55,248	$60,270	$65,293	$80,360
4	$24,250	$60,625	$66,688	$72,750	$78,813	$97,000
5	$28,410	$71,025	$78,128	$85,230	$92,333	$113,640
6	$32,570	$81,425	$89,568	$97,710	$105,853	$130,280
7	$36,730	$91,825	$101,008	$110,190	$119,373	$146,920
8	$40,890	$102,225	$112,448	$122,670	$132,893	$163,560

*In no case will the Patient's Balance Due after Discount is applied be more than 10% of annual gross family income

For families with more than 8 members, add $4,160 (multiplying factor) for each additional member

Medically Indigent/Catastrophic Financial Assistance*

Medically Indigent/Catastrophic Eligibility:	
Balance Due	Discount
Balance due is ≥ **100%** of patient's annual gross family	90% of balance due
Balance due is ≥ **90%** of patient's annual gross family	85% of balance due
Balance due is ≥ **80%** of patient's annual gross family	80% of balance due
Balance due is ≥ **70%** of patient's annual gross family	75% of balance due
Balance due is ≥ **60%** of patient's annual gross family	70% of balance due
Balance due is ≥ **50%** of patient's annual gross family	65% of balance due

*In no case will the Patient's Balance Due after Discount is applied be more than 10% of annual gross family income

Average Generally Billed* (AGB's) by Facility/Group

Facility/Physician Group	Average Generally Billed (AGB)	Uninsured Discount as of 1/1/16
Backus Hospital	41%	59%
Hospital of Central Connecticut	41%	59%
Hartford Hospital	40%	60%
Hartford Healthcare Medical Group	40%	60%
Midstate Medical Center	41%	59%
Windham Hospital	41%	59%
Natchaug	64%	36%
Rushford	66%	34%

*AGB rates calculated using all allowable claims including commercial, Medicare and Medicaid claims using period YTD September 2015. Each facility AGB will be calculated annually and effective on 1/1 of the next year.

APPENDIX B

Contact Information for Financial Assistance

Hartford HealthCare
Customer Service
1-877-HHC-Bill
hartfordhealthcare.org

Hartford Hospital
Financial Assistance Clearance Team
Main Admitting Department
80 Seymour Street
Hartford, CT 06102
1-877-545-3914
hartfordhospital.org

The Hospital of Central Connecticut
Financial Counselors
Main Admitting Department
100 Grand Street
New Britain, CT 06050
860-224-5181
thocc.org

MidState Medical Center
Financial Counselors
Main Admitting Department

435 Lewis Avenue
Meriden, CT 06451
203-694-8213
midstatemedical.org

or

455 Lewis Avenue
Meriden, CT 06451
203-694-8456
midstatemedical.org

William W. Backus Hospital
Financial Counselors
Financial Counseling Unit
326 Washington Street
Norwich, CT 06030
860-889-8331 x 2917
backushospital.org

Windham Memorial Hospital
Financial Counselors

Main Admitting Department
112 Mansfield Avenue
Willimantic, CT 06226
860.456.6706 or 860.456.6109
windhamhospital.org

Natchaug Hospital
189 Storrs Road
Mansfield, CT 06250
1-800-426-7792
nathaug.org

Rushford
1250 Silver Street
Middletown, CT 06457
1-877-577-3233
rushford.org

APPENDIX C

List of Providers Independent of HHC Which Are Covered/Not Covered by the HHC Financial Assistance Policy

With respect to the provision of emergency and medically necessary care in HHC's facility, care provided by the following independent providers is covered by this Policy:

1. Hartford Medical Group (HHCMG)

2. Employed Physicians of Hartford Healthcare including all hospitalists and ED providers at Harford Hospital, The Hospital of Central Connecticut and William W. Backus Hospital.

With respect to the provision of emergency and medically necessary care in HHC's facility, care provided by the following independent providers is not covered by this Policy:

1. Services provided by Hartford Healthcare affiliates other than those listed in Appendix B are not covered by this policy.

2. Providers providing the following services are excluded from this policy: Radiology, Pathology, Anesthesia and ED providers at Midstate Medical Center and Windham Memorial Hospital.

3. If you have questions regarding the status of your provider, please call your hospital contact listed in Appendix B.

Appendix D: Hartford Healthcare Facilities covered by this policy

Backus Hospital

Hospital of Central Connecticut

Hartford Hospital

MidState Medical Center

Natchaug Hospital

Rushford

Windham Hospital

Exhibit 8: Letter of Interest from Bank of America.

Bank of America

November 9, 2016

To Whom It May Concern:

This letter is offered to confirm that Bank of America is considering the opportunity to provide financing for an endoscopy center located in Meriden, Ct. Please note that we have an extensive history with parties related to the new enterprise and there is interest in offering a loan structure that works for all stakeholders. We look forward to reviewing the conditions set forth in the Certificate of Need.

The general terms of financing will be definitively provided following full credit underwriting and approval. As projected, we anticipate financing $2,014,085 million in a term loan to support tenant improvements and equipment. The term of the loan would range from 60 to 84 months, fully amortizing. Rates for the term financing would have the option to float with Libor or be fixed at closing. The floating rate would be in the range of Libor + 2.75% (labor is .47% today). The fixed rate for a term of 60 to 84 months, if closed today, would be 4.43%.

Sincerely,

Jonathan B. Dayton

Jonathan B. Dayton
Senior Vice President
Global Commercial Banking
157 Church Street
New Haven, CT 06510

Exhibit 9: Financial Worksheet A and B.

NON-PROFIT

MidState Medical Center
Financial Worksheet (A)

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

LINE	Total Entity:	(1) FY 2015 Actual Results	(2) FY 2018 Projected W/out CON	(3) FY 2018 Projected Incremental	(4) FY 2018 Projected With CON	(5) FY 2019 Projected W/out CON	(6) FY 2019 Projected Incremental	(7) FY 2019 Projected With CON	(8) FY 2020 Projected W/out CON	(9) FY 2020 Projected Incremental	(10) FY 2020 Projected With CON	(11) FY 2021 Projected W/out CON	(12) FY 2021 Projected Incremental	(13) FY 2021 Projected With CON
	Description													
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$549,527,239	$549,976,706		$549,976,706	$558,226,357		$558,226,357	$566,599,752		$566,599,752	$575,098,748		$575,098,748
2	Less: Allowances	$326,495,410	$320,516,525		$320,516,525	$325,324,273		$325,324,273	$330,204,137		$330,204,137	$335,157,199		$335,157,199
3	Less: Charity Care	$6,216,157	$5,416,319		$5,416,319	$5,497,564		$5,497,564	$5,580,027		$5,580,027	$5,663,728		$5,663,728
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$216,815,672**	**$224,043,862**	**$0**	**$224,043,862**	**$227,404,520**	**$0**	**$227,404,520**	**$230,815,588**	**$0**	**$230,815,588**	**$234,277,821**	**$0**	**$234,277,821**
5	Medicare	$83,772,561	$81,692,843		$81,692,843	$82,918,236		$82,918,236	$84,162,009		$84,162,009	$85,424,440		$85,424,440
6	Medicaid	$22,462,697	$22,586,112		$22,586,112	$22,924,904		$22,924,904	$23,268,777		$23,268,777	$23,618,809		$23,618,809
7	CHAMPUS & TriCare	$213,932	$334,048		$334,048	$337,211		$337,211	$340,404		$340,404	$343,625		$343,625
8	Other				$0			$0			$0			$0
	Total Government	**$106,449,190**	**$104,613,003**	**$0**	**$104,613,003**	**$106,180,351**	**$0**	**$106,180,351**	**$107,771,190**	**$0**	**$107,771,190**	**$109,386,874**	**$0**	**$109,386,874**
9	Commercial Insurers	$105,563,639	$110,637,503		$110,637,503	$112,297,065		$112,297,065	$113,981,521		$113,981,521	$115,691,244		$115,691,244
10	Uninsured				$0			$0			$0			$0
11	Self Pay	$2,037,612	$5,730,619		$5,730,619	$5,816,578		$5,816,578	$5,903,827		$5,903,827	$599,384		$599,384
12	Workers Compensation	$2,765,231	$3,062,737		$3,062,737	$3,108,678		$3,108,678	$3,155,308		$3,155,308	$3,202,638		$3,202,638
13	Other				$0			$0			$0			$0
	Total Non-Government	**$110,366,482**	**$119,430,859**	**$0**	**$119,430,859**	**$121,222,321**	**$0**	**$121,222,321**	**$123,040,656**	**$0**	**$123,040,656**	**$119,493,266**	**$0**	**$119,493,266**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$216,815,672**	**$224,043,862**	**$0**	**$224,043,862**	**$227,402,672**	**$0**	**$227,402,672**	**$230,811,846**	**$0**	**$230,811,846**	**$228,880,140**	**$0**	**$228,880,140**
14	Less: Provision for Bad Debts	$4,423,863	$3,498,038		**$3,498,038**	$3,415,031		**$3,415,031**	$3,483,332		**$3,483,332**	$3,552,998		**$3,552,998**
	Net Patient Service Revenue less provision for bad debts	**$212,391,809**	**$220,545,824**	**$0**	**$220,545,824**	**$223,989,489**	**$0**	**$223,989,489**	**$227,332,256**	**$0**	**$227,332,256**	**$230,724,823**	**$0**	**$230,724,823**
15	Other Operating Revenue	$14,304,616	$13,561,666	$585,470	**$14,147,136**	$13,832,899	$624,454	**$14,457,353**	$14,109,557	$694,440	**$14,803,997**	$14,391,748	$768,360	**$15,160,108**
17	Net Assets Released from Restrictions	$101,856	$143,000		**$143,000**	$144,430		**$144,430**	$145,874		**$145,874**	$147,333		**$147,333**
	TOTAL OPERATING REVENUE	**$226,798,281**	**$234,250,490**	**$585,470**	**$234,835,960**	**$237,966,818**	**$624,454**	**$238,591,272**	**$241,587,687**	**$694,440**	**$242,282,127**	**$245,263,904**	**$768,360**	**$246,032,264**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$66,713,505	$63,223,942		$63,223,942	$64,488,421		$64,488,421	$65,778,189		$65,778,189	$67,093,753		$67,093,753
2	Fringe Benefits	$17,327,268	$18,043,212		$18,043,212	$18,584,508		$18,584,508	$19,142,044		$19,142,044	$19,716,305		$19,716,305
3	Physicians Fees	$6,307,847	$2,386,564		$2,386,564	$2,422,362		$2,422,362	$2,458,698		$2,458,698	$2,495,578		$2,495,578
4	Supplies and Drugs	$34,375,460	$35,728,314		$35,728,314	$36,800,163		$36,800,163	$37,904,168		$37,904,168	$39,041,293		$39,041,293
5	Depreciation and Amortization	$12,593,806	$10,907,637		$10,907,637	$11,016,713		$11,016,713	$11,126,881		$11,126,881	$11,238,149		$11,238,149
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense	$3,968,133	$3,901,404		$3,901,404	$3,851,404		$3,851,404	$3,800,562		$3,800,562	$3,794,512		$3,794,512
8	Malpractice Insurance Cost	$2,190,432	$3,247,839		$3,247,839	$3,410,231		$3,410,231	$3,580,742		$3,580,742	$3,759,780		$3,759,780
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses	$66,787,297	$76,528,194		$76,528,194	$80,354,604		$80,354,604	$84,372,334		$84,372,334	$88,590,951		$88,590,951
	TOTAL OPERATING EXPENSES	**$210,263,748**	**$213,967,106**		**$213,967,106**	**$220,928,406**	**$0**	**$220,928,406**	**$228,163,618**	**$0**	**$228,163,618**	**$235,730,321**	**$0**	**$235,730,321**
	INCOME/(LOSS) FROM OPERATIONS	**$16,534,533**	**$20,283,384**	**$585,470**	**$20,868,854**	**$17,038,412**	**$624,454**	**$17,662,866**	**$13,424,069**	**$694,440**	**$14,118,509**	**$9,533,583**	**$768,360**	**$10,301,943**
	NON-OPERATING REVENUE	**($1,492,950)**	**$2,100,000**		**$2,100,000**			**$0**			**$0**			**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$15,041,583**	**$22,383,384**	**$585,470**	**$22,968,854**	**$17,038,412**	**$624,454**	**$17,662,866**	**$13,424,069**	**$694,440**	**$14,118,509**	**$9,533,583**	**$768,360**	**$10,301,943**
	Principal Payments	**$1,099,156**	$1,337,545		**$1,337,545**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**7.3%**	**8.6%**	**100.0%**	**8.8%**	**7.2%**	**100.0%**	**7.4%**	**5.6%**	**100.0%**	**5.8%**	**3.9%**	**100.0%**	**4.2%**
2	Hospital Non Operating Margin	**-0.7%**	**0.9%**	**0.0%**	**0.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**6.7%**	**9.5%**	**100.0%**	**9.7%**	**7.2%**	**100.0%**	**7.4%**	**5.6%**	**100.0%**	**5.8%**	**3.9%**	**100.0%**	**4.2%**
D.	**FTEs**	**877**	848		**848**	845		**845**	843		**843**			**0**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	9,208	8,469		**8,469**	8,300		**8,300**	8,228		**8,228**	8,189		**8,189**
2	Outpatient Visits	8,977	2,940		**2,940**	3,028		**3,028**	3,119		**3,119**	3,213		**3,213**
	TOTAL VOLUME	**18,185**	**11,409**	**0**	**11,409**	**11,328**	**0**	**11,328**	**11,347**	**0**	**11,347**	**11,402**	**0**	**11,402**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] 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.

FOR-PROFIT

Wallingford Endoscopy Center, LLC
Financial Worksheet (B)

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

LINE	Total Entity:	(1) FY Actual Results	(2) FY-2018 Projected W/out CON	(3) FY-2018 Projected Incremental	(4) FY-2018 Projected With CON	(5) FY-2019 Projected W/out CON	(6) FY-2019 Projected Incremental	(7) FY-2019 Projected With CON	(8) FY-2020 Projected W/out CON	(9) FY-2020 Projected Incremental	(10) FY-2020 Projected With CON	(11) FY-2021 Projected W/out CON	(12) FY-2021 Projected Incremental	(13) FY-2021 Projected With CON
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$12,691,000	$12,691,000		$13,072,100	$13,072,100		$13,462,450	$13,462,450		$13,867,600	$13,867,600
2	Less: Allowances	$0	$0	$8,650,852	$8,650,852		$8,843,771	$8,843,771		$9,038,234	$9,038,234		$9,235,558	$9,235,558
3	Less: Charity Care	$0	$0	$92,500	$92,500		$96,200	$96,200		$98,050	$98,050		$101,750	$101,750
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$3,947,648**	**$3,947,648**	**$0**	**$4,132,129**	**$4,132,129**	**$0**	**$4,326,166**	**$4,326,166**	**$0**	**$4,530,292**	**$4,530,292**
5	Medicare	$0	$0	$910,277	$910,277		$937,492	$937,492		$965,590	$965,590		$994,684	$994,684
6	Medicaid	$0	$0	$854,090	$854,090		$879,958	$879,958		$906,272	$906,272		$784,711	$784,711
7	CHAMPUS & TriCare	$0	$0	$45,492	$45,492		$46,830	$46,830		$49,956	$49,956		$198,520	$198,520
8	Other	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$1,809,859**	**$1,809,859**	**$0**	**$1,864,280**	**$1,864,280**	**$0**	**$1,921,818**	**$1,921,818**	**$0**	**$1,977,915**	**$1,977,915**
9	Commercial Insurers	$0	$0	$2,137,789	$2,137,789		$2,267,849	$2,267,849		$2,404,348	$2,404,348		$2,552,377	$2,552,377
10	Uninsured	$0	$0	$0	$0			$0			$0			$0
11	Self Pay	$0	$0	$0	$0			$0			$0			$0
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$2,137,789**	**$2,137,789**	**$0**	**$2,267,849**	**$2,267,849**	**$0**	**$2,404,348**	**$2,404,348**	**$0**	**$2,552,377**	**$2,552,377**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$3,947,648**	**$3,947,648**	**$0**	**$4,132,129**	**$4,132,129**	**$0**	**$4,326,166**	**$4,326,166**	**$0**	**$4,530,292**	**$4,530,292**
14	Less: Provision for Bad Debts	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$3,947,648**	**$3,947,648**	**$0**	**$4,132,129**	**$4,132,129**	**$0**	**$4,326,166**	**$4,326,166**	**$0**	**$4,530,292**	**$4,530,292**
15	Other Operating Revenue	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$3,947,648**	**$3,947,648**	**$0**	**$4,132,129**	**$4,132,129**	**$0**	**$4,326,166**	**$4,326,166**	**$0**	**$4,530,292**	**$4,530,292**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$1,131,000	$1,131,000		$1,165,000	$1,165,000		$1,200,000	$1,200,000		$1,236,000	$1,236,000
2	Fringe Benefits	$0	$0	$213,000	$213,000		$276,300	$276,300		$286,914	$286,914		$298,861	$298,861
3	Physicians Fees	$0	$0	$135,000	$135,000		$135,000	$135,000		$135,000	$135,000		$135,000	$135,000
4	Supplies and Drugs	$0	$0	$308,000	$308,000		$317,200	$317,200		$326,700	$326,700		$336,500	$336,500
5	Depreciation and Amortization	$0	$0	$168,000	$168,000		$168,000	$168,000		$168,000	$168,000		$168,000	$168,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$0	$0	$114,393	$114,393		$99,664	$99,664		$84,026	$84,026		$68,003	$68,003
8	Malpractice Insurance Cost	$0	$0	$0	$0		$0	$0		$0	$0		$0	$0
9	Lease Expense	$0	$0	$382,775	$382,775		$382,775	$382,775		$382,775	$382,775		$382,775	$382,775
10	Other Operating Expenses	$0	$0	$347,500	$347,500		$363,770	$363,770		$381,105	$381,105		$398,564	$398,564
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$2,799,668**	**$2,799,668**	**$0**	**$2,907,709**	**$2,907,709**	**$0**	**$2,964,520**	**$2,964,520**	**$0**	**$3,023,703**	**$3,023,703**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$1,147,980**	**$1,147,980**	**$0**	**$1,224,420**	**$1,224,420**	**$0**	**$1,361,646**	**$1,361,646**	**$0**	**$1,506,589**	**$1,506,589**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$0**	**$0**	**$1,147,980**	**$1,147,980**	**$0**	**$1,224,420**	**$1,224,420**	**$0**	**$1,361,646**	**$1,361,646**	**$0**	**$1,506,589**	**$1,506,589**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	NET INCOME	**$0**	**$0**	**$1,147,980**	**$1,147,980**	**$0**	**$1,224,420**	**$1,224,420**	**$0**	**$1,361,646**	**$1,361,646**	**$0**	**$1,506,589**	**$1,506,589**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**		**$1,147,980**	**$1,147,980**		**$2,372,400**	**$2,372,400**		**$3,734,046**	**$3,734,046**
	Retained Earnings, end of year	**$0**	**$0**	**$1,147,980**	**$1,147,980**		**$2,372,400**	**$2,372,400**		**$3,734,046**	**$3,734,046**		**$5,240,635**	**$5,240,635**
	Principal Payments	$0	$0	$238,815	**$238,815**		$253,544	**$253,544**		$269,182	**$269,182**		$285,205	**$285,205**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**29.1%**	**29.1%**	**0.0%**	**29.6%**	**29.6%**	**0.0%**	**31.5%**	**31.5%**	**0.0%**	**33.3%**	**33.3%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**29.1%**	**29.1%**	**0.0%**	**29.6%**	**29.6%**	**0.0%**	**31.5%**	**31.5%**	**0.0%**	**33.3%**	**33.3%**
E.	**FTEs**	**0**	**0**	**16**	**16**		**16**	**16**		**16**	**16**		**16**	**16**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	6,860	**6,860**		7,066	**7,066**		7,278	**7,278**		7,496	**7,496**
	TOTAL VOLUME	**0**	**0**	**6,860**	**6,860**	**0**	**7,066**	**7,066**	**0**	**7,278**	**7,278**	**0**	**7,496**	**7,496**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c] Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d] 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.

Exhibit 10: Financial assumptions used in this proposal.

Assumptions

MidState Medical Center
Financial Schedule A

Revenue:

1. **70% of GI volume at MidState Medical Center will shift to the proposed WEC**
2. **Net revenue will increase by 1.5% per year per payer contracts**
3. **Bad debt and other operating revenue will increase 2% per year**
4. **3% growth in G.I. procedures performed at MidState Medical Center**

Expense:

1. **Salaries increase 2% per year**
2. **Benefits increase 3% per year**
3. **Professional fees increase 1.5% per year**
4. **Supplies increase 3% per year**
5. **Depreciation increases 1% per year**
6. **Malpractice increases 5% per year**
7. **Other Expenses increased 5% per year**

Wallingford Endoscopy Center, LLC
Financial Schedule B

Revenue:

1. **70% volume shift from MidState Medical Center**
2. **3% growth in procedures per year**

Expense:

1. **Salaries and Wages- 16 FTE's with 3% increase per year**
2. **Fringe Benefits- projected at 5% of total compensation**
3. **Supplies and Drugs – 3% of net patient revenue**
4. **Interest- based on $2,014,825 term loan repaid over 7 years, at 6%**
5. **Lease costs- 6,000 sq. ft. at $40 per square foot, including all utilities**
   Lease of 6 colon scopes and 4 endoscopes, $20 per procedure
6. **Other operating Expenses – increase 3% per year**

Greer, Leslie

From: Carney, Brian
Sent: Friday, December 30, 2016 1:01 PM
To: Greer, Leslie
Subject: FW: 16-32136-CON Completeness
Attachments: 16-32136 Completeness Letter Final.docx; con_main_form.docx

Leslie, please add to the record.

Thanks
Brian

Brian A. Carney, MBA
Office of Health Care Access

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov

From: Carney, Brian
Sent: Friday, December 30, 2016 11:27 AM
To: Walker, Shauna
Subject: 16-32136-CON Completeness

Shauna,

In case you were worried. This went out at 11:23 am……☺ Kaila had me add one question. Also, sent the Main Form (we said it was attached) and adjusted a page number to reflect recent changes in the form.

Brian

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

December 30, 2016 VIA EMAIL

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare
181 Patricia M. Genova Blvd
Newington, CT 06111
Barbara.Durdy@hhchealth.org

RE: Certificate of Need Application, Docket Number 16-32136-CON
Establishment of an Outpatient Surgical Facility

Dear Ms. Durdy:

On November 30th, 2016, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application on behalf of Wallingford Endoscopy Center, LLC ("WEC") and MidState Medical Center ("MidState" or "Hospital") to establish an outpatient surgical facility for gastroenterological ("GI") services at WEC, in Wallingford, Connecticut. WEC will be jointly owned by the Hospital and MidState Endoscopy Center Holdings, LLC ("MEC"); with ownership interests of 51% and 49%, respectively.

After reviewing the new outpatient surgical facility application, OHCA has determined that MEC will be added as an applicant in the above-referenced matter.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. *Please email your responses to all of the following email addresses:* **OHCA@ct.gov** and **kaila.riggott@ct.gov**.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

request was transmitted. Therefore, please provide your written responses to OHCA no later than **February 28, 2017**, otherwise your application will be automatically considered withdrawn. Repeat each question before providing your response and paginate and date your response, (i.e., each page, in its entirety). Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be numbered sequentially from the applicant's document preceding it. Please begin your submission using **Page 175** and reference "**Docket Number: 16-32136-CON**."

1. As an applicant, MEC is required to submit the following information and documents:
    a. general application information contained on page 3 of the CON Main Form (attached to this email); and
    b. a notarized affidavit indicated on page 4 of the attached CON Main Form.

2. The published notice on page 3 of the application lists a capital expenditure of $2,008,825, while pages 11, 25 and 31 state that the capital expenditure is $2,788,600. Please verify the appropriate amount and explain the discrepancy.

3. Confirm the start date of the proposal.

4. Page 13 of the application compares endoscopy service rates in both outpatient surgical facilities ("OSF") and hospital settings. Given that the Hospital and proposed location for WEC are located in New Haven County, why have Hartford County rates been applied in this example? Please revise using New Haven County rates or explain why it is appropriate to use Hartford County rates.

5. Is the proposed OSF service location accessible by public transportation? Describe overall accessibility to the new service location (e.g., parking, handicap access, etc.).

6. Page 15 of the application states that patients benefit from minimal wait times at ambulatory surgical centers, "compared to crowded and sometimes uncomfortable settings found at larger organizations." Has MidState experienced problems with scheduling and wait times for GI services due to its hospital setting? Please describe in detail.

7. Page 19 of the application states that the benefits of affiliations and acquisitions "include economies of scale when purchasing supplies and services, sharing of best practices, increased ability to participate in evolving payer models, improved access to capital, and integration with the Hospitals' Centers of Excellence in the wider Hartford HealthCare network." Please provide specific examples of how these benefits will directly impact WEC's clinical services and operations.

8. The projected payer mix on page 34 of the application accounts for a proportion of uninsured patients, yet the Financial Worksheet for WEC does not reflect any net patient service revenue from the uninsured. Please verify if there is any net patient revenue associated with the proportion of uninsured, and if so, updated the Financial Worksheet for WEC on page 172 of the application.

9. Update Table 7 on page 34 of the application to include the Hospital's payer mix for fiscal year ("FY") 2016. Also, please explain the method and calculations used to project the reported numbers for WEC.

10. Confirm that the new WEC will provide GI services to Medicaid patients.

11. Revise Table A on page 38 of the application with complete information (e.g., Number of OR/Procedure Rooms, Estimated Capacity and Current Utilization) for MidState's GI services. Provide this information for the past three fiscal years (FY 2014-FY 2016).

12. Provide the number of outpatient GI procedures performed at MidState, per procedure room, for the past three fiscal years (FY 2014-FY 2016).

13. Provide the following information for WEC for the first three years following adoption of the proposal:
    a. number of procedure rooms;
    b. projected number of procedures, per room, per year;
    c. estimated annual capacity per room; and
    d. annual utilization rate per room.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

Checklist

Instructions:

1. Please check each box below, as appropriate; and
2. The completed checklist *must* be submitted as the first page of the CON application.

☐ Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.

☐ (**New*).* A completed supplemental application specific to the proposal type can be found on OHCA's website at "OHCA Forms." A list of supplemental forms can be found on page 2.

☐ Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.

☐ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☐ Attached is a completed Financial Attachment

☐ Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2 An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: _____ Check No.: _____
OHCA Verified by:_____ Date: _____

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHCA main number (860-418-7001) for assistance. All CON forms can be found on OHCA's website at OHCA Forms.

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
☐	(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
☐	(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
☐	(3)	**Transfer of ownership of a group practice**
☐	(4)	**Establishment of a freestanding emergency department**
☐	(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
☐	(6)	**Establishment of an outpatient surgical facility**
☐	(9)	**Establishment of cardiac services**
☐	(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
☐	(12)	**Increase in licensed bed capacity** of a health care facility
☐	(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
☐	(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
☐	Other	**Transfer of Ownership / Sale of Hospital**

***This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHCA main number (860-418-7001) for assistance.

Proposal Type (select from dropdown)	Choose an item.
Brief Description	
Proposal Address	
Capital Expenditure	$ Click here to enter text.

Is this Application the result of a Determination indicating a CON application must be filed?

☐ No

☐ Yes, Docket Number: Click here to enter text.

Applicant(s) Information

	Applicant One	**Applicant Two*** (if applicable)
Applicant Name & Address		
Parent Corporation Name & Address (if applicable)		
Contact Person Name		
Title		
Email Address		
Phone		
Fax Number		
Tax Status (check one box)	☐ For Profit ☐ Not-for-Profit	☐ For Profit ☐ Not-for-Profit

**For more than two Applicants, attach a separate sheet with the above information*

FOR OFFICE USE ONLY	
Docket #:	Staff Assigned :
Date Received:	

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: _____

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

3. Provide the following information:

   a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

   b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

4. List the health care facility license(s) that will be needed to implement the proposal;

5. Submit the following information as attachments to the application:

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

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

   c. copies of any scholarly 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;

   d. letters of support for the proposal;

   e. the protocols or 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 the protocols or guidelines.

   f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Public Need and Access to Care

§ *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

§ *"The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

§ *"Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

   a. identify the target patient population to be served;

   b. discuss how the target patient population is currently being served;

   c. document the need for the equipment and/or service in the community;

   d. explain why the location of the facility or service was chosen;

   e. provide incidence, prevalence or other demographic data that demonstrates community need;

   f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

   g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

   h. explain how access to care will be affected; and

   i. discuss any alternative proposals that were considered.

§ *"Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

   a. improve the quality of health care in the region;

   b. improve accessibility of health care in the region; and

   c. improve the cost effectiveness of health care delivery in the region.

10. How will the Applicant(s) ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (More details on CLAS standards can be found at http://minorityhealth.hhs.gov/).

11. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

12. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

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

§ *"Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

14. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

§ *"Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

15. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Financial Information

> *§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))*

16. Provide the Applicant's fiscal year: start date (mm/dd) and end date (mm/dd).

17. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

18. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

19. 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 and funds received to date; letter of interest or approval from a lending institution.

20. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

21. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

22. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

23. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

24. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Utilization

> *§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))*

25. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

26. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

27. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))*

28. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

29. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

> *§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))*

30. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

31. Describe the effect of the proposal on these existing providers.

32. Describe the existing referral patterns in the area served by the proposal.

33. Explain how current referral patterns will be affected by the proposal.

> § *"Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

34. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

> § *"Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))*

35. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

[back to question]

TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	**Cost**
Equipment (Medical, Non-medical, Imaging) Land/Building Purchase* Construction/Renovation** Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	

* 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.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 20__*	**FY 20__***	**FY 20__***
Revenue from Operations	$	$	$
Total Operating Expenses			
Gain/Loss from Operations	$	$	$

* Fill in years using those reported in the Financial Worksheet attached.

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 20__***	FY 20__***	FY 20__***	FY 20__***
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 6 months, report actual volume and identify the period covered.
** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 20__**	FY 20__**	FY 20__**
Total			

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** 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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
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. New programs may leave the "current" column blank.

[back to question]

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 20__**

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

User, OHCA

From: Klein, Megan <Megan.Klein@hhchealth.org>
Sent: Wednesday, February 08, 2017 9:57 AM
To: Riggott, Kaila; User, OHCA
Cc: Durdy, Barbara
Subject: Completeness Response: Docket Number 16-32136-CON Establishment of an Outpatient Surgical Facility
Attachments: Completeness Response, Docket Number 16-32136-CON Establishment of an Outpatient Surgical Facility_.pdf; Completeness Response, Docket Number 16-32136-CON Establishment of an Outpatient Surgical Facility.docx

Follow Up Flag: Follow up
Flag Status: Completed

Good morning Kaila,

Attached, please find MidState Medical Center's response to OHCA's Completeness Questions dated December 30th 2016.

Please confirm the receipt of this email, thank you!

Megan

Megan Klein, MHA
181 Patricia M. Genova Drive.
Newington, CT 06111
Office: 860-972-9814
Cell: 860-670-1312
megan.klein@hhchealth.org

Hartford HealthCare

Hartford HealthCare
Connect to healthier.™

February 8, 2017

Ms. Kaila Riggott
Department of Public Health
Office of Health Care Access
410 Capitol Avenue,
MS#13HCA
P.O. Box 340308
Hartford, CT 06106

RE: **Completeness Response, Docket Number 16-32136-CON Establishment of an Outpatient Surgical Facility**

Dear Ms. Riggott:

Enclosed please find MidState Medical Center's responses to the Office of Health Care Access's completeness questions dated December 30, 2016.

Please do not hesitate to contact me at 860-972-4231 if you have any questions. Thank you for your time and consideration.

Sincerely,

Barbara A. Durdy

Barbara A. Durdy

Enclosures

Certificate of Need Application, Docket Number 16-32136-CON
Establishment of an Outpatient Surgical Facility
Completeness Responses

1. As an applicant, MEC is required to submit the following information and documents:
   a. general application information contained on page 3 of the CON Main Form (attached to this email); and
   b. a notarized affidavit indicated on page 4 of the attached CON Main Form.

   As indicated on page 11 of the Applicants' Certificate of Need Application ("Application"), MidState Endoscopy Center Holdings, LLC ("MEC") does not exist as a legal entity at this time. Therefore, MEC cannot supply the requested information, and MEC cannot formally be named an applicant.

2. The published notice on page 3 of the application lists a capital expenditure of $2,008,825, while pages 11, 25 and 31 state that the capital expenditure is $2,788,600. Please verify the appropriate amount and explain the discrepancy.

   The public notice filing did not include the pre-opening costs and development fees. Further at the time the public notice was filed, the estimated space requirement for the facility was 6,000 sq. ft. After considerable review, the space was increased to 7,165 to optimize patient flow. Please see schedule below for reconciliation of capital costs.

Capital Cost Reconciliation	Total Revised Cost*	Cost Reflected in Public Notice Filing
Pre-opening cost	$ 186,000	
Development Fees/Preliminary Design	320,000	
	$506,000	
Equipment	598,825	598,825
Build Out (7,165 sq. feet @ $235)	1,683,775	1,410,000
	$ 2,788,600	$ 2,008,825
Difference		$ 779,775

* Total revised cost per pages 11, 25 and 31 of CON application

3. Confirm the start date of the proposal.

   The start date of the proposal will be one year after CON approval.

4. Page 13 of the application compares endoscopy service rates in both outpatient surgical facilities ("OSF") and hospital settings. Given that the Hospital and proposed location for WEC are located in New Haven County, why have Hartford County rates been applied in this example? Please revise using New Haven County rates or explain why it is appropriate to use Hartford County rates.

Top 25 Procedures - GI Outpatient Endoscopy Services												
	2016 Medicare Rates - New Haven County				Savings							
	2016 OSF		2016 HOPD		CMS		Patient		Total System	
Procedure Description	CMS Payment	Patient Payment*	CMS Payment	Patient Payment*	$	%	$	%	$	%
Colonoscopy	$ 473.00	$ 118.25	$ 565.00	$ 188.00	$ 92.00	16%	$ 69.75	37%	$ 161.75	21%
Endoscopy	$ 468.00	$ 117.00	$ 561.00	$ 184.00	$ 93.00	17%	$ 67.00	36%	$ 160.00	21%

* Assumes 25% patient co-pay

Hartford County Rates were used in the application for demonstration purposes only. The chart above has been revised to reflect New Haven County rates which are higher than the rates reported for Hartford County. Although the New Haven County rates are higher there is still significant saving which will accrue to both CMS and patients.

5. Is the proposed OSF service location accessible by public transportation? Describe overall accessibility to the new service location (e.g., parking, handicap access, etc.).

   The proposed WEC service location is directly accessible by public transportation. There is a bus stop within walking distance of the facility that serves multiple bus routes, allowing for transfer points. There are two entry points to the building that are easily accessible from the parking lot, which contains the requisite and standard number of parking spaces. Passageways within the building are large for handicap accessibility and all services are within close range of the elevator.

6. Page 15 of the application states that patients benefit from minimal wait times at ambulatory surgical centers, "compared to crowded and sometimes uncomfortable settings found at larger organizations." Has MidState experienced problems with scheduling and wait times for GI services due to its hospital setting? Please describe in detail.

   MidState Medical Center, not unlike other hospitals, has difficulty streamlining the scheduling and appointment process which leads to less than optimal patient experience. Frequent interruptions in outpatient services occur due to medical urgencies and emergencies that require the Hospital to shift resources to other settings. A dedicated outpatient setting is able to provide patient focused scheduling with minimal wait times due to delays or other scheduling interruptions. In addition, a dedicated center can provide a more comfortable environment where patients feel less anxiety thus increasing the likelihood of regular screening and ultimately reducing the risk of colon cancer.

7. Page 19 of the application states that the benefits of affiliations and acquisitions "include economies of scale when purchasing supplies and services, sharing of best practices, increased ability to participate in evolving payer models, improved access to capital, and integration with the Hospitals' Centers of Excellence in the wider Hartford HealthCare

network." Please provide specific examples of how these benefits will directly impact WEC's clinical services and operations.

Significant benefits of this alignment will be the collaborative sharing of best practices, physician participation in hospital quality councils, a common medical record, and ability to track and measure outcomes necessary for participation in alternative payment models. This partnership will facilitate the establishment of clinical protocols consistent with best practice established at other Hartford HealthCare facilities.

To the extent possible, supply chain savings achieved resulting from more advantageous vendor contracting, will be reflected in lower operating costs.

8. The projected payer mix on page 34 of the application accounts for a proportion of uninsured patients, yet the Financial Worksheet for WEC does not reflect any net patient service revenue from the uninsured. Please verify if there is any net patient revenue associated with the proportion of uninsured, and if so, updated the Financial Worksheet for WEC on page 172 of the application.

The gross charge for the uninsured is reflected in Total Gross Patient Revenue. Since we do not anticipate any reimbursement from the uninsured patients, a corresponding deduction under Charity Care Allowances was reported.

9. Update Table 7 on page 34 of the application to include the Hospital's payer mix for fiscal year ("FY") 2016. Also, please explain the method and calculations used to project the reported numbers for WEC.

Payer	MidState Payer Mix FY 2016	
	*Discharges	%
Medicare*	4,861	48.00%
Medicaid*	2,329	23.00%
CHAMPUS & TriCare	25	0.25%
Total Government	**7,216**	**71.25%**
Commercial Insurers	2,507	24.75%
Uninsured	354	3.50%
Workers Compensation	51	0.50%
Total Non-Government	**2,912**	**28.75%**
Total Payer Mix	**10,128**	**100.00%**

*Represents outpatient volume only

The calculations used to project the payer mix for WEC were based on average historical payer mix for endoscopy and colonoscopy procedures performed at both MidState Medical Center and CT GI outpatient surgical facilities in Connecticut.

10. Confirm that the new WEC will provide GI services to Medicaid patients.

If this proposal is approved, Wallingford Endoscopy Center, LLC will comply with Hartford HealthCare's Financial Assistance policy, and will provide services to all patients regardless of race, ethnicity, religion, income or ability to pay for services.

Please see Exhibit 7 of the Main Application for a copy of Harford HealthCare's Financial Assistance Policy.

11. Revise Table A on page 38 of the application with complete information (e.g., Number of OR/Procedure Rooms, Estimated Capacity and Current Utilization) for MidState's GI services. Provide this information for the past three fiscal years (FY 2014-FY 2016).

Facility Name	Facility ID	Facility Address	Number of Procedure Rooms				Estimated Capacity for Proposal		Current Utilization	Current Utilization
			Avaliable	Utilized	Not Utilized	Equipped for Proposal	Min	Max		
MidState Medical Center- GI Services	070017	435 Lewis Ave	4	4	0	n/a	7,200	12,000	2014 (10,462)	87%
									2015 (10,548)	88%
									2016 (10,888)	90%

12. **The table above reflects the number of procedure rooms at MidState Medical Center for FY 2014-2016. The four procedure rooms at MidState Medical Center are used for both inpatient and outpatient GI procedures. Estimated capacity and current utilization presented in the above chart reflect total utilization including both inpatient and outpatient procedures.**

Provide the number of outpatient GI procedures performed at MidState, per procedure room, for the past three fiscal years (FY 2014-FY 2016).

MidState Medical Center GI Procedure Room Outpatient Utilization FY14-FY16					
	Room 1	Room 2	Room 3	Room 4	Total
FY2014	2,025	1,585	3,346	1,849	8,806
FY2015	2,154	1,436	3,501	1,885	8,977
FY2016	2,431	1,317	4,254	2,127	10,128

13. Provide the following information for WEC for the first three years following adoption of the proposal:
    a. number of procedure rooms;

    There will be 2 procedure rooms.

    b. projected number of procedures, per room, per year;

Question 13(b)-Projected number of procedures, per room

2018		2019		2020	
Room 1	Room 2	Room 1	Room 2	Room 1	Room 2
3,430	3,430	3,533	3,533	3,639	3,639

    c. estimated annual capacity per room; and

Question 13(C) Annual capacity

2018		2019		2020	
Room 1	Room 2	Room 1	Room 2	Room 1	Room 2
4,200	4,200	4,200	4,200	4,200	4,200

    d. annual utilization rate per room.

Question 13 (d) Annual utilization per room

2018		2019		2020	
Room 1	Room 2	Room 1	Room 2	Room 1	Room 2
81.67%	81.67%	84.12%	84.12%	86.64%	86.64%

Estimated annual capacity for each room in the proposed facility is based on the maximum scheduling efficiencies that can be obtained in a dedicated outpatient environment as well as the ability to extend hours of operation to evenings and weekends if necessary.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

March 3, 2017 VIA EMAIL

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare
181 Patricia M. Genova Blvd.
Newington, CT 06111
Barbara.Durdy@hhchealth.org

RE: Certificate of Need Application, Docket Number 16-32136-CON
Establishment of an Outpatient Surgical Facility
Connecticut Certificate of Need Second Completeness Letter

Dear Ms. Durdy:

On February 8th, 2017, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received completeness responses on behalf of Wallingford Endoscopy Center, LLC ("WEC") and MidState Medical Center ("MidState" or "Hospital") to establish an outpatient surgical facility for gastroenterological ("GI") services at WEC, in Wallingford, Connecticut.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. *Please email your responses to all of the following email addresses:* **OHCA@ct.gov** and **kaila.riggott@ct.gov**.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **May 2, 2017**, otherwise your application will be automatically considered withdrawn.
Repeat each question before providing your response and paginate and date your response, (i.e., each page, in its entirety). Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions and the like) must be

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

numbered sequentially from the applicant's document preceding it. Please begin your submission using **Page 181** and reference "**Docket Number: 16-32136-CON**."

1. Pages 179 and 180 of the application provide estimated capacity figures for MidState and WEC. Please submit the calculation used to determine capacity (minimum/ maximum, if applicable) at these facilities.

2. WEC's projected payer mix (page 34 of the application) lists the following: Medicare (29.75%), Medicaid (27.92%) and commercial insurers (40.85%). However, MidState's historical payer mix (page 178) reflects: Medicare (48%), Medicaid (23%) and commercial insurers (24.75%). Explain why the payer mix at WEC will differ from MidState's historical results (i.e., specifically address the proportional changes to Medicare, Medicaid and commercial insurers).

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Walker, Shauna
Sent: Friday, March 03, 2017 7:21 AM
To: Durdy, Barbara
Cc: Riggott, Kaila; User, OHCA
Subject: Completeness Questions on CON Application # 16-32136
Attachments: 16-32136 2nd Completeness Final.docx

Dear Ms. Durdy:

See attached request for additional information regarding CON application 16-32136 – Establishment of an Outpatient Surgical Facility in Wallingford, CT. There are additional items that need to be addressed.

Responses are due by close of business on **Tuesday May 2, 2017**.

Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

User, OHCA

From: Klein, Megan <Megan.Klein@hhchealth.org>
Sent: Wednesday, March 08, 2017 3:36 PM
To: Riggott, Kaila; User, OHCA
Cc: Durdy, Barbara
Subject: Completeness Response Docket Number 16-32136-CON
Attachments: Certificate of Need Application Docket Number 16-32136-CON Second Completeness .pdf

Hi Kaila,

Please see attached the Completeness Response Docket Number 16-32136-CON, to OHCA's Establishment of an Outpatient Surgical Facility Connecticut Certificate of Need Second Completeness Letter dated March 3, 2017.

Please confirm the receipt of this email, thank you!

Megan

Megan Klein, MHA
181 Patricia M. Genova Drive.
Newington, CT 06111
Office: 860-972-9814
Cell: 860-670-1312
megan.klein@hhchealth.org

Hartford HealthCare

March 8, 2017

Ms. Kaila Riggott
Department of Public Health
Office of Health Care Access
410 Capitol Avenue,
MS#13HCA
P.O. Box 340308
Hartford, CT 06106

RE: **Certificate of Need Application, Docket Number 16-32136-CON**

Establishment of an Outpatient Surgical Facility
Connecticut Certificate of Need Second Completeness Letter

Dear Ms. Riggott:

Enclosed please find MidState Medical Center's response to the Office of Health Care Access's completeness questions dated March 3, 2017.

Please do not hesitate to contact me at 860-972-4231 if you have any questions. Thank you for your time and consideration.

Sincerely,

Barbara A. Durdy

Barbara A. Durdy

Enclosures

1. Pages 179 and 180 of the application provide estimated capacity figures for MidState and WEC. Please submit the calculation used to determine capacity (minimum/ maximum, if applicable) at these facilities.

The calculation for minimum and maximum capacity at MidState Medical Center is based on existing utilization of the 4 procedure rooms. The maximum capacity of 12,000 cases on page 179 is calculated as follows:

Maximum capacity = 12,000 (10,888 = 90% capacity)
Minimum Capacity = 12,000 x 60% = 7200

Maximum capacity for WEC at 4,200 procedures per room is based on historical utilization at other CTGI endoscopy centers and is calculated as follows:

8 hours per day
250 days per year
Maximum utilization = 16 - 17 procedures per room
250 x 17 = 4,250

We assumed 4,200 procedures per room would be maximum capacity of each room.

2. WEC's projected payer mix (page 34 of the application) lists the following: Medicare (29.75%), Medicaid (27.92%) and commercial insurers (40.85%). However, MidState's historical payer mix (page 178) reflects: Medicare (48%), Medicaid (23%) and commercial insurers (24.75%). Explain why the payer mix at WEC will differ from MidState's historical results (i.e., specifically address the proportional changes to Medicare, Medicaid and commercial insurers).

The payer mix at WEC will differ from MidState's historical results because WEC reflects a blend of CT GI's payer mix and MidState GI payer mix. The location of WEC, in Wallingford, is a larger geographical area, different from that of MidState. In addition colorectal surgeons will not be providing any outpatient colonoscopy procedures at WEC, another reason why the payer mix will differ.

Olejarz, Barbara

From: Carney, Brian
Sent: Tuesday, March 21, 2017 1:03 PM
To: 'Barbara.Durdy@hhchealth.org'
Cc: Riggott, Kaila; Walker, Shauna; Olejarz, Barbara
Subject: 16-32136-CON Deemed Complete
Attachments: 16-32136-CON Deemed Complete.pdf

Good afternoon Barbara,

Please see the attached letter deeming the above-referenced application complete. Please confirm receipt of this email and corresponding attachment.

Sincerely,
Brian A. Carney

Brian Carney, MBA
Associate Research Analyst
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308
Phone - 860-418-7014
brian.carney@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 21, 2017

Via Email Only

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare
181 Patricia M. Genova Blvd
Newington, CT 06111
Barbara.Durdy@hhchealth.org

RE: Certificate of Need Application, Docket Number 16-32136-CON
Establishment of an Outpatient Surgical Facility

Dear Ms. Durdy:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of March 21, 2017.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7014.

Sincerely,

Brian A. Carney
Associate Research Analyst

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

User, OHCA

From: Walker, Shauna
Sent: Wednesday, June 07, 2017 9:15 AM
To: User, OHCA
Subject: FW: Quick Question Regarding CON 16-32136 - Wallingford Endoscopy, LLC

From: Walker, Shauna
Sent: Tuesday, June 06, 2017 10:39 AM
To: 'Durdy, Barbara' <Barbara.Durdy@hhchealth.org>
Cc: Carney, Brian <Brian.Carney@ct.gov>
Subject: Quick Question Regarding CON 16-32136 - Wallingford Endoscopy, LLC

Hi Barbara,

We have a quick question regarding CON 16-32136 (Wallingford Endoscopy, LLC) we hope you can help us with. On Page 14 of the application you reference data from The Advisory Board Market Scenario Planner. Would you be able to provide us with the release date of the data used in the application from this tool? Are we able to get a copy of the results?

Thank you!

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

User, OHCA

From: Olejarz, Barbara
Sent: Wednesday, June 07, 2017 8:35 AM
To: User, OHCA
Subject: FW: Quick Question Regarding CON 16-32136 - Wallingford Endoscopy, LLC
Attachments: Copy of Outpatient Market Advisory Projections_June 2017.xlsx

From: Durdy, Barbara [mailto:Barbara.Durdy@hhchealth.org]
Sent: Tuesday, June 06, 2017 1:23 PM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Cc: Carney, Brian <Brian.Carney@ct.gov>
Subject: RE: Quick Question Regarding CON 16-32136 - Wallingford Endoscopy, LLC

Shauna,
Since filing the CON application on November 29, 2016 , the Advisory Board has updated their data to reflect 2016 volumes and the 5 and 10 year projections are based on this updated data source. Consequently, the numbers are now somewhat different but consistent in that they continue to show significant growth both nationally and in the identified primary service area. The projections included on page 14 of the CON application were run by a former employee and unfortunately I no longer have access to the data files associated with the original filing. I suspect at the time they were run, the projections were based on 2015 data with additional mid-year refinements as necessary.
As you know, the Advisory Board projections are fluid, constantly being refined and updated. I have attached the updated projections based on 2016 data.
Please let me now if you have additional questions or would like to discuss in more detail.
Thank you
Barbara

From: Walker, Shauna [mailto:Shauna.Walker@ct.gov]
Sent: Tuesday, June 06, 2017 10:39 AM
To: Durdy, Barbara
Cc: Carney, Brian
Subject: Quick Question Regarding CON 16-32136 - Wallingford Endoscopy, LLC

Hi Barbara,

We have a quick question regarding CON 16-32136 (Wallingford Endoscopy, LLC) we hope you can help us with. On Page 14 of the application you reference data from The Advisory Board Market Scenario Planner. Would you be able to provide us with the release date of the data used in the application from this tool? Are we able to get a copy of the results?

Thank you!

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue

Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

National Service Line

Data and Analytics | Market Scenario Planner - Outpatient					
Service Line	**2016 Volume**	**2021 Volume**	**2026 Volume**	**5 Yr Growth**	**10 Yr Growth**
Gastroenterology	23,913,252	28,871,747	32,226,893	20.7%	34.8%

Data and Analytics | Market Scenario Planner - Outpatient

Service Line	2016 Volume	2021 Volume	2026 Volume	5 Yr Growth	10 Yr Growth
Gastroenterology	283,380	330,381	355,957	16.6%	25.6%

Data and Analytics | Market Scenario Planner - Outpatient

Service Line	2016 Volume	2021 Volume	2026 Volume	5 Yr Growth	10 Yr Growth
Gastroenterology	11,485	13,282	14,228	15.7%	23.9%

Data and Analytics | Market Scenario Planner - Outpatient

Service Line	2016 Volume	2021 Volume	2026 Volume	5 Yr Growth	10 Yr Growth
Gastroenterology	3,129,605	4,026,840	4,728,673	28.7%	51.1%

Data and Analytics | Market Scenario Planner - Outpatient

Service Line	2016 Volume	2021 Volume	2026 Volume	5 Yr Growth	10 Yr Growth
Gastroenterology	1,503	1,852	2,086	23.2%	38.8%

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

Certificate of Need
Final Decision

Applicants:

Wallingford Endoscopy Center, LLC
863 North Main Street Extension
Wallingford, CT 06492

MidState Medical Center
435 Lewis Avenue
Meriden, CT 06451

Docket Number: 16-32136-CON

Project Title: **Establishment of an Outpatient Surgical Facility in Wallingford, Connecticut**

Project Description: Wallingford Endoscopy Center, LLC ("WEC"), a joint venture between MidState Endoscopy Center Holdings, LLC ("MEC") and MidState Medical Center, is proposing to establish an outpatient surgical facility for gastroenterological services at 863 North Main Street Extension, Wallingford, Connecticut.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in *The Record-Journal* (Meriden) on September 2, 3 and 4, 2016. On November 30, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on March 21, 2017. OHCA received no responses from the public concerning the proposal and no hearing requests from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. MidState Medical Center ("Hospital"), a wholly owned subsidiary of Hartford HealthCare Corporation, Inc. ("Hartford HealthCare"), is a 156-bed acute care hospital located at 435 Lewis Avenue, Meriden, Connecticut. Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2015

2. MidState Endoscopy Center Holdings, LLC ("MEC") is a new company that will be jointly owned by nine gastroenterology physicians that are currently members of the Hospital's medical staff. Ex. A, pp. 11, 12

3. The Hospital and MEC plan to establish an outpatient surgical facility ("OSF") dedicated to gastroenterological services, owned and operated by a Connecticut limited liability company known as Wallingford Endoscopy Center, LLC ("WEC"). Ex. A, p. 12

4. WEC will be located at the Wallingford Family Health Center ("WFHC"), 863 North Main Street Extension in Wallingford, Connecticut. Ex. A, p. 12

5. The WFHC location was chosen for the proposal for the following reasons:

    a. Available space for procedure rooms;
    b. Accessibility for residents of the service area by public transportation; and
    c. Ease of access from the parking lot to the building via two entry points.

    Ex. A, p. 20; Ex. C, p. 177

6. The Hospital will own a 51% controlling membership interest in WEC, with the remaining 49% ownership to be held by MEC. Ex. A, p. 12

7. Initially, WEC will have two fully-equipped and operational procedure rooms. A third procedure room will be shelled for future use to accommodate gastrointestinal ("GI") volume growth. Ex. A, p. 37

8. Patients who are at higher risk due to medical complications or comorbidities or who prefer to be treated in a hospital environment will still be able to schedule their procedures at the Hospital. It is estimated that 30% of endoscopy patients will continue to receive services at the Hospital. Ex. A, p. 16

9. WEC will serve the same patient population as the Hospital.

TABLE 1
MIDSTATE MEDICAL CENTER OUTPATIENT GI UTILIZATION BY TOWN

SERVICE AREA	FISCAL YEAR ("FY") 2016 VISITS	PERCENT OF TOTAL*
Meriden	4,351	43%
Wallingford	1,808	18%
Cheshire	710	7%
Southington	473	5%
New Britain	369	4%
Waterbury	264	3%
All Other Towns	2,153	21%
Total	**10,128**	**100%**

*May not add up due to rounding.
Ex. A, pp. 20, 35

10. The following table summarizes the existing service area providers:

TABLE 2
GI SERVICE AREA PROVIDERS

PROVIDER	PROVIDER ADDRESS
MidState Medical Center	435 Lewis Avenue, Meriden
MasoniCare Health Center	22 Masonic Avenue, Wallingford
Central Connecticut Endoscopy Center	440 New Britain Avenue, Plainville
Middlesex Endoscopy Center	410 Saybrook Road, Middletown

Ex. A, p. 38

11. The utilization rate for inpatient and outpatient GI procedures at the Hospital has steadily increased, reaching 90% in FY 2016.

TABLE 3
PROCEDURE ROOM UTILIZATION AT MIDSTATE MEDICAL CENTER*

	FY 2014	FY 2015	FY 2016
Number of Cases	10,462	10,548	10,888
Percent Change from Previous Year	-	0.8%	3.2%
Number of Procedure Rooms	4	4	4
**Maximum Number of Cases, Annually	12,000	12,000	12,000
Utilization Rate	87%	88%	90%

*Includes both inpatient and outpatient GI procedures
**Based on existing utilization for the four procedure rooms at the hospital
Ex. C, p. 179; Ex. E, p. 182

12. Between FY 2015 and FY 2016, there was an increase in outpatient GI procedures at the Hospital due to a surge in the number of endoscopic retrograde cholangiopancreatography (ERCP)[1] procedures and the implementation of an outpatient acid reflux clinic. Anticipated growth for the Hospital and WEC is 3% annually, driven by an aging population and increased access to services. Ex. A, pp. 27, 39

TABLE 4
MIDSTATE MEDICAL CENTER AND WEC HISTORICAL AND PROJECTED OUTPATIENT UTILIZATION

PROVIDER	HISTORICAL VOLUME		PROJECTED VOLUME		
	FY 2015	FY 2016	FY 2018	FY 2019	FY 2020
MidState Medical Center*	8,977	10,128	2,940	3,028	3,119
Wallingford Endoscopy Center, LLC	-	-	6,860	7,066	7,278
Total	**8,977**	**10,128**	**9,800**	**10,094**	**10,397**

Fiscal Year is October 1 – September 30
Ex. A, p. 27

13. It is estimated that approximately 70% of the outpatient GI volume will shift from the Hospital to WEC.

TABLE 5
WEC PROJECTED UTILIZATION BY SERVICE

SERVICE	PROJECTED UTILIZATION		
	FY 2018	FY 2019	FY 2020
Endoscopy	2,610	2,688	2,769
Colonoscopy	4,250	4,378	4,509
Total	**6,860**	**7,066**	**7,278**

Ex. A, p. 33

14. The following table summarizes the number of projected procedures (per room) to be performed at WEC:

TABLE 6
WEC PROJECTED UTILIZATION BY PROCEDURE ROOM

	FY 2018	FY 2019	FY 2020
Number of Procedures	6,860	7,066	7,278
Number of Procedure Rooms	2	2	2
Number of Procedure Performed Per Room	3,430	3,533	3,639
Maximum Number of Procedures Per Room, Annually*	4,200	4,200	4,200
Utilization Rate	82%	84%	87%

*Based on a maximum of 16-17 procedures per room per eight hour day for 250 days
Ex. C, p. 180; Ex. E, p. 182

[1] ERCP procedures are used for the treatment and diagnosis of pancreatic diseases.

15. According to 2016 data from the Advisory Board Company[2], volume for outpatient gastroenterology procedures is expected to increase by 35% nationally and 24% for WEC's primary service area over the ten year period from 2016 to 2026. Within the ambulatory surgery setting, a 51% growth in national volume for outpatient GI procedures is anticipated over the same period. Ex. H, pp. 183, 185-186

16. The two factors contributing the most to the overall projected growth in gastroenterology services are an aging population and a rise in the incidence of obesity. Epidemiologic data indicate that obesity is associated with chronic gastrointestinal complaints, many of which overlap with functional gastrointestinal disorders, such as irritable bowel syndrome or dyspepsia. In addition, nearly 50% of the population of the three towns which represent the largest share of utilization for the primary service area (Cheshire, Meriden and Wallingford), is age 45 years or older. This is significant as clinical guidelines suggest that all individuals have an initial colorectal screening at age 50. Ex. A, pp. 14-15, 52

17. WEC will operate as a freestanding OSF. As a result, the payment rates paid by payers and patients will be substantially lower than those paid for hospital-based surgical services. Ex. A, p. 13

18. A study conducted by the American Journal of Gastroenterology states that ambulatory surgery centers ("ASCs") are paid a fraction of what is paid to hospitals for the same procedures under Medicare and a migration from other settings to ASCs could reduce Medicare spending. The 2016 Medicare rates for outpatient endoscopy services in New Haven County show a 16% to 17% savings to CMS and 36% to 37% savings in patient out-of-pocket costs compared to a hospital-based setting. Ex. A, pp. 22-23; Ex. C, p. 177

19. The affiliation of WEC with the Hospital is expected to utilize economies of scale (purchasing of supplies and services), allow consistency among clinical protocols with other Hartford HealthCare facilities, foster sharing of best practices, increase the ability to participate in evolving payer models and improve access to capital. Ex. A, p. 19; Ex. C, p. 78

20. WEC will be an EPIC medical record site, connecting WEC to patient records at the Hospital and other Hartford HealthCare facilities. Ex. A, p. 23

21. WEC will meet and maintain all national standards required to achieve accreditation by the Accreditation Association for Ambulatory Health Care Centers. Ex. A, p. 17

22. WEC will adopt the same charity care policy as the Hospital, which provides for the provision of services to patients covered by Medicare and Medicaid, as well as providing free or reduced charge services to the poor or indigent. Ex. A, pp. 21, 156-158; Ex. C, p. 179

23. WEC will execute a transfer agreement with the Hospital that will require both parties to make their facilities available to receive and care for all patients, who in the professional opinion of the patient's physician, would receive more appropriate treatment or care in the receiving institution. Ex. A, p. 150

[2]The Advisory Board Company is a global research, technology, and consulting firm.

24. The proposal has an associated capital expenditure of $2,788,600; $598,825 for medical equipment, $1,683,775 for construction and $506,000 in pre-opening development expenses. Approximately $2M of the total will be financed over a 7-year period -- the balance will be funded through an equity contribution. Ex. A, pp. 25, 31, 169

25. WEC projects gains from operations in each of the proposal's first three fiscal years.

TABLE 7
WEC'S PROJECTED INCREMENTAL GAIN FROM OPERATIONS

	FY 2018	FY 2019	FY 2020
Revenue from Operations[1]	$3,947,648	$4,132,129	$4,326,166
Total Operating Expenses[2]	$2,799,668	$2,907,709	$2,964,520
Gain/Loss from Operations	**$1,147,980**	**$1,224,420**	**$ 1,361,646**

[1]Net patient revenue is based on a shift in volume from MidState Medical Center and 3% annual growth in procedures.
[2]Total operating expenses are based on salaries/wages, fringe benefits, supplies/drugs and other expenses.
Ex. A, pp. 172,174

26. Based on the average historical payer mix for endoscopy and colonoscopy procedures performed at MidState Medical Center, more than 25% of WEC's patients are projected to be Medicaid recipients.

TABLE 8
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	FY 2016[2]		Projected[4]					
			FY 2018		FY 2019		FY 2020	
	Visits	%[3]	Visits	%[3]	Visits	%[3]	Visits	%[3]
Medicare[1]	4,861	48.0%	2,041	29.8%	2,102	29.8%	2,165	29.8%
Medicaid[1]	2,329	23.0%	1,915	27.9%	1,973	27.9%	2,032	27.9%
CHAMPUS & TriCare	25	0.3%	52	0.8%	54	0.8%	55	0.8%
Total Government	**7,216**	**71.3%**	**4,008**	**58.5%**	**4,129**	**58.5%**	**4,252**	**58.5%**
Commercial Insurers	2,507	24.8%	2,802	40.9%	2,886	40.9%	2,972	40.9%
Uninsured	354	3.5%	50	0.7%	52	0.7%	54	0.7%
Workers Compensation	51	0.5%	0	0.0%	0	0.0%	0	0.0%
Total Non-Government	**2,912**	**28.8%**	**2,852**	**41.6%**	**2,938**	**41.6%**	**3,025**	**41.6%**
Total Payer Mix	**10,128**	**100%**	**6,860**	**100%**	**7,006**	**100%**	**7,278**	**100%**

[1]Includes managed care activity.
[2]Represents outpatient volume only for MidState Medical Center.
[3]May not add up due to rounding.
[4]Projected payer mix reflects MidState's GI payer mix, WEC's geographical location and the exclusion of colorectal surgeons from providing services at the outpatient facility.
Ex. A, p. 34; Ex. C, pp. 178-179; Ex. E, p. 182

27. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

28. This CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

29. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

30. The Applicants have demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

31. The Applicants have satisfactorily demonstrated that the proposal will improve the accessibility, quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)).

32. The Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).

33. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

34. The Applicants' historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

35. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

36. The Applicants have demonstrated that there will be increased access to services for Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).

37. The Applicants have demonstrated that the proposal will not negatively impact the diversity of health care providers and client choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)).

38. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

Discussion

CON applications are decided on a case-by-case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013)*.

MidState Medical Center and MEC, a limited liability company that will be jointly owned by nine MidState Medical Center gastroenterologists, are proposing to establish an outpatient surgical facility for gastroenterological services, WEC, in Wallingford, CT. The proposal was developed, in part, in response to current demand and projected future growth for outpatient GI procedures. Between FY 2015 and FY 2016, outpatient GI procedures surged at the Hospital, with an increase of over 11%. Additionally, factors such as an aging population and a rise in the incidence of obesity is expected to accelerate growth in GI procedures in future years. The proposal will help shift GI patients from the Hospital to a lower-cost outpatient setting. *FF1-FF4; FF12-FF13; FF16-FF17*

Access to outpatient GI procedures will improve as WEC will accept Medicare and Medicaid, as well as provide free or reduced charge services to the poor or indigent. Moreover, patients will continue to have the option to receive treatment from any of the four existing service area providers. GI procedures performed at the hospital will be based on patient choice, medical complications or other risk factors. *FF8; FF10; FF22*

Although there is an associated capital expenditure of $2,788,600, incremental gains exceeding $1.1 million are projected in each of the first three years of operation. Income from operations, supplemented with capital contributions and lender financing, will fund the WEC, demonstrating financial feasibility. *FF24-FF25*

The affiliation of WEC with the Hospital will help contain costs by utilizing economies of scale, allowing consistency among clinical protocols with other Hartford HealthCare facilities, fostering sharing of best practices, increasing the ability to participate in evolving payer models and improving access to capital. *FF19*

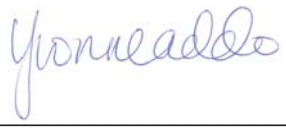
Overall, the proposal demonstrates a clear public need for high quality care at a reduced cost, while increasing access to outpatient GI procedures in the primary service area, both of which are consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of Wallingford Endoscopy Center, LLC and MidState Medical Center to establish an outpatient surgical facility for gastroenterological services at 863 North Main Street Extension, Wallingford, Connecticut, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access



6/8/17
Date

Yvonne T. Addo, MBA
Deputy Commissioner

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Thursday, June 08, 2017 1:06 PM
To: 'Barbara.durdy@hhchealth.org'
Subject: Final Decision
Attachments: 16-32136 CON Final Decision.pdf

Tracking:

Recipient	Delivery	Read
'Barbara.durdy@hhchealth.org'		
OHCA-DL All OHCA Users		
Foreman, Rebecca	Delivered: 6/8/2017 1:06 PM	
Jensen, Dana	Delivered: 6/8/2017 1:06 PM	
'daniels@chime.org'		
Bruno, Anthony M.	Delivered: 6/8/2017 1:06 PM	
McLellan, Rose	Delivered: 6/8/2017 1:06 PM	
Johnson, Colleen M		
Srinivasa.Chalikonda@ct.gov	Delivered: 6/8/2017 1:06 PM	
Kaila.Riggott@ct.gov	Delivered: 6/8/2017 1:06 PM	
Barbara.Olejarz@ct.gov	Delivered: 6/8/2017 1:06 PM	
Jessica.Schaeffer-Helmecki@ct.gov	Delivered: 6/8/2017 1:06 PM	
Steven.Lazarus@ct.gov	Delivered: 6/8/2017 1:06 PM	
Ronald.Ciesones@ct.gov	Delivered: 6/8/2017 1:06 PM	
Olga.Armah@ct.gov	Delivered: 6/8/2017 1:06 PM	
Kevin.Hansted@ct.gov	Delivered: 6/8/2017 1:06 PM	
Christopher.Wyvill@ct.gov	Delivered: 6/8/2017 1:06 PM	
Colleen.Johnson@ct.gov	Delivered: 6/8/2017 1:06 PM	
Carmen.Cotto@ct.gov	Delivered: 6/8/2017 1:06 PM	
Reeya.Khurana@ct.gov	Delivered: 6/8/2017 1:06 PM	
Yvonne.Addo@ct.gov	Delivered: 6/8/2017 1:06 PM	
Shauna.Walker@ct.gov	Delivered: 6/8/2017 1:06 PM	
David.Fernandes@ct.gov	Delivered: 6/8/2017 1:06 PM	
Kimberly.Martone@ct.gov	Delivered: 6/8/2017 1:06 PM	
Brian.Carney@ct.gov	Delivered: 6/8/2017 1:06 PM	
Karen.Roberts@ct.gov	Delivered: 6/8/2017 1:06 PM	
Tillman.Foster@ct.gov	Delivered: 6/8/2017 1:06 PM	
Leslie.Greer@ct.gov	Delivered: 6/8/2017 1:06 PM	
Gloria.Sancho@ct.gov	Delivered: 6/8/2017 1:06 PM	
Alla.Veyberman@ct.gov	Delivered: 6/8/2017 1:06 PM	
Ormand.Clarke@ct.gov	Delivered: 6/8/2017 1:06 PM	
Jessica.Rival@ct.gov	Delivered: 6/8/2017 1:06 PM	
Micheala.Mitchell@ct.gov	Delivered: 6/8/2017 1:06 PM	
Chalikonda, Srinivasa		Read: 6/8/2017 1:06 PM

Recipient	Delivery	Read
Carney, Brian		Read: 6/8/2017 1:06 PM
Ciesones, Ron		Read: 6/8/2017 1:06 PM
Roberts, Karen		Read: 6/8/2017 1:06 PM

6/8/17

Barbara,

Please see the attached final decision for Wallingford Endoscopy Center, LLC and MidState Medical Center for the establishment of an Outpatient Surgical Facility in Wallingford.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov