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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	Stuart C. Calle MD	
Doing Business As	A Walk-In Medical Center LLC	
Name of Parent Corporation	A Walk-In Medical Center LLC	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	30 Roosevelt St Apt 2 PO Box 710 Plainville, CT 06062	
What is the Applicant's Status: P for Profit or NP for Nonprofit	For Profit	
Does the Applicant have Tax Exempt Status?	Yes No NO	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Stuart C. Calle MD Medical Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	365 Willard Avenue 2E Newington, CT 06111	

Contact Person's Telephone Number	860-436-3226	
Contact Person's Fax Number	860-436-3229	
Contact Person's e-mail Address	stuartcalle@yahoo.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

A Walk-In Medical Center LLC

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☒ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 3,000,000

☐ Equipment Acquisition

☒ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

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

365 Willard Avenue 2E Newington, CT 06111

d. List each town this project is intended to serve: Newington, West Hartford, New Britain, Berlin, and surrounding towns.

e. Estimated starting date for the project: May 1, 2007

f. Type of project: (17) OUTPATIENT Urgent Care Unit
(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 30,000

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

Medical Equipment Purchases	$15,000
Major Medical Equipment Purchases	$6,000
Non-Medical Equipment Purchases*	$8,000
Land/Building Purchases	
Construction/Renovation	$1,000
Other (Non-Construction) Specify:	
Total Capital Expenditure	$30,000
Medical Equipment – Fair Market Value of Leases	$15,000
Major Medical Equipment – Fair Market Value of Leases	$6,000
Non-Medical Equipment – Fair Market Value of Leases*	$8,000
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	$30,000
Total Project Cost	$30,000
Capitalized Financing Costs (Informational Purpose Only)	- 0 -

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

routine office equipment and furnishings such as fax, phone, copier, computer systems, waiting room and reception area chairs and tables and exam room chairs for public use.

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☒ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Defib/AED	HP	43100	1	$950
Pulse Oximeter	Ohmeda	3700	1	$350

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

see Page 4a and Page 4b of 7 Pages

d. Type of financing or funding source (more than one can be checked):

☒ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

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

SECTION IV. PROJECT DESCRIPTION

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

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

SOMA TECHNOLOGY, INC.
Worldwide Medical Equipment Sales and Service

SALES ORDER

Date:04/24/07

Regional Director: Hiren Desai

Ship Via: Delivery

PO #: 2030401

Quote #: SHD-2030401

Bill To:	Ship To:
Accounts Payable Calle, Stuart 365 willard avenue 2E Newington, CT 060111	Calle, Stuart Dr. Stuart Calle 365 Willard avenue 2E Newington, CT 060111 (203) 912-8427

Qty	Name	Description	Unit Price	Total
1	Gomco 3001	Portable Suction Pump	$250.00	$250.00
1	HP 43100 & 43110	Defibrillator with ECG & Recorder	$950.00	$950.00
1	Ohmeda 3700	Pulse oximeter with adult probe & new battery	$350.00	$350.00
1	Flex 2 probe	pediatric probe	$180.00	$180.00
5	Matching Otoscope / Ophalmascope	transformer with leads	$300.00	$1,500.00
1	Critikon 8100	NIBP Monitor with new cuff	$500.00	$500.00
1	New stand	Pro stand	$150.00	$150.00
		Refurbished – Patient ready with 90 days warranty		

Soma Technology, Inc.
1486 Highland Ave Unit #3 Cheshire, CT 06410 USA
Tel: 203-272-2300 Fax: 203-272-2250
Email: soma@somatechnology.com
www.somatechnology.com

		AS IS – Not refurbished Just clean units		
1	Hausted	Stretcher	$1,250.00	$1,250.00
2	Stryker	Stretcher	$950.00	$1,900.00
1	Ritter 107	Table S. Green	$550.00	$550.00
2	S.S. 2 drawer	S.S.	$300.00	$600.00
1	1 Drawer SS		$300.00	$300.00
2	Step stool		$25.00	$50.00
1	Step up stool		$35.00	$35.00
3	Matching Blickman Mayo Stand		$175.00	$525.00
4	E Cylinder O2 Tank		$25.00	$100.00
4	E Regulators		$40.00	$160.00
1	Metal Tank Rack		$10.00	$10.00
1	Step up with Rail		$35.00	$35.00
2	Foot steps UP		$25.00	$50.00

Subtotal	$9,445.00
Tax 6%	$566.70
Freight	$350.00
Total	$10361.70
Advance Received	$3000.00
Balance Amount	$7361.70

Payment Terms:

**Note: All sales are subject to availability*

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and who is the target population to be served.

4. Identify any unmet need and describe how this project will fulfill that need.

5. Are there any similar existing service providers in the proposed geographic area?

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

see page 5a

Form 2030 Letter of Intent
Stuart C. Calle MD

1. This letter shows an intent to start a new medical practice.

2. The medical center will provide routine walk-in medical care. General pediatrics, internal medicine, minor surgery, and basic Ob-gyn services will be available to the public 365 days a year. A license to operate a clinic by a corporation (19-13-D45) is sought.

3. The population of Newington, CT and surrounding Hartford County towns will be served. Care is available to patients of all ages.

4. This medical center offers the public a place to have their urgent medical needs met on a daily basis. Patients find the surrounding emergency room care too slow and expensive. Their primary care doctor is not available to them on nights, weekends, and holidays. This center will help provide a remedy to these problems. The center will be open 12 hours/day on average.

5. There are no other service providers offering urgent care in Newington, CT.

6. The medical center accepts insured and uninsured patients. The fees are less than those offered in an ER. The effect of the center will be positive since the public will have another more affordable way to receive their medical care.

7. Stuart Calle MD is a Connecticut physician experienced in Urgent Care, Pediatrics, and minor Surgery. He also serves as medical director of the center. Other physicians in Internal Medicine and Family Practice are contracted to provide additional medical care to the public. Medical assistants and support staff assist in completing the work performed in the center. Cases deemed beyond the scope of this center will be referred to The Hospital of Central Connecticut or to a physician/hospital of the patient's choice.

8. The medical center is currently negociating contracts with Connecticut HMO's and small businesses. The center will offer affordable fee for service rates for the uninsured patient. All Radiology procedures will be handled by the Newington Diagnostic Center affiliated with The Hospital Of Central Connecticut which is nearby.

AFFIDAVIT

To be completed by each Applicant

Applicant: Stuart C. Calle' MD

Project Title: A Walk-In Medical Center LLC

I, Stuart C. Calle' MD (Name), Medical Director CEO (Position – CEO or CFO)

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

RECEIVED
2007 APR 30 PM 12:03
OFFICE OF HEALTH CARE ACCESS

Stuart C. Calle' MD
Signature

4-27-07
Date

Subscribed and sworn to before me on April 27, 2007

Antonia St. Pierre
Notary Public/Commissioner of Superior Court

ANTONIA ST. PIERRE
NOTARY PUBLIC
MY COMMISSION EXPIRES JULY 31, 2009

My commission expires:

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

30. Facility Development
31. Non-Medical Equipment
32. Land and Building Acquisitions
33. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
34. Renovations
35. Other Non-Clinical

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 10, 2007

Mr. Stuart Calle, M.D.
Medical Director
365 Willard Avenue, Suite 2E
Newington, CT 06111

Re: Letter of Intent, Docket Number 07-30962
Mr. Stuart Calle, M.D. d/b/a A Walk-In Medical Center, LLC
Establishment of a Walk-In Medical Center
Notice of Letter of Intent

Dear Dr. Calle:

On April 30, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of d/b/a A Walk-In Medical Center, LLC ("Applicant") for Establishment of a Walk-In Center, at a total capital expenditure of $30,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Herald* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 10, 2007

Requisition # HCA07-181
FAX #: 225-2611

The Herald
One Herald Square
New Britain, CT 06050

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, May 14, 2007**.

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Jack Huber/Alexis Fedorjaczenko** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone /sc

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

The Herald
Docket Number 07-30962

Letter of Intent
May 10, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Mr. Stuart Calle, M.D. d/b/a A Walk-In Medical Center, LLC
Town:	Newington
Docket Number:	07-30962
Proposal:	Establishment of a Walk-In Medical Center
Expenditure	$30,000

The Applicant may file its Certificate of Need application between June 29, 2007 and August 28, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

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

TRANSMISSION OK

TX/RX NO	2111
RECIPIENT ADDRESS	92252611
DESTINATION ID	
ST. TIME	05/10 15:16
TIME USE	00'55
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LEGAL AD

FAX: (860) 225-2611

AGENCY: THE HERALD

FROM: LESLIE GREER

DATE: 5/10/07 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: **Corrected** copy please replace with previously submitted fax

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 10, 2007

Stuart C. Calle, M.D.
Medical Director
A Walk-In Medical Center, LLC
365 Willard Avenue, Suite 2E
Newington, CT 06111

RE: Certificate of Need Application Forms; Docket Number: 07-30962-CON
Stuart C. Calle, M.D. d/b/a A Walk-In Medical Center, LLC
Establishment of a Walk-In Medical Center in Newington

Dear Doctor Calle:

Enclosed are the application forms for your Certificate of Need ("CON") proposal for the Establishment of a Walk-In Medical Center in Newington with an associated capital expenditure of $30,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON Application may be filed between June 29, 2007, and August 28, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachments and other data as appropriate be in MS Excel format.

The OHCA analyst assigned to the CON application is Jack Huber. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, a response of "Not Applicable" may be acceptable. Your Certificate of Need application will be eligible for submission no earlier than June 29, 2007, and may be submitted no later than August 28, 2007. The Analyst assigned to your application is Jack A. Huber and may be reached at the Office of Health Care Access by dialing (860) 418-7034 directly.

Docket Number:	07-30962-CON
Applicant Name:	Stuart C. Calle, M.D. d/b/a A Medical Walk-In Medical Center, LLC
Contact Person:	Stuart C. Calle, M.D.
Contact Title:	Medical Director
Contact Address:	365 Willard Avenue, Suite 2E Newington, CT 06111
Project Location:	Newington
Project Name:	Establishment of a Walk-In Medical Center
Proposal Type:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$30,000

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

SECTION A – NEW CERTIFICATE OF NEED APPLICATION 1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above <u>OR</u> if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment) _____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b) _____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns.
   b) Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information, as appropriate.
   c) Scheduling backlogs in service area.
   d) Travel distance from proposed site to service area towns.
   e) Hours of operation of the proposed service.

ii) Identify the existing providers of the proposed service in your service area.

iii) Provide the information as outlined in the following table concerning the existing providers in the Applicant's PSA and SSA:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of visits, if known.

iv) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

v) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

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

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Medical Director, and financial officer(s), physicians, nurses, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

D. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH
☐ JCAHO
☐ Fire Marshall Report
☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC
☐ AAAASF
☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant, its physicians and any staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Applicant, its physicians working at the facility and/or any staff related to the proposal.

G. Provide a copy of the following:

☐ A copy of the related Quality Assurance plan

☐ Protocols for service

☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

What measures will your facility undertake to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Will this proposal result in any change to your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) The DPH licensure category you are seeking.

ii) If not applicable, please explain why.

8. Financial Information

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

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

iii) Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	

Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Capitalized Financing Costs	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Land/ Building Purchase

If the CON involves any land/building purchase, please answer all of the following that apply:

1.	Please submit a copy of the Real Estate Property Appraisal.	$_____
2.	What is the useful life of the building?	___ Years
3.	Please submit a schedule of depreciation for the purchased building as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$_____
CON Proposed lease financing	$_____
Fair market value of leased assets at lease inception	$_____
Interest rate	_____%
Monthly payment	$_____
Term	_____Years

☐ Other financing alternatives:

Amount	$_____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:

i. Letter of interest from the lending institution,

ii. Letter of interest from CHEFA,

iii. Amortization schedule (if not level amortization payments),

iv. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%
Medicaid* (includes other medical assistance)			
CHAMPUS or TriCare			
Total Government Payers			
Commercial Insurers*			
Uninsured			
Workers Compensation			
Total Non-Government Payers			
Total Payer Mix	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please refer to Financial Attachment 1, enclosed.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Please complete Financial Attachment II, enclosed.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

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

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

Type of Service Description

Type of Unit Description:
# of Months in Operation

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