

MURTHA CULLINA LLP

A T T O R N E Y S A T L A W

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LOUIS B. TODISCO
(203) 772-7718
LTODISCO@MURTHALAW.COM

July 5, 2007

VIA HAND DELIVERY

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

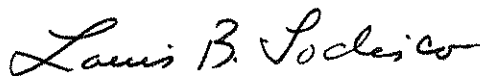
Re: Windsor Dispensary Clinic, Inc.
Letter of Intent

Dear Commissioner Vogel:

Enclosed please find an original and five copies of the Letter of Intent of Windsor Dispensary Clinic, Inc.

We look forward to receiving certificate of need application forms and instructions.

Sincerely yours,

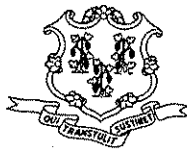


Louis B. Todisco

Enclosures

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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	Windsor Dispensary Clinic, Inc	
Doing Business As	Windsor Dispensary Clinic	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail ---	180 Poquonock Ave. Windsor, CT 06095	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes IRC § 501(c)(3)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Louis B. Todisco Murtha Cullina, LLP	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Two Whitney Ave. 4 th Floor New Haven, CT 06510	

Contact Person's Telephone Number	(203) 772-7718	
Contact Person's Fax Number	(203) 772-7723	
Contact Person's e-mail Address	<u>ltodisco@murthalaw.com</u>	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establish a Methadone Maintenance, Ambulatory Detoxification, Intensive Outpatient Day-Evening Treatment Program in Windsor, CT.

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:

180 Poquonock Ave, Windsor, CT.

- d. List each town this project is intended to serve: **The primary service area for this facility will include the following municipalities: Windsor, Bloomfield, East Granby, East Windsor, Enfield, Granby, Simsbury, Suffield, South Windsor, Windsor Locks, Somers, Ellington, Avon and Canton. Please see also Section IV, Project Description.**

- e. Estimated starting date for the project: **January 1, 2008**

- f. Type of project: **18**
(Fill in the appropriate number(s) from page 7 of this Form)

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

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Project Cost: **\$14,150**
- b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	\$10,150
Land/Building Purchases	
Construction/Renovation	\$2,000
Other (Non-Construction) Specify: Miscellaneous	\$2,000
Total Capital Expenditure	\$14,150
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	

Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all non-medical equipment to be purchased and leased.
(See Attached List)

- 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: N/A

Equipment Type	Name	Model	Number of Units	Cost per unit

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

- 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

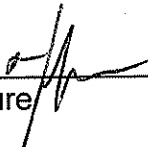
Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

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.
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?

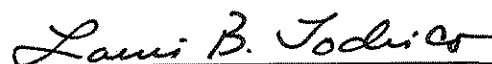
(See Attached Project Description)

AFFIDAVIT**To be completed by each Applicant**Applicant: Windsor Dispensary Clinic, IncProject Title: Establish a Methadone Maintenance, Ambulatory Detoxification, Intensive Outpatient Day-Evening Treatment Program in Windsor, CT.I, Edwin A. Njoku, MD, CEO
(Name) (Position – CEO or CFO)of East Hartford 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 Windsor Dispensary Clinic, Inc. complies with the appropriate (Facility Name)

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.


Signature7/5/07

Date

Subscribed and sworn to before me on 7/5/07
Notary Public/Commissioner of Superior Court

My commission expires: _____

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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 3).

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 Abuse 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

Section IV. Project Description

Windsor Dispensary Clinic, Inc. (WDC) is a non stock Connecticut Corporation. WDC has been determined by the Internal Revenue Service to be a public charity and exempt from Federal income taxes under section 501(c)(3) of the Internal Revenue Code. WDC proposes to establish a methadone maintenance, ambulatory detoxification, intensive outpatient day-evening treatment program (the "Program") in Windsor CT. WDC is a new organization which is not currently providing services.

The Director of the program will be Edwin A. Njoku, M.D. Dr. Njoku is the principal of Christus Medical Group, P.C., a professional corporation which provides primary medical services in East Hartford and Windsor. The Program will be conducted at the same location as Dr. Njoku's existing medical practice at 180 Poquonock Ave, Windsor, Connecticut. The Program will be licensed by the Department of Public Health as a "Facility for the Care and Treatment of Substance Abusive or Dependent Persons." The Program will offer detoxification services utilizing methadone, drug counseling and other services appropriate to a detoxification program and treatment program.

The population to be served by the Program will be persons age 18 and over, who are addicted to opiates such as heroin and synthetic opiates such as percocet, vicodin, oxycontin and morphine and who desire to cease using these drugs. WDC will also service individuals that are dependent on alcohol or dependent on cocaine, amphetamines and other drugs of abuse in its intensive day and evening treatment program. It is anticipated that the Program will serve primarily persons from the anticipated primary service area which includes Windsor, Bloomfield, East Granby, East Windsor, Enfield, Granby, Simsbury, Suffield, South Windsor, Windsor Locks, Somers, Ellington, Avon and Canton. A secondary service area is believed to include West Hartford, East Hartford, Manchester, Vernon and Hartford. The Program will, of course, serve any persons who seek its services. It is believed that there is a need for services by persons from the suburban communities to be served and that the suburban location will provide an accessible location and encourage treatment of persons who are reluctant to seek treatment in urban areas.

There are currently no providers of maintenance and detoxification and related services in the primary service area which WDC expects to serve. WDC anticipates that the establishment of its maintenance treatment Program will have a beneficial effect in the health care delivery system in its service area. The existence of the WDC Program will make detoxification and treatment services more accessible as a result of its suburban location. Persons who may not have otherwise sought drug treatment services will do so because of its location. Also, it will provide an alternative program for persons who for one reason or another do not wish to utilize an existing provider of services.

Dr. Edwin Njoku, the principal of WDC, will be responsible for the providing services together with all other staff necessary to provide the services involved.

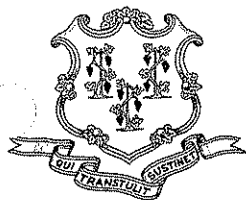
It is anticipated that payers will include Medicaid, commercial insurance and self pay patients. Also, WDC has been designated a public charity under the Internal Revenue Code and is qualified to receive tax deductible bequests, devises, transfers and gifts under applicable sections of the Internal Revenue Code. It is the intent of WDC to undertake fundraising to assist in financing its treatment initiatives and to have an "open-door" treatment policy for persons requesting treatment and or counseling services. WDC intends to implement a "sliding scale" fee schedule.

Itemized list of non-medical equipment to be purchased

1. Alarm System (including installation)	\$3,000
2. Camera System (including installation)	\$5,000
3. Steel Safe (including installation)	<u>\$2,150</u>
	\$10,150

Construction/Renovation

1. Reinforcing Floor for safe	\$2,000
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M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

July 13, 2007

Louis Todisco, Esq.
Murtha Cullina, LLP
Two Whitney Avenue, 4th Floor
New Haven, CT 06510

Re: Letter of Intent, Docket Number 07-30999
Windsor Dispensary Clinic, Inc.
Establish and operate Windsor Dispensary Clinic to provide methadone
maintenance, ambulatory detoxification, intensive outpatient, and day-evening
treatment programs for substance abuse in Windsor
Notice of Letter of Intent

Dear Attorney Todisco,

On July 5, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Windsor Dispensary Clinic, Inc. ("Applicant") to establish and operate Windsor Dispensary Clinic, Inc. to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor, at a total capital expenditure of \$14,150.

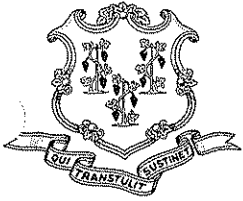
A notice to the public regarding OHCA's receipt of a LOI was published in *The Hartford Courant* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in cursive script, reading "Kimberly R. Martone".

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

July 13, 2007

Requisition # HCA08-006
EMAIL: Publicnotices@courant.com

Hartford Courant
285 Broad Street
Hartford, CT 06115

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 **Tuesday, July 17, 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 **Laurie Greci** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,



Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Windsor Dispensary Clinic, Inc.
Town:	Windsor
Docket Number:	07-30999
Proposal:	Establish and operate Windsor Dispensary Clinic, Inc. to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor
Capital Expenditure:	\$14,150

The Applicant may file its Certificate of Need application between September 3, 2007 and November 2, 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.

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Friday, July 13, 2007 10:26 AM
To: Greer, Leslie
Subject: RE: Legal Ad 07-30999

Leslie,
This notice is set to run statewide on 7/17, 1x3.00 inches, for \$156.50
Ad #2058363

Thank you!
Caitlin

From: Greer, Leslie [mailto:Leslie.Greer@po.state.ct.us]
Sent: Friday, July 13, 2007 10:07 AM
To: publicnotices@courant.com
Subject: Legal Ad 07-30999

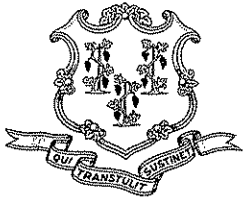
July 13, 2007

Legal Department,
Please post the attached legal ad in your newspaper by July 17, 2007. Please notify me that you have received this request.

Thank you,

Leslie Greer
Office of Health Care Access
(860) 418-7001
Leslie.Greer@po.state.ct.us

7/13/2007



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

July 16, 2007

Louis Todisco, Esquire
Murtha Cullina LLP
Two Whitney Avenue, 4th Floor
New Haven, CT 06510

RE: Certificate of Need Application Forms, Docket Number 07-30999-CON
Windsor Dispensary Clinic, Inc.
Establish and Operate Windsor Dispensary Clinic, Inc. and provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse.

Dear Attorney Todisco:

Enclosed are the application forms for Windsor Dispensary Clinic, Inc.'s Certificate of Need ("CON") proposal to establish and operate Windsor Dispensary Clinic, Inc. and provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse, with an associated capital expenditure of \$14,150. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between September 3, 2007, and November 2, 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 in Adobe Acrobat format. OHCA also requests that an electronic copy of the application be provided in MS Word format and that the financial attachments and other data, as appropriate, be provided in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact her at (860) 418-7001, if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Kim R Martone".

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, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than September 2, 2007, and may be submitted no later than November 2, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30999-CON

Applicant's Name: Windsor Dispensary Clinic, Inc.

Contact Person: Louis Todisco, Esq.
Contact Title: Attorney
Murtha Cullina, Inc.

Contact Address: Two Whitney Avenue, 4th Floor
New Haven, CT 06510

Project Location: Windsor

Project Name: Establish and Operate Methadone Maintenance,
Ambulatory Detoxification, Intensive Outpatient, and Day-
Evening Treatment Programs for Substance Abuse

Type proposal: Section 19a-638

Est. Capital Expenditure: \$14,150

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.
- B. Provide the primary and secondary service area towns.
- C. Provide the rationale for choosing the proposed primary and secondary service area towns.
- D. If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
- E. If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic information, as appropriate. Address each service level individually.
- F. Scheduling backlogs in service area
- G. Travel distance from proposed site to service area towns
- H. Hours of operation of existing/proposed service

- I. Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

- J. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?
- K. Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**
- L. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

- | | |
|--|---|
| <input type="checkbox"/> Cultural | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Geographic | <input type="checkbox"/> Economic |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Other (Identify) _____ |

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

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

- | | |
|--|--|
| <input type="checkbox"/> Epidemiological studies | <input type="checkbox"/> Needs assessments |
| <input type="checkbox"/> Public information reports | <input type="checkbox"/> Market share analysis |
| <input type="checkbox"/> Other (Identify) | |
| <input type="checkbox"/> None, <i>Explain</i> why no reports, studies or market share analysis was undertaken related to the proposal: | |

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> American College of Cardiology | <input type="checkbox"/> National Committee for Quality Assurance | <input type="checkbox"/> Public Health Code & Federal Corollary |
| <input type="checkbox"/> National Association of Child Bearing Centers | <input type="checkbox"/> American College of Obstetricians & Gynecologists | <input type="checkbox"/> American College of Surgeons |
| <input type="checkbox"/> Report of the Inter-Council for Radiation Oncology | <input type="checkbox"/> American College of Radiology | <input type="checkbox"/> Substance Abuse Society and Mental Health Services Administration |
| <input type="checkbox"/> Other, Specify: | | |

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

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, 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.

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

- | | |
|---|---|
| <input type="checkbox"/> DPH | <input type="checkbox"/> JCAHO |
| <input type="checkbox"/> Fire Marshall Report | <input type="checkbox"/> Other States Health Dept. Reports (New Out-of-State Providers) |
| <input type="checkbox"/> AAAHC | <input type="checkbox"/> AAAASF |
| <input type="checkbox"/> Other: | |

Note: Above referenced acronyms are defined below. ¹

- F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital (Applicant), Physicians and any staff related to the proposal, for the past five (5) years.
- G. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital (Applicant), Physician(s) working at the Hospital and/or any staff related to the proposal.
- H. Provide a copy of the following (as applicable):
- ☐ A copy of the related Quality Assurance plan
 - ☐ Protocols for service (new service only)
 - ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- | | |
|--|---|
| <input type="checkbox"/> Energy conservation | <input type="checkbox"/> Group purchasing |
| <input type="checkbox"/> Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.) | <input type="checkbox"/> Reengineering |
| <input type="checkbox"/> None of the above | |
| <input type="checkbox"/> Other (identify): | |

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.

7. Miscellaneous

- A. Will this proposal result in new (or a 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) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.
- ii) The DPH licensure category you are seeking.
- iii) The service levels you are seeking to provide.
- iv) If licensing is not applicable, please explain why.

8. Financial Information

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

<input type="checkbox"/> Corporation (Inc.)	<input type="checkbox"/> Limited Liability Company (LLC)
<input type="checkbox"/> Partnership	<input type="checkbox"/> Professional Corporation (PC)
<input type="checkbox"/> Joint Venture	
<input type="checkbox"/> Other (Specify):	

- B. Provide the following financial information:

- i) 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.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify: _____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV))	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
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. Explain how the proposed new construction or renovations will affect the delivery of patient care.
- D. 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. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

What is the anticipated residual value at the end of the lease or loan term?	\$ _____
What is the useful life of the equipment?	____ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
Please submit a schedule of depreciation for the purchased equipment 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:
- Letter of interest from the lending institution,
 - Letter of interest from CHEFA,
 - Amortization schedule (if not level amortization payments),
 - 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	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	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. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

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

- i) Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I. Note: The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.**
- ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, Financial Attachment II.**
- iii) List the assumptions utilized in developing the projections reported on Financial Attachments I and II (e.g., FTE's by position, volume statistics,

other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Note: *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

- iv) 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.
- v) Provide a copy of the rate schedule for the proposed service.
- vi) Describe how this proposal is cost effective.
- vii) Provide a copy of the facility's charity care policy and sliding fee scale applicable to the proposal.

***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. C. ii) Please provide three years of projections of <u>incremental</u> 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										
Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				\$0				\$0	\$0	\$0
Medicaid		\$0		\$0				\$0	\$0	\$0
CHAMPUS/TriCare		\$0		\$0				\$0	\$0	\$0
Total Governmental			0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial 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

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: _____

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ELNORA M. NEWTON, now
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whose residence(s) is/are
ELLA SMITH OLMS, 7, 1000
Connecticut, if living, and
residence(s) is/are unknown.
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children; and
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formerly of East Hartford.
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