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	Morris Foundation, Inc.	
Doing Business As	Liberty Center	
Name of Parent Corporation	Morris Foundation, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	402 East Main Street Waterbury, CT 06702	
What is the Applicant's Status: P for Profit or NP for Nonprofit	Nonprofit	
Does the Applicant have Tax Exempt Status?	(Yes) No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Joan M. Pesce President / CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	402 East Main Street Waterbury, CT 06702	

Contact Person's Telephone Number	203-755-1143 ext. 312	
Contact Person's Fax Number	203-755-1447	
Contact Person's e-mail Address	jpesce@morris4change.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Relocation of Morris Foundation, Inc. Liberty Center Mental Health Outpatient Services

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:

30 Controls Drive, Shelton, CT 06484

d. List each town this project is intended to serve:
Shelton, Ansonia, Derby, Seymour, Oxford

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

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)

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 60,000

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	$60,000
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$60,000**
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	**$60,000**
Total Project Cost	**$60,000**
Capitalized Financing Costs (Informational Purpose Only)	

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

Phone System	**- $20,000**
Alarm System	**- 10,000**
Office & Group Room Furniture	**- $30,000**

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

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. **Currently, Outpatient mental health services are being provided adults in Ansonia, Derby, Shelton, Seymour and Oxford at 75 Liberty Street, Ansonia, CT under Psychiatric Care Clinic License.**

2. 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.
   Currently, outpatient mental health services are being provided to adults in Ansonia, Derby, Shelton, Seymour, and Oxford (the Lower Naugatuck Valley area) at 75 Liberty Street, Ansonia, CT under the Psychiatric Outpatient Clinic for Adults license (copy attached).

3. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.
   The types of services being proposed are the relocation of the current mental health outpatient and intensive outpatient adult services operated under our current Psychiatric Outpatient Clinic license.

4. Identify the current population served and who is the target population to be served.
   Currently, adults with mental health disorders are being served and will remain the target population to be served.

5. Identify any unmet need and describe how this project will fulfill that need.
   Currently in Shelton there is no non-profit agency providing mental health services for adults. The Morris Foundation program would continue to service people in the Lower Naugatuck Valley while being located in a community where there is no similar service.

6. Are there any similar existing service providers in the proposed geographic area?
   There are two similar service providers in the Lower Naugatuck Valley: Griffin Hospital Outpatient Behavioral Health in Derby, and Birmingham Group Health Services in Ansonia.

7. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   The anticipated effect on the health care delivery system of relocating Liberty Center to Shelton is an improvement in the accessibility of outpatient behavioral health services to a larger community that has no such program currently available. At the same time, services will remain accessible to adults in the neighboring towns.

8. Who will be responsible for providing the service?
   Liberty Center is an outpatient satellite office of Morris Foundation, Inc. The Executive Management Team oversees the entire agency. Medical personnel are deployed on an "as

needed" basis. On site, there is a program manager, full and part-time clinicians, and administrative support staff. The staff list follows:

Executive Management:
Joan M. Pesce, M.Div., President/CEO
Rachael Petitti, LCSW, Vice President, Operations/COO
Patricia Strasdauskas, Vice President, Finance

Medical Services:
Kunjathan Thankappan, M.D.
Lori Sills, APRN

Liberty Center:

Program Manager:	Vincent Delaney, MS
Clinicians:	Ellen Szumagala, MS
	Geraldine Cippolla, MS
	Elizabeth Nicoletti, CADC
	Robert Gard, CADC
Admin. Support:	Rashelle Brown
	Chantal Brown

9. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?
Current payers of this service include: Commercial insurance payers:

Medicaid (T-19)	**Connecticut Behavioral Health Partnership (CT BHP)**
SAGA	**Anthem**
CIGNA	**United Behavioral Health (UBH)**
Oxford	**Northeast Health Direct**
Medicare	**Managed Health Network (MHN)**

Anticipated payers: DMHAS SAGA, CSSD

AFFIDAVIT

To be completed by each Applicant

Applicant: Morris Foundation, Inc. Liberty Center

Project Title: Relocation of Morris Foundation, Inc. Liberty Center Mental Health Outpatient Services

I, Joan M. Pesce (Name), President / CEO (Position – CEO or CFO)

of Morris Foundaiton, Inc. 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 Morris Foundation, Inc. (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.

Joan M. Pesce
Signature

08/08/07
Date

Subscribed and sworn to before me on 8/8/07

Notary Public/~~Commissioner of Superior Court~~

My commission expires: July 31, 2010

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

Department of Public Health

LICENSE

License No. 0343

Psychiatric Outpatient Clinic for Adults

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

Morris Foundation, Inc. of Waterbury, CT, d/b/a Liberty Center is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Liberty Center is located at 75 Liberty Street, Ansonia, CT 06401 with:

Joan M. Pesce as Executive Director
Rachael A. Petitti, LCSW as Director

The service classification(s) and if applicable, the residential capacities are as follows:

MULTI SERVICE

This license expires **June 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2007. RENEWAL.

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 22, 2007

Joan M. Pesce
President/CEO
Morris Foundation, Inc.
402 East Main Street
Waterbury, CT 06702

Re: Letter of Intent, Docket Number 07-31019-LOI
Morris Foundation, Inc. d/b/a Liberty Center
The Proposal of Morris Foundation, Inc. for the Termination of the Liberty Center Outpatient Behavioral Health Services in Ansonia and an Establishment of the Liberty Center Outpatient Behavioral Health Services in Shelton
Notice of Letter of Intent

Dear Ms. Pesce:

On August 9, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Morris Foundation, Inc. ("Applicant") for the termination of its Liberty Center Outpatient Behavioral Health Services and an establishment of the Liberty Center Outpatient Behavioral Health Services in Shelton, at a total capital expenditure of $60,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Waterbury Republican American* 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:dd

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 22, 2007

Requisition # HCA08-035
FAX: (203) 754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

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, August 27, 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 **Diane Duran** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:dd

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Morris Foundation, Inc. d/b/a Liberty Center
Town:	Ansonia
Docket Number:	07-31019-LOI
Proposal:	Termination of Liberty Center Outpatient Behavioral Health Services in Ansonia and Establishment of the Liberty Center Outpatient Behavioral Health Services in Shelton
Capital Expenditure:	$60,000

The Applicant may file its Certificate of Need application between October 19, 2007 and December 18, 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	2472
RECIPIENT ADDRESS	912037540644
DESTINATION ID	
ST. TIME	08/22 15:41
TIME USE	00'31
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 22, 2007

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 30, 2007

Joan Pesce
Executive Director
Morris Foundation, Inc.
402 East Main Street
Waterbury, CT 06702

RE: Certificate of Need Application Forms, Docket Number 07-31019-CON
Morris Foundation, Inc.
Termination of Liberty Center Mental Health Outpatient Services in Ansonia and
Establishment of Liberty Center Mental Health Outpatient Services in Shelton

Dear Ms. Pesce:

Enclosed are the application forms for Morris Foundation, Inc.'s Certificate of Need ("CON") proposal for the termination of Liberty Center Mental Health Outpatient Services in Ansonia and Establishment of Liberty Center Mental Health Outpatient Services in Shelton with an associated capital expenditure of $60,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between October 19, 2007, and December 18, 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 Attachment and other data as appropriate be in MS Excel format.

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

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 19, 2007, and may be submitted no later than December 18, 2007. The Analyst assigned to your application is Diane Duran and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-31019-CON

Applicant(s) Name: Morris Foundation, Inc.

Contact Person: Joan Pesce
Contact Title: Executive Director
Morris Foundation, Inc.
Contact Address: 402 East Main Street
Waterbury, CT 06702

Project Location: Shelton

Project Name: Termination of Liberty Center Mental Health Outpatient Services in Ansonia and Establishment of Liberty Center Mental Health Outpatient Services in Shelton

Type proposal: Section(s) 19a-638 and/or 19a-639, C.G.S.

Est. Capital Expenditure: $60,000

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. Regarding this termination of services, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Ansonia location.

ii) Identify the primary and secondary service area towns for the Ansonia service location.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Ansonia service location.

iv) Discuss any scheduling backlogs that exist at the Ansonia service location at the time of the decision to terminate this service location.

v) Are there any waiting lists in place? If so, identify the number of patients on the waiting list.

vi) Describe the pattern of referrals to the Ansonia service location that exist prior to termination of this service location.

C. Regarding the impact on the patient and provider community of the termination of services, provide the following information:

i) Discuss how the services described above will continue to be made available to the patients that have previously utilized this service location. List any special populations that are utilizing the services and explain how these clients will continue to access this service after it is closed.

ii) Provide the information as outlined in the following table concerning the existing providers services in the Ansonia service area:

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 clients served by Provider for the most recent 12 month period, if known.

iii) What will be the effect of the termination of the Ansonia service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Will this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

v) Provide information and supporting documentation addressing the issue of transportation for the Ansonia patients. Describe how

patients would be able to travel to a new service location if without benefit of a personal vehicle.

D. Explain how it was determined there was a need for the proposal in Shelton.

E. Has the applicant undertaken any needs assessment for the proposed mental health center in Shelton.

G. Has the applicant considered alternative locations other than Shelton?, if so, provide a list and describe all of the alternative locations.

H. Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) 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.
   d) Scheduling backlogs in service area
   e) Travel distance from proposed site to service area towns
   f) Hours of operation of existing/proposed service

I. Identify the existing providers of the proposed service in the Shelton service area.

J. Provide the information as outlined in the following table concerning the existing provider's of sleep services in the Shelton service area:

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 clients served by Provider for the most recent 12 month period, if known.

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

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

M. 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.

N. 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) _____

☐ None: *explain* 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:

☐ 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-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐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:

☐	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.

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the 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 Applicant, Physician(s) working at the Health Center 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?

- ☐ 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 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) 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) Provide the total current assets balance as of the date of submission of this application.

iii) Provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) Provide the name and units of service for the new cost center to be established for the proposal.

v) 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. 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.

11. 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) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** 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) Please complete the enclosed, OHCA's **Financial Attachment II**.

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.

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: _____

12.C(ii). 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
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by 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

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

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$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.