



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

RECEIVED
2007 SEP 12 AM 11:21
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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	365 Willard Avenue Newington, CT 06111-2316	
What is the Applicant's Status: P for Profit or NP for Nonprofit	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	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	365 Willard Avenue Newington, CT 06111-2316	

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 - Newington

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.:

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> New (F, S, Fnc) | <input type="checkbox"/> Replacement | <input type="checkbox"/> Additional (F, S, Fnc) |
| <input type="checkbox"/> Expansion (F, S, Fnc) | <input type="checkbox"/> Relocation | <input type="checkbox"/> Service Termination |
| <input type="checkbox"/> Bed Addition | <input type="checkbox"/> Bed Reduction | <input type="checkbox"/> Change in Ownership/Control |

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

☐ Project expenditure/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 Newington, CT 06111-2316

- d. List each town this project is intended to serve:
Newington, West Hartford, Wethersfield, New Britain, Berlin
- e. Estimated starting date for the project: June 11 2007
- f. Type of project: 17. Outpatient (Urgent Care Units)
 (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,
 Form 2030 phone, copier, computer systems, waiting room, and
 Revised 7/06 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.

- 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.



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 / Ophthalmoscope	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?

1. This letter shows an intent to start a private medical practice devoted to minor emergency care.
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. Primary care doctors are often not available for private office visits on nights, weekends, and holidays. This center will help provide a remedy to these problems. The center will be open 12 hours/day.
5. There are no other service providers offering urgent care in Newington, CT.
6. The medical center provides care to insured and un-insured patients at reasonable fee for services rates. The fees are less than those offered in an ER. The effect of the center will be positive since the public will have 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. Cases deemed beyond the scope of the center will be referred to the main ER at surrounding area hospitals of the patients choice.
8. Patients pay a reasonable fee for the diagnostic and treatment services of a physician after they visit at the medical center. Radiologic and lab work can be paid by insurance plans or out of pocket by the patient.

AFFIDAVIT**To be completed by each Applicant**Applicant: Stuart C. Calle' MDProject Title: A Walk-In Medical Center LLCI, Stuart C. Calle' MD, Medical Director
(Name) (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 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.

Stuart C. Calle' MD
Signature

9/11/07
Date

Subscribed and sworn to before me on September 11, 2007

Antonia St Pierre
Notary Public/Commissioner of Superior Court

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

My commission expires: _____

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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

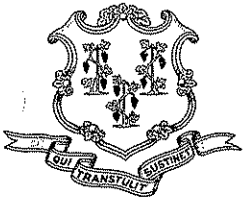
1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

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 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



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

September 19, 2007

Mr. Stuart Calle, Medical Director
Stuart C. Calle, M.D.
365 Willard Avenue, Suite 2E
Newington, CT 06111-2316

Re: Letter of Intent, Docket Number 07-31036
Stuart C. Calle, M.D.
Proposal to Establish a Walk-In Medical Center in Newington
Notice of Letter of Intent

Dear Dr. Calle:

On September 12, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Stuart C. Calle, M.D. ("Applicant") for the proposal to Establish a Walk-In Medical Center in Newington, at a total capital expenditure of \$30,000.

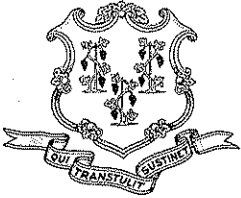
A notice to the public regarding OHCA's receipt of a LOI was published in *The Herald* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in cursive script, reading "Kim 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

September 19, 2007

Requisition # HCA08-050
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 **Sunday, September 23, 2007**.

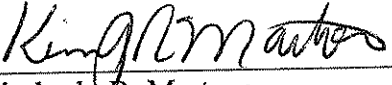
Please provide the following **within 30 days** of publication:

- 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 at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,



Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Stuart C. Calle, M.D.
Town:	Newington
Docket Number:	07-31036
Proposal:	Establish a Walk-In Medical Center in Newington
Capital Expenditure:	\$30,000

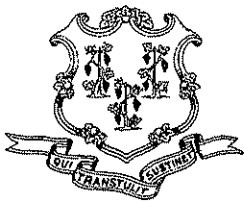
The Applicant may file its Certificate of Need application between November 11, 2007 and January 10, 2008. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

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	2618
RECIPIENT ADDRESS	92252611
DESTINATION ID	
ST. TIME	09/19 10:11
TIME USE	00'43
PAGES SENT	2
RESULT	OK



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

September 19, 2007

Requisition # HCA08-050
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 **Sunday, September 23, 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.

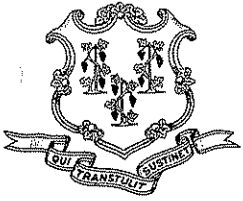
If there are any questions regarding this legal notice, please contact Jack Huber at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

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

Kimberly R. Martone



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

September 19, 2007

Stuart Calle, M.D.
Medical Director
365 Willard Avenue, Suite 2E
Newington, CT 06111 2316

RE: Certificate of Need Application Forms
Docket Number: 07-31036-CON
Proposal to Establish a Walk-In Medical Center in Newington

Dear Dr. Calle:

Enclosed are the application forms for Dr. Stuart C. Calle's 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 November 11, 2007, and January 10, 2008.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Kim 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, a response of "Not Applicable" may be acceptable. Your Certificate of Need application will be eligible for submission no earlier than November 11, 2007, and may be submitted no later than January 10, 2008. The OHCA analyst assigned to your application is Jack A. Huber. He may be reached at the Office of Health Care Access by dialing (860) 418-7034 directly.

Docket Number: 07-31036-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: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">DATE</th> <th style="width: 15%;">INITIAL</th> </tr> </thead> <tbody> <tr> <td>1. Check logged (Front desk)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. Check rec'd (Clerical/Cert.)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. Check correct (Superv.)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4. Check logged (Clerical/Cert.)</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		DATE	INITIAL	1. Check logged (Front desk)	_____	_____	2. Check rec'd (Clerical/Cert.)	_____	_____	3. Check correct (Superv.)	_____	_____	4. Check logged (Clerical/Cert.)	_____	_____
	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: _____	\$ 1,000.00
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)	\$ _____ .00
c. Sum of base fee plus additional fee: (Lines A4a + A4b) _____	\$ _____ .00
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
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:

1. Primary and secondary service area towns.
2. Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic information, as appropriate.
3. Scheduling backlogs in service area.
4. Travel distance from proposed site to service area towns.
5. 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.

- | | |
|--|---|
| <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.

- C. 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) _____ | |

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:

- | | | |
|---|--|--|
| <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-Society Council for Radiation Oncology | <input type="checkbox"/> American College of Radiology | <input type="checkbox"/> Substance Abuse and Mental Health Services Administration |
| <input type="checkbox"/> 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:

- | | |
|---|---|
| <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

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 DPH licensure category you are seeking. 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.
- i) Identify the entity that will be billing for the proposed service.
- ii) 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,
- i. Letter of interest from CHEFA,
- ii. Amortization schedule (if not level amortization payments),
- iii. 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 complete Financial Attachment I 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) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Please complete Financial Attachment II, enclosed.
- iii) 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.). **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.

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:

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

*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		Rate	Units	Gross Revenue	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Col. 2 * Col. 3	Deductions	Care	Debt	Revenue	Expenses	from Operations
								Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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
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