Updike, Kelly & Spellacy, P.C.

Counselors at Law

Please reply to the Hartford Office

One State Street, P.O. Box 231277
Hartford, Connecticut 06123-1277
Telephone (860) 548-2600
Facsimile (860) 548-2680

One Century Tower, 265 Church Street
New Haven, Connecticut 06510-7002
Telephone (203) 786-8300
Facsimile (203) 772-2037

RECEIVED
2008 DEC -3 P 1:
MERITAS
LAW FIRMS WORLDWIDE
An Alliance Member
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

December 2, 2008

VIA HAND DELIVER

Cristine Vogel, Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: Letter of Intent for Change of Ownership of Mountainside Lodge

Dear Commissioner Vogel:

Enclosed please find an original and three (3) copies of a Letter of Intent Form 2030 for the proposed change of ownership of Mountainside Lodge, a substance abuse treatment facility located in Canaan. Should you require anything further at this time, please feel free to call me at (203) 786.8316.

Very truly yours,

Jennifer L. Groves

Enclosures

cc: Mr. Martin Fedor (w/enc.)
Mr. Terence R. Dougherty (w/enc.)
Ms. Karen Banoff (w/enc.)
Greg Pepe, Esq. (w/enc.)

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 the Applicant(s), 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	**Mountainside Foundation, Inc.**	**Artemis Partners, LLC**
Doing Business As	**Mountainside Lodge**	**Artemis Partners**
Name of Parent Corporation	**N/A**	**N/A**
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**P.O. Box 717 Route 7 Canaan, CT 06018**	**P.O. Box 1294 187 So Canaan Road Canaan, CT 06018**
Identify Applicant Status: P for Profit or NP for Nonprofit	**NP**	**P**
Does the Applicant have Tax Exempt Status?	**Yes**	**No**
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	**Terence R. Dougherty President/CEO**	**Martin Fedor Managing Member**
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**B.O. Box 717 Route 7 Canaan, CT 06108**	**P.O. Box 1294 187 So Canaan Road Canaan, CT 06018**
Contact Person Telephone Number	**(860) 824.1397**	**(917) 573.5084**
Contact Person Fax Number	**(860) 824.4021**	**(877) 893-6560**
Contact Person e-mail Address	**trd@mountainside.org**	**martin.fedor@gmail.com**

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Change of Ownership of Mountainside Lodge**

b. Project Proposal: **Mountainside Foundation, Inc., a non-profit entity, proposes to transfer ownership of Mountainside Lodge in Canaan to Artemis Partners, LLC, a for-profit entity.**

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☒ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☒ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

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

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service
☐ Reduction ☒ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

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

☐ New equipment acquisition and operation
☐ Replacement equipment with disposal of existing equipment
☐ Major medical equipment
☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code: **187 Route 7**

Canaan, CT 06108

g. List each town this project is intended to serve: **All towns in the State of Connecticut and tri-state area**

h. Estimated starting date for the project: **The change of ownership will take place immediately upon receipt of necessary regulatory approvals.**

i. If the proposal includes change in the number of beds provide the following information: **N/A**

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: **$ 385,000**

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	**$235,500**
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify: **Legal/Consulting Fees**	**$150,000**
Total Capital Expenditure	**$385,500**
Major Medical Equipment – Fair Market Value of Leases 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	**$385,500**
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference. **N/A**

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. 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 each major medical/imaging equipment.

e. 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

Description of Proposed Project

This proposal involves a change of ownership through sale of the real and personal property of Mountainside Treatment Center ("Mountainside Lodge"), an inpatient substance abuse treatment facility located in Canaan, Connecticut, which is owned and operated by Mountainside Foundation, Inc. ("Mountainside Foundation"). Mountainside Foundation is a Connecticut non-stock corporation that qualifies as a non-profit under Section 501(c)(3) of the Internal Revenue Code. The purchaser of the real and personal property of Mountainside Foundation is Artemis Partners, LLC ("Artemis") (collectively with Mountainside Foundation "Applicants"), a Connecticut limited liability company.

Several key factors have contributed to the Applicants' decision to put forth this proposal; first and foremost, is the ongoing public need for the treatment services being provided by Mountainside Lodge. The facility provides critically needed residential drug and alcohol treatment services to approximately 600 individuals each year. Substance abuse and dependence continues to be a significant health and societal problem and affects approximately 10% of Connecticut's residents. The additional factors prompting this proposal include declining philanthropic donations, increasing capital needs and the current restrictive credit markets.

1. **List the type of services currently being provided and,**

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

   Mountainside Lodge is licensed by the Department of Public Health as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons (see ***Exhibit B*** attached). Artemis Partners will be applying for the same category of DPH license.

3. **Identify the current population served and the target population to be served.**

   The current client population being served by Mountainside Lodge is 18 year and older individuals in need of residential alcohol and drug addiction treatment. The facility provides services for individuals throughout the State of Connecticut and from the tri-state area. The target population to be served will be the same as the current client population.

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

   Mountainside Lodge has regularly met the need for those seeking its services as is evidenced by its historic as well as current utilization rates that are greater than 85 percent. This transaction will ensure that these services will continue.

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

Trinity Glen	Ministry of the High Watch
Sharon, CT	Kent, CT

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

   This proposal will have a positive effect on health care delivery in the State of Connecticut. Continued access to residential drug and alcohol programs is critical for the successful treatment of many with substance abuse. This proposal will ensure the continued delivery of critical health care services to Connecticut residents in need.

7. **Who will be responsible for providing the service?**

   Artemis Partners, LLC will own and operate Mountainside Lodge. Current management personnel and other staff will continue to be employed under the new ownership.

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

   Mountainside Lodge is currently a self-pay facility; there are no anticipated payer changes.

AFFIDAVIT

To be completed by each Applicant

Applicant: **Mountainside Foundation, Inc.**

Project Title: **Change of Ownership of Mountainside Lodge Treatment Center**

I, **Terence R. Dougherty**, **President and CEO** of **Mountainside Foundation, 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 **Mountainside Treatment Center** 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 12·1·08

Subscribed and sworn to before me on 1 December 2008

Vanessa Millard

Notary Public/Commissioner of Superior Court

My commission expires: Vanessa Millard Notary Public My Commission Expires Sep. 30, 2009

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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

AFFIDAVIT

To be completed by each Applicant

Applicant: **Artemis Partners, LLC**

Project Title: **Change of Ownership of Mountainside Lodge Treatment Center**

I, **Martin Fedor**, **Managing Member** of **Artemis Partners, LLC,** 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 **Artemis Partners, 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.

Signature

12-01-2008
Date

Subscribed and sworn to before me on 1 December 08

Vanessa Millard
Notary Public/Commissioner of Superior Court

My commission expires: Vanessa Millard Notary Public My Commission Expires Sep. 30, 2009

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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

EXHIBIT A

Non-Medical Equipment

Estimated Capital Expenditures	
Driveway and curtain drain	17,000
Bedrooms	63,310
Conference Chairs	777
Drever Hall Chairs	12,950
Dining Room Chairs	12,950
Offices	14,800
Painting	30,000
Bathrooms	4,500
Break Room	6,500
Rugs	3,000
Shipping	5,500
Industrial wash and dryer	5,200
Tractor	18,000
Ropes Course	41,000
Total:	235,487

EXHIBIT B

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. SA-0187

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

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

Mountainside Foundation, Inc. of Canaan, CT, d/b/a Mountainside Lodge is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Mountainside Lodge is located at 187 South Canaan Rd., Rte 7, Canaan, CT 06018 with:

Timothy J. Walsh as Executive Director

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

66 Intermediate and Long Term Treatment and Rehabilitation Beds

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

Intermediate and Long Term Treatment and Rehabilitation

This license expires **December 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2008.

License revised to reflect:
CHANGE OF EXECUTIVE DIRECTOR EFF: 11/1/08

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

Greci, Laurie

From: Greci, Laurie
Sent: Thursday, December 11, 2008 8:51 AM
To: 'trd@mountainside.org'; 'martin.fed@gmail.com'
Subject: CON Application for Mountainside Lodge (08-31282-CON)
Attachments: 08-31282-CON.doc; 08-31282-CON CL.doc; CON Affidavit-General.doc; 08-31282-CON Financial Attachments.xls

Dear Sirs,

Attached you will find the electronic files for the Certificate of Need application submitted by you for the change of ownership of Mountainside Lodge to Artemis Partners. The hard copy is being mailed to you today.

Sincerely,

Laurie Greci

Associate Research Analyst
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134
Laurie.Greci@ct.gov
(860) 418-7032
(860) 418-7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 8, 2008

Terence Dougherty
President & CEO
Artemis Partners, LLC
P.O. Box 717
187 So. Canaan Road/Route 7
Canaan, CT 06018

Re: Letter of Intent, Docket Number 08-31282
Proposal to Transfer Ownership of Mountainside Foundation, Inc. to Artemis Partnership, LLC
Notice of Letter of Intent

Dear Mr. Dougherty:

On December 2, 2008 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Artemis Partners, LLC ("Applicant") for the proposal to transfer ownership of Mountainside Foundation, Inc. to Artemis partnership, LLC in Canaan, with a total capital expenditure of $385,500.

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

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 8, 2008

Requisition # HCA09-081
Fax: (860) 489-6790

The Register Citizen
190 Water Street
Torrington, CT 06790-0058

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 **Friday, December 12, 2008.**

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 or Alexis Fedorjaczenko 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:AF:lmg

c: Sandy Salus, OHCA

The Register Citizen
Docket Number 08-31282

Letter of Intent
December 8, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Artemis Partners, LLC
Town:	Canaan
Docket Number:	08-31282-LOI
Proposal:	Proposal to transfer ownership of Mountainside Foundation, Inc. to Artemis Partnership, LLC
Capital Expenditure:	$385,500

The Applicant may file its Certificate of Need application between January 31, 2009 and April 1, 2009. 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

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ST. TIME	12/08 17:11
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PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 8, 2008

Requisition # HCA09-081
Fax: (860) 489-6790

The Register Citizen
190 Water Street
Torrington, CT 06790-0058

Gentlemen/Ladies:

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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 or Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 10, 2008

Terence Dougherty
President & CEO
Mountainside Foundation, Inc.
P.O. Box 717
Canaan, CT 06018

Martin Fedor
Managing Member
Artemis Partners, LLC
P.O. Box 1294
Canaan, CT 06018

RE: Certificate of Need Application Forms, Docket Number 08-31282-CON
Mountainside Foundation, Inc. and Artemis Partnership, LLC
Proposal to transfer ownership of Mountainside Foundation, Inc. to Artemis Partnership, LLC

Dear Mr. Dougherty and Mr. Fedor:

Enclosed are the application forms for Mountainside Foundation, Inc.'s and Artemis Partners, LLC's Certificate of Need ("CON") proposal for the proposal to transfer ownership of Mountainside Foundation, Inc. to Artemis Partnership, LLC with an associated capital expenditure of $385,500. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between January 31, 2009, and April 1, 2009.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

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

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 31, 2009, and may be submitted no later than April 1, 2009. The Analyst assigned to your application is Laurie Greci and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31282-CON

Applicant Name:	Mountainside Foundation, Inc.	Artemis Partners, LLC
Contact Person:	Terence Dougherty	Martin Fedor
Contact Title:	President & CEO	Managing Member
Contact Address:	P.O. Box 717 Canaan, CT 06018	P.O. Box 1294 Canaan, CT 06018

Project Location: Canaan

Project Name: Transfer of ownership of Mountainside Foundation, Inc. to Artemis Partnership, LLC

Type proposal: Section 19a-638, C.G.S.

Estimated Capital Expenditure: $385,500

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. Applicants' Long Range Plan

Is this application consistent with each of the Applicants long-range plan?

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

4. Clear Public Need

A. Explain the need for the proposal and how the need was determined.

B. Provide the following information:

i. List the service area towns. Provide a rationale for choosing the elected towns.
ii. The units of service for the past three fiscal years and the current fiscal year-to-date by service area town.
iii. The units of service for the past three fiscal years and the current fiscal year- to-date by service type.
iv. Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic Information as appropriate.
v. Scheduling backlogs in service area.
vi. Travel distance from the proposed site to service area towns.
vii. Hours of operation of existing and the proposed service.

C. Identify the existing providers of the proposed service in your service area as outlined in the following table:

Legal Name of Provider, Street, Town, Zip Code	Similar Services Provided? (Y/N)	Affiliated Physicians (Name, Practice)

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

E. Provide the units of service projected for the first three years of operation. of the proposed service. Include the derivation/calculation. List the start and end date for each time period.

F. Will the Applicants' proposal remedy any of the following barriers to access? Provide an explanation.

☐ Cultural
☐ Geographic
☐ None
☐ Transportation
☐ Economic
☐ Other (Identify) _____

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

G. Provide copies of any epidemiological, public information or other similar studies related to your proposal. If there are none, please explain why none are available for submission.

H. Provide copies of needs assessments and market share analyses performed to support the need for the proposal. If there are none, explain why no such assessments or analyses were undertaken by the Applicant.

5. Quality Measures

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

☐ American College of Cardiology
☐ National Association of Child Bearing Centers
☐ Report of the Inter-Council for Radiation Oncology
☐ Other, Specify:
☐ National Committee for Quality Assurance
☐ American College of Ob. & Gyn.
☐ American College of Radiology
☐ Public Health Code & Federal Corollary
☐ American College of Surgeons
☐ Substance Abuse and Mental Health Servs. Admin.

B. Describe in detail how the Applicants plan to meet the each of the guidelines checked off above.

C. Submit a list of all key professional and administrative personnel of each Applicant, including the 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.*

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

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports (New Out-of-State Providers)
- ☐ AAAASF

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

E. 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
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

7. Miscellaneous

A. Will this proposal result in new (or a change to) the teaching or research responsibilities of the Applicants?

☐ Yes ☐ No If you checked "Yes," please provide an explanation.

[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.

B. Are there any characteristics of the patient/physician mix that make the 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. Affiliations, Mergers, Acquisitions and Changes in Ownership

A. Provide a copy of the written agreement or memorandum of understanding between the Applicants related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

B. Identify the following items for each Applicant:

i. Geographical service area.
ii. Health care services provided.
iii. Physician referral patterns.
iv. Corporate or entity structural relationships.
v. Shared service arrangements (e.g., Group Purchasing, billing etc.).

C. Provide for each Applicant the following information related to the proposal:

i. Articles of Incorporation, Articles of Organization or Partnership Agreements (all that are appropriate).
ii. Legal chart of corporate or entity structure.
iii. Board of Directors or governing body resolutions approving the proposal.
iv. Current and proposed percentage of ownership.
v. Changes in legal status.
vi. Changes in membership of board of directors or governing body.
vii. Changes in independence of board of directors or governing body.
viii. Changes in facility licensed beds, health care services, service areas, locations and management.
ix. Medicare provider number.

9. Financial Information

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

- ☐ Corporation (Inc.)
- ☐ Partnership
- ☐ Joint Venture
- ☐ Other (Specify): _____
- ☐ Limited Liability Company (LLC)
- ☐ Professional Corporation (PC)

B. Provide the following financial information:

i. Submit audited financial statements for each Applicant for the most recently completed fiscal year. If an 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.

10. 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 medical and non-medical equipment.

11. 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. 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.

9. Revenue, Expense and Volume Projections

A. Payer Mix Projection

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

Total Facility Description	FY____ Current Payer Mix	FY____ Year 1 Projected Payer Mix	FY____ Year 2 Projected Payer Mix	FY____ Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (incl. other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100%	100%	100%	100%

*Includes managed care activity.

B. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

C. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

D. 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, Financial Attachment I.*
   Note: 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. 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.

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

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

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

12. Dii. 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 _____ (Year _) **FY Projected Incremental** Total Incremental Expenses:	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations 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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0