The William W. Backus Hospital

February 2, 2009

Cristine A. Vogel
Commissioner
State of Connecticut
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Enclosed please find an original and five (5) copies of our Certificate of Need Letter of Intent Form 2030 concerning the continuation of a primary care practice through CONNCare, Inc. in Plainfield, CT, located at 120-122 Plainfield Road.

The total project cost associated with this renovation project is $20,000.

If you have any questions concerning this submittal, please contact me at 860-889-8331, extension 2722 or at dwhitehead@wwbh.org. As always, I look forward to working with your staff on this submission.

Sincerely,

David A. Whitehead
Vice President, Planning

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	**CONNCare, Inc.**	
Doing Business As	**Same**	
Name of Parent Corporation	**Backus Health Care, Inc.**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**112 Lafayette Street, Norwich, CT 06360**	
Identify Applicant Status: P for Profit or NP for Nonprofit	**NP**	
Does the Applicant have Tax Exempt Status?	**Yes**	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	**David Whitehead, Administrator**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**326 Washington Street, Norwich, CT 06360**	
Contact Person Telephone Number	**860-889-8331, x2722**	
Contact Person Fax Number	**860-892-2728**	

Contact Person e-mail Address	dwhitehead@wwbh.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Continuation of Established Primary Care Practice**

Project Proposal: **CONNCare, Inc. proposes to continue to provide primary care services at the Plainfield Medical Center at 120-122 Plainfield Road, Plainfield, CT due to the retirement (10/01/08) of Dr. Savador Aromin, and the closure of Dr. Wilcon's primary care practice at this location (OHCA Final Decision, Docket Number 07-31052-CON). CONNCare will continue the operation of a licensed outpatient services practice at this location to ensure the continued access to quality primary care/urgent care for the patient population served currently and formerly by the practices at this location in the Backus Service Area.**

b. 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 **X** Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency **X** 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: _____

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

X Yes ☐ No

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

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

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

☐ Reduction ☐ Change in Ownership/Control

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

☐ Yes **X 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:

Plainfield Medical Center, 120-122 Plainfield Road, Plainfield, CT 06374

g. List each town this project is intended to serve:

Plainfield, Moosup, Central Village, Canterbury, Sterling, Voluntown

h. Estimated starting date for the project: **May 2009**

i. If the proposal includes change in the number of beds provide the following information:

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: **$20,000**

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	**$20,000**
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
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	**$20,000**
Capitalized Financing Costs (Informational Purpose Only)	

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

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.

☐ 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:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

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):

X Applicant's Equity	☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	
☐ Other *(specify)* _____		

SECTION IV. PROJECT DESCRIPTION

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

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

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

3. Identify the current population served and 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?

AFFIDAVIT

To be completed by each Applicant

Applicant: **CONNCare, Inc.**

Project Title: **Continuation of Established Primary Care Practice**

I, Daniel E. Lohr, Senior Vice President and CFO of Backus Health Care, 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 Backus Health Care, Inc. 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.

Daniel E Lohr — Signature

2/2/2009 — Date

Subscribed and sworn to before me on February 2, 2009

Donna M. Carter — Notary Public/Commissioner of Superior Court

My commission expires: September 30, 2010

RECEIVED
2009 FEB -4 A 11:01
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

SECTION IV. PROPOSAL 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 elements need to be addressed, if applicable.

CONNCare, Inc. proposes to provide, within its outpatient clinic license, primary and urgent care services at the Plainfield Medical Center at 120-122 Plainfield Road, Plainfield, CT due to the retirement (10/01/08) of Dr. Savador Aromin, and the closure of Dr. Wilcon's primary care practice at this location (OHCA Final Decision, Docket Number 07-31052-CON). CONNCare will continue the operation of a primary care/urgent care practice at this location to ensure the continued access to quality care for the patient population served currently and formerly by the practices at this location in the Backus Service Area.

CONNCare, Inc. given its current operation of three primary and urgent care outpatient clinics, located in Colchester, Gales Ferry and Montville, CT, would be the licensed entity to provide this service (See Attachment 1). As Plainfield is in the Backus Service Area the seamless continuation of this service is important to meeting the medical needs of that population. As OHCA identified in Final Decision, Docket Number 07-31052-CON, the greater Plainfield community is designated as a Primary Health Professional Shortage Area by the State of Connecticut Department of Public Health. Furthermore, the U.S. Department of Health and Human Services has designated the communities of Plainfield, Sterling and Voluntown within the proposed service area as Medically Underserved Populations. This proposal will maintain accessibility to outpatient care services in the proposed service area in response to these designations. Alternatively, failure to replace Dr. Aromin will exacerbate clinical shortage within the service area.

Currently within this proposed service area there are 10 primary/urgent walk-in care physicians providing medical services:

Physician	Service Area	Medical Staff affiliation
Arabinda Chatterjee, MD	N. Grosvenordale	Day Kimball Hospital
	Canterbury	The William W. Backus Hospital
Nita Chatterjee, MD	N. Grosvenordale	Day Kimball Hospital
	Canterbury	The William W. Backus Hospital
Leah Briones, MD	Plainfield	The William W. Backus Hospital
Deepa Ramachandran, MD	Plainfield	The William W. Backus Hospital
Claire Warren, MD	Plainfield	The William W. Backus Hospital
Sherry Kroll, MD	Plainfield	Day Kimball Hospital
Wagdy Habashy, MD	Plainfield	Day Kimball Hospital
Leilani Nixon	Plainfield	Day Kimball Hospital

CONNCare, Inc. will lease the outfitted space, approximately 2,100 square feet, formerly occupied by Dr. Aromin. The facility, which houses the Plainfield Medical Center, is owned by

Backus Properties, Inc. specifically for the purpose of providing medical services to this community. The Town of Plainfield, which had previously owned the building specifically for the provision of medical services to its community, based upon the intent of the property donor, approached Backus on the acquisition of the facility to maintain the delivery of medical services for its citizens.

The payers of this service will be consistent with the payers at established CONNCare, Inc. Backus Health Centers in Colchester, Gales Ferry and Montville:

HMO/PPO	49%
Commercial	13%
Medicare	16%
Medicaid	9%
Self-pay	2%
Workers' Compensation	7%
Other governmental (TRICARE)	4%

ATTACHMENT 1

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0274

Outpatient Clinic

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

Conncare, Inc. of Norwich, CT, d/b/a Conncare, Inc is hereby licensed to maintain and operate an Outpatient Clinic.

Conncare, Inc is located at 112 Lafayette Street, Norwich, CT 06360.

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

Dated at Hartford, Connecticut, January 1, 2006. RENEWAL.

Services:
Primary Care Services

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

February 6, 2009

David Whitehead
Vice President, Planning
CONNCare, Inc.
326 Washington Street
Norwich, CT 06360

Re: Letter of Intent, Docket Number: 09-31305
CONNCare, Inc.
Establishment of Primary Care Services
Notice of Letter of Intent

Dear Mr. Whitehead:

On February 4, 2009 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of CONNCare, Inc. ("Applicant") for the establishment of primary care services in Plainfield, with a capital expenditure of $20,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Norwich Bulletin* 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

February 6, 2009

Requisition # HCA09-102
Email: ndouglas@norwich@gannett.com

Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, February 10, 2009.**

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 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:AF:lmg

c: Sandy Salus, OHCA

The Norwich Bulletin **Letter of Intent**
Docket Number: 09-31305 **February 6, 2009**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	CONNCare, Inc.
Town:	Plainfield
Docket Number:	09-31305-LOI
Proposal:	Establishment of Primary Care Services in Plainfield
Capital Expenditure:	$20,000

The Applicant may file its Certificate of Need application between April 5, 2009 and June 4, 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

Greer, Leslie

From: Douglas, Nancy [ndouglas@norwichbulletin.com]
Sent: Friday, February 06, 2009 10:14 AM
To: Greer, Leslie
Subject: RE: Legal Ad 09-31305

Thanks – all set for tomorrow – 1 time Sat., Feb 7
NOTE MY EMAIL BELOW HAS CHANGED

Nancy C. Douglas
Classified Adv
Phone 860-889-3363
Fax 860-887-1949
email ndouglas@norwichbulletin.com

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Friday, February 06, 2009 9:30 AM
To: Douglas, Nancy
Subject: Legal Ad 09-31305

Legal Ad,
Please run the attached public notice in your newspaper no later than February 10, 2009. Please notify me that you have received this request.

Thank you,

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Legals

Vehicles Wanted

Department.

Dated at Griswold, CT
this 4th day of February 2009

Courtland Kinnie, Chairman

Statute Reference:	19a-638
Applicant:	CONNCare, Inc.
Town:	Plainfield
Docket Number:	09-31305-LOI
Proposal:	Establishment of Primary Care Services in Plainfield
Capital Expenditure:	$20,000

The Applicant may file its Certificate of Need application between April 5, 2009 and June 4, 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 13, 2009

David Whitehead
Administrator
Backus Hospital
326 Washington Street
Norwich, CT 06360

RE: Certificate of Need Application Forms, Docket Number 09-31305-CON
CONNCare, Inc.
Establishment of Primary Care Services in Plainfield

Dear Mr. Whitehead:

Enclosed are the application forms for CONNCare Inc's Certificate of Need ("CON") proposal for the establishment of promary care services in Plainfield with an associated capital expenditure of $20,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between April 5, 2009 and June 4, 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 four (4) 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 Alexis Fedorjaczenko. Please contact her at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone (agf)

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 april 5, 2009, and may be submitted no later than June 4, 2009. The OHCA analyst assigned to your application is Alexis G. Fedorjaczenko. She may be reached at the Office of Health Care Access by dialing (860) 418-7067.

Docket Number:	09-31305-CON
Applicant Name:	CONNCare, Inc.
Contact Person:	David Whitehead
Contact Title:	Administrator
Contact Address:	326 Washington Street Norwich, CT 06360
Project Location:	Plainfield
Project Name:	Establishment of Primary Care Services in Plainfield
Proposal Type:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$20,000

1. Expansion of Existing or New Service

A. What services are currently offered at the facility that the proposal will augment or replace?

B. What related services are provided by the Applicant at other locations?

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

A. Is this application consistent with your long-range plan?

☐ Yes ☐ No (please explain)

4. Clear Public Need

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

B. List and explain in narrative fashion the type of services that will be provided at the proposed center.

C. List the service area towns & explain how the service area was determined.

D. Describe the population to be served, including the number of individuals to receive the proposed service. Include demographic information as appropriate.

E. Hours of operation of the proposed service.

F. Provide the information as outlined in the following table concerning existing providers of the proposed service in your service area:

Provider Name & Location	Similar Services Provided? (Y/N) Describe services.	Affiliated Physicians & Hospital Affiliation

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

H. Provide the units of service projected for the first three years of operation of the proposed service. **Include all derivation/calculations used to develop the projections.**

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

☐	Cultural	☐	Transportation
☐	Geographic	☐	Economic
☐	None of the above	☐	Other (Specify)

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

☐	Epidemiological studies	☐	Market share analysis
☐	Public information reports	☐	Other (Specify)

K. Provide a copy of the needs assessment completed for the purposes of this proposal. If no needs assessment Was conducted, explain why not.

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 & describe in detail your plans to meet the each of the guidelines.

☐ 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 Abuse and Mental Society Health Services Administration

☐Other: (Specify)

B. 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.

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

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other State Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other (Specify)

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

D. Provide a copy of the following:

☐ Any Quarterly Action Reports, Consent Decrees or Statement of Charges against the you, your physicians and any staff related to the proposal, for the past five years

☐ Any plan of action which has been formulated to address the above action against the you, your physicians working at the facility and/or any staff related to the proposal

☐ A copy of the related Quality Assurance plan

☐ Protocols for service

☐ Patient Selection Criteria/Intake form

6. Miscellaneous

A. What measures will your facility undertake to improve productivity & contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

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

☐ Other (Specify)

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

☐ Yes (please explain) ☐ No

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

☐ Yes (please explain) ☐ No

D. Identify the DPH licensure you are seeking. If not applicable, explain why.

---

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

7. Financial Information

A. Type of ownership (Check off all that apply)

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

B. Does the Applicant have Tax Exempt Status?

☐ Yes ☐ No

C. Provide the following financial information:

i. Audited financial statements for the most recently completed fiscal year. If you have no audited financial statements, 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. Total current assets balance as of the date of submission of this application.

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

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

v. The entity that will be billing for the proposed service.

8. Major Cost Components/Total Capital Expenditure

A. 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.

9. Type of Financing

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

☐ Applicant's equity Provide Source and amount:

Operating Funds: Source/Entity Name Total Funds Available	$
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. Amortization schedule (if not level amortization payments)

ii. Lease agreement.

10. Revenue, Expense and Volume Projections

A. Payer Mix Projection. Provide both the and projected payer mix with the CON proposal for the Total Facility based on Gross Patient Revenue in the following reporting format:

Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid*				
CHAMPUS or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*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. 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. 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.*

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

iv. Three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Please complete Financial Attachment II, enclosed.**

v. A copy of the rate schedule for the proposed service.

vi. Describe how this proposal is cost effective.

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

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

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

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

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: _____

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

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

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

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	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
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

****
*** TX REPORT ***
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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: DAVID WHITEHEAD

FAX: (860) 892-2728

AGENCY: BACKUS HOSPITAL

FROM: ALEXIS FEDORJACZENKO

DATE: 2/13/09 **TIME:**

NUMBER OF PAGES: 14
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Comments: Docket 09-31305 CON Application

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