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	Julie Ann Sullivan	
Doing Business As	New Beginnings Rehabilitation Center	
Name of Parent Corporation	Same	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	17 Lakeview Ave Shelton, CT 06484	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Julie Sullivan, CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	17 Lakeview Ave Shelton, CT 06484	
Contact Person Telephone Number	203-685-3932	
Contact Person Fax Number	203-540-5448	
Contact Person e-mail Address	Erie23@SBCGlobal.Net	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: New Beginnings Rehabilitation Center, Inc.

b. Project Proposal: Substance Abuse Tx (Medicated Assisted and outpatient).

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:

Derby, CT 06418

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

Derby, Ansonia, Shelton, Seymour, Naugatuck, Beacon Falls.

h. Estimated starting date for the project: 9/1/09

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: $ 60,800.00

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	7400.00
Non-Medical Equipment Purchases*	15400.00
Land/Building Purchases	
Construction/Renovation	10,000.00
Other (Non-Construction) Specify: Office Furniture	10,000.00
Total Capital Expenditure	42800.00
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	18,000.00
Total Capital Cost	18,000.00
Total Project Cost	60,800.00
Capitalized Financing Costs (Informational Purpose Only)	120,000.00

* 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 N/A

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.

Itemized list of all medical and non-medical equipment for New Beginnings Rehabilitation Center

Medical Equipment

Methadone dispensing pump	$6500.00
Doctor's examining table	$400.00
Methadone measuring and mixing equipment	$500.00
Total	$7400.00

Non- Medical Equipment

Label Printer	$200.00
Dispensing Computer	$1000.00
8 Desktop Computers & Printers	$8000.00
Laptop	$1000.00
Networking Equipment	$1500.00
Office Copier	$1000.00
Telephone system	$1500.00
Safe for Methadone	$1200.00
Total	$15400.00

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 See Attached

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?

Section IV. PROJECT DESCRIPTION

1. N/A

2. The type of services being proposed are 1-methadone maintenance treatment and 2 – outpatient substance abuse treatment. The DPH licensure category that will be sought is Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons.

3. The target population for methadone maintenance treatment will be adults, 18 and over, that are opioid dependent. The target population for the outpatient treatment will be adults, 18 and over, in need of outpatient substance abuse treatment.

4. The unmet need in the proposed geographically area of the facility is the lack of methadone treatment. Currently there is no methadone treatment program in the Valley. A patient living in Ansonia would have to travel to New Haven, Bridgeport or Waterbury to obtain methadone treatment. Having a clinic in Derby treatment will be more readily accessible to people in the Valley community.

5. There are other substance abuse programs that offer outpatient services but there is no other methadone treatment in the area.

6. Offering methadone maintenance treatment in the Valley would alleviate some of the burden on hospitals and emergency rooms. According to the ONDCP web site MMT allows patients to be free of heroin addiction. The National Institute on Drug Abuse found that, among outpatients receiving MMT, weekly heroin use decreased by 69%. This decrease in use allows for **the individual's health and productivity to improve** (Office of National Drug Control Policy, 1998a). Patients were no longer required to live a life of crime to support their habit, and criminal activity decreased by 52% among these patients. Full-time employment increased by 24%. In a 1994 study of drug treatment in California, researchers found that rates of illegal drug use, criminal activity, and **hospitalization were lower** for MMT patients than for addicts in any other type of drug treatment program. This research shows the benefit for the heath care delivery system of the State of Connecticut when patient are stable in a methadone treatment program.

7. The methadone will be dispensed by a licensed nurse, the physicals and initial assessments will be conducted by a medical doctor that specializes in patients with addiction disorders. The counseling and clinical aspects of the MMT and the OPT will be delivered by licensed and certified substance abuse counselors. The methadone will be prepared by a licensed pharmacist.

8. The anticipated payers of the services will be public and private insurance and cash paying clients. We would also except other third party payers such as employers, DCF and court support services.

AFFIDAVIT

To be completed by each Applicant

Applicant: Julie A. Sullivan

Project Title: New Beginnings Rehabilitation Center

I, Julie A. Sullivan (Name), CEO (Position – CEO or CFO)

of New Beginnings Rehabilitation Center, 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 New Beginnings (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Julie Sullivan — Signature

3/10/09 — Date

Subscribed and sworn to before me on March 10, 2009

Nancy Ellen deMaddo

Notary Public/Commissioner of Superior Court

My commission expires: Oct 31 2009

RECEIVED
2009 MAR 12 A 11: 11
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

Julie Sullivan, CEO
New Beginnings Rehabilitation Center
17 Lakeview Avenue
Shelton, CT 06484

Re: Letter of Intent; Docket Number: 09-31329
New Beginnings Rehabilitation Center
Establish and Operate Methadone Maintenance and Outpatient Substance Abuse Treatment Programs in Derby

Dear Ms. Sullivan:

On March 12, 2009 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of New Beginnings Rehabilitation Center ("Applicant") to establish and operate Methadone Maintenance and Outpatient Substance Abuse Treatment programs in Derby, at a total capital expenditure of $42,800.

A notice to the public regarding OHCA's receipt of a LOI was published by the *Connecticut Post* 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
Director of Operations

KRM:lmg

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

Requisition # HCA09-120
Fax: (203) 384-1158
Acct# 106794

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 no later than **Tuesday, March 24, 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
Director of Operations
Attachment

KRM:AF:lmg

c: Sandy Salus, OHCA

Connecticut Post
Docket Number: 08-31329

Letter of Intent
March 20, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	New Beginnings Rehabilitation Center
Town:	Derby
Docket Number:	08-31329-LOI
Proposal:	Establish and Operate Methadone Maintenance and Outpatient Substance Abuse Treatment Programs in Derby
Capital Expenditure:	$42,800

The Applicant may file its Certificate of Need application between May 11, 2009 and July 10, 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.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	4913
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	03/20 13:58
TIME USE	00'19
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

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Fax: (203) 384-1158
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Sincerely,

Kimberly R. Martone

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 20, 2009

Julie Ann Sullivan, CEO
New Beginnings Rehabilitation Center
17 Lakeview Avenue
Shelton, CT 06484

RE: Certificate of Need Application Forms, Docket Number 09-31329-CON
New Beginnings Rehabilitation Center, Inc.
Establish and Operate Methadone Maintenance and Outpatient Substance Abuse Treatment Programs in Derby

Dear Ms. Sullivan:

Enclosed are the application forms for New Beginnings Rehabilitation Center's Certificate of Need ("CON") proposal to establish and operate methadone maintenance and outpatient substance abuse treatment programs with an associated capital expenditure of $42,800. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between May 11, 2009, and July 10, 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
Director of Operations

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 May 11, 2009, and may be submitted no later than July 10, 2009. The Analyst assigned to your application is Alexis Fedorjaczenko; she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31329-CON

Applicant's Name: New Beginnings Rehabilitation Center, Inc.

Contact Person: Julie Ann Sullivan
Contact Title: CEO

Contact Address: 17 Lakeview Avenue
Shelton, CT 06484

Project Location: Derby

Project Name: Establish and Operate Methadone Maintenance and Outpatient Substance Abuse Treatment Programs in Derby

Type proposal: Section 19a-638

Est. Capital Expenditure: $42,800

1. New or Expansion of Existing Service

A. Provide a narrative detailing each component of the proposal.

B. Provide a brief description of the Applicant organization, its history, and any services currently offered by the Applicant that the proposal will augment or replace.

C. Identify the location of the proposed service, including street address, town, and zip code.

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, provide an explanation.)

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area. Provide specific evidence of the need, including, but not limited to, incidence and prevalence of conditions to be treated, the demand for the service and the Applicant's market share of the service area.

B. Describe the target population for each service included in the proposal.

C. Explain how it was determined that there was a significant patient base in the proposed service area that would benefit from the proposal.

D. List the proposal's service area towns and provide the rationale for their selection.

E. Identify the name, location, and services provided by existing providers of the proposed services in the proposed service area towns.

F. Identify the effect of your proposal on existing providers (i.e. patient volume, quality of care, etc.).

G. Describe how the Applicant will work with other organizations providing similar or related services.

H. Provide the hours of operation and proposed staffing plan for the proposal, by service.

I. Provide the number of persons in each service area towns who received each proposed service in the last three fiscal years.

J. Identify where residents of the proposed service area towns currently receive the proposed service types.

K. Provide the units of service projected for the first three years of operation of the proposal, by service. **Include the derivation/calculation.**

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

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

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

M. Provide copies of any of any epidemiological studies, public information reports, market share analyses, needs assessments, or other documents used in development of the proposal. Provide a brief narrative addressing the relevancy of each study/report.

5. Quality Measures

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

☐ Yes ☐ No (If "No", please provide an explanation) ☐ N/A

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

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians &	☐ American College of Surgeons

☐ Report of the Inter-Council for Radiation Oncology

☐ Gynecologists American College of Radiology

☐ Substance Abuse Society and Mental Health Services Administration

☐ Other, Specify:

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

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae. ***Note**: For physicians, please include a list of hospitals where the physicians have admitting privileges.*

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

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

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

F. Provide copies of the relevant sections of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant or Physicians/staff related to the proposal, for the past five (5) years. Provide a copy of any plan of action formulated to address the above action.

G. Provide a copy of relevant sections of the following:

☐ Quality Assurance plan
☐ Protocols for service
☐ Patient Selection Criteria/Intake form
☐ Diversion control Plan

[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.

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) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

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

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) The service levels you are seeking to provide.

iv) Identify any other entities that regulate the proposed services and describe the Applicant's plans to obtain the required certifications.

8. 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 the Applicant's audited financial statements for the most recently completed fiscal year. **If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year.** These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description (including the related gross square feet) of the proposed 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:

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. Type of Financing

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

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	
Funding institution/ entity	

☐ Conventional loan or

☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$
CON Proposed debt financing	$
Interest rate	%
Monthly payment	$
Term	Years
Debt service reserve fund	$

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution
   ii. Letter of interest from CHEFA
   iii. Amortization schedule (if not level amortization payments)
   iv. Lease agreements

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

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

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

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

i) Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** ***Note:*** *The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer.** **See attached, Financial Attachment II**.

iii) List the assumptions utilized in developing the projections reported on Financial Attachments I and II (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

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

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

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

vii) Provide a copy of the facility's charity care policy and sliding fee scale applicable to the proposal.

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: 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)_____	$ 1,000.00
(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)

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

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.

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*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JULIE ANN SULLIVAN, CEO

FAX: (203) 540-5448

AGENCY: NEW BEGINNINGS REHABILITATION CENTER

FROM: ALEXIS FEDORJACZENKO

DATE: 3/20/09 **TIME:**

NUMBER OF PAGES: 16
(including transmittal sheet

Comments: Docket 09-31329-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*