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	Turning Point Foundation	
Doing Business As	Turning Point Foundation	
Name of Parent Corporation	Turning Point Foundation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	980 Townsend Ave New Haven, CT 06512	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes No Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Luke Gilleran, LADC	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	980 Townsend Avenue New Haven, CT 06512	
Contact Person Telephone Number	203.520.3465	
Contact Person Fax Number	203.468.8359	
Contact Person e-mail Address	lukegilleran@yahoo.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Turning Point Foundation Intensive Outpatient Program

b. Project Proposal: Establish a licensed outpatient treatment facility for residents of its sober houses.

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:
One Grand Street, Suite B, New Haven CT 06512

g. List each town this project is intended to serve:
Will receive referrals from all over U.S.

h. Estimated starting date for the project: 1-1-2010

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: $ 5000

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	Furniture $5000
Total Capital Expenditure	$5000
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	$5000
Total Project Cost	$5,000
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

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
- ☐ Funced Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION See Attachment

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: Turning Point Foundation

Project Title: Turning Point Foundation Intensive Outpatient Program

I, David Viea, President
(Name) (Position – CEO or CFO)

of Turning Point Foundation 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 Turning Point Foundatio (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.

Signature 08/17/09
Date

Subscribed and sworn to before me on 8/17/09

Cheryl a Maratea
Notary Public/Commissioner of Superior Court

My commission expires: MY COMMISSION EXPIRES JUNE 30, 2014

RECEIVED
2009 AUG 18 A 11: 17
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Form 2030
Revised 10/2007

TURNING POINT FOUNDATION - **ATTACHMENT TO FORM 2030**

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.

Turning Point Foundation operates two Sober Residences (sober houses) in the New Haven area. Established throughout Connecticut and the country, sober houses (similar to half-way houses) are residences that house those usually in early recovery from addiction who either can't afford independent living or have families that won't allow them to return home from inpatient treatment centers until they are able to demonstrate stable recovery. Sober Houses vary in the level of structure they employ, but most have rules that require complete abstinence, employment, and a nighttime curfew. Some use urine drug screens to detect drug use and those found to be using drugs are expelled from the residence, usually. Until recently, Turning Point's two sober houses currently operated similar to prototypical sober houses.

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

Sober Houses, although useful, could do a much better job at assisting residents to remain sober. The rate of relapse in sober houses mirrors that of recovery in general, with a significant portion of those in early recovery relapsing into active drug and/or alcohol use within ninety days of initial abstinence, even when residents attend day or evening treatment programs outside of the residence. Turning Point recently added and Extended Care Program to its sober houses by adding spiritual care components in the form of additional structure as well as supervised activities such as mixed martial arts, yoga and music appreciation. In addition, licensed, local therapists have provided counseling to the sober house residents who want it, which they pay for at a much reduced rate. Adding these components has had an observable impact on the residents who are demonstrating the ability to remain sober at an increased rate. To augment and formalize this approach by standardizing and tailoring the counseling efforts to the unique needs of sober house residents, Turning Point wishes to seek a license to administer an Intensive Outpatient Program for its residents. This Letter of Intent is to inform the OHCA of the proposal to apply for licensure as an outpatient treatment facility. The Intensive Outpatient Program, will operate within the sober house model and as such change it to a treatment model as described below.

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

Turning Point Foundation's target population for its sober houses is males over the age of 18. Turning Point Foundation is respected throughout the treatment community in Connecticut and beyond, evidenced by the fact that it receives referrals to its sober houses from many of the inpatient treatment programs operated both in and outside of Connecticut. The target population for its Intensive Outpatient Program will remain the same, and discussions with its current referral sources indicate a high rate of excitement and perceived need for the new model.

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

In the current addiction treatment model, patients are discharged from inpatient treatment programs and return to independent living or sober houses. Often this return happens abruptly and before they have developed the skills necessary to withstand the stress and relapse triggers of normal living. Even when attending outside Intensive Outpatient Programs (IOP), the need to leave home unsupervised to attend treatment exposes them to relapse triggers before they have developed the skills to handle them. Having operated sober housing for close to a decade, Turning Point understands typical sober house residents and their specific needs. Of those who are discharged to sober housing, many are disabled, unemployed and/or younger, comprising a demographic requiring treatment interventions that focus on developing not just recovery skills, but also coping skills, increased self confidence, emotional management skills and most importantly, self-monitoring skills needed to replace the oversight provided by the treatment program and staff, when the resident is ready for independent living. We have seen our own residents relapse while in traditional Intensive Outpatient Programs because they travel unsupervised, and because traditional outpatient programs are generic by design, treating all clients from all demographics and circumstances simultaneously. Turning Point Foundation's proposed Intensive Outpatient Program is a natural enhancement to the traditional sober house model by adding a formal treatment component administered by Turning Point in a commercial property to which residents will be transported daily. By transporting residents and operating the program itself, Turning Point can eliminate the dangers inherent in unsupervised travel to treatment in early recovery, and in addition, tailor the treatment to the specific needs of sober house residents. Combined with the proposed Intensive Outpatient Program operated by Turning Point, the residents will take part in Turning Point's current Extended Care Program which has introduced to the sober house model enhanced structure in the form of a phased-reintegration that restricts activities outside the residence to those where residents are accompanied by staff who can observe them for relapse prevention skills needed for unsupervised exposure, and then gradually

allow unsupervised exposure over time when the resident is prepared. Before the resident is given full, unsupervised access to the "outside world" and all its relapse potential, they have completed all or a large portion of an Intensive Outpatient Program and developed the relapse prevention skills commensurate with the level of exposure granted over the length of treatment.

The proposed, customized Intensive Outpatient Program operated by Turning Point, coupled with Turning Point's current Extended Care Program which restricts access to unsupervised activities outside the residence until the client is ready, is proposed in response to two studies - one that indicates the longer the person is in some kind of formal treatment, the better the outcome, and one that indicates a high rate of relapse after discharge from inpatient treatment to independent living or a traditional sober house model .

By attending a customized, formal IOP (Intensive Outpatient Program) to be operated by Turning Point, treatment started in the inpatient facility is prolonged to create a better outcome, and exposure to "normal life" and its relapse potential is gradual, thereby lowering the high rate of relapse following discharge and abrupt, unsupervised return to independent living found in the traditional treatment model. Implementation of the program will require the Certificate of Need and state DPH licensure to allow Turning Point to operate a formal Intensive Outpatient Program exclusively for the residents of the sober house.

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

To our knowledge and that of our numerous referral sources, there are no other sober houses operating in this fashion, despite the perceived need.

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

Turning Point Foundation believes this may change the sober house model going forward by eliminating the inherent flaw in today's traditional treatment model by using the residential setting of the sober house to delay exposure to relapse triggers until the resident displays the skills to withstand the exposure while providing outpatient treatment during that delay. The combination is a treatment model that prolongs treatment and eliminates the abrupt discharge from the inpatient setting. It is possible that the future could see this model become a less costly and more effective alternative to inpatient treatment program

7. Who will be responsible for providing the service?

The Intensive Outpatient Program (IOP) operated by Turning Point for the residents of its sober houses will be administered by licensed counselors who will be employed or contracted by Turning Point Foundation. Initially it will be implemented and administered by a Connecticut, Licensed Alcohol and Drug Counselor (LADC) who has a decade of experience in developing and administering Intensive Outpatient Programs in both the inpatient and outpatient settings. In addition, he has the state's credential, "Certified Co-Occurring Disorder Professional" (CCDP) which is given to those who are qualified to work with those individuals with simultaneously occurring substance abuse and mental health disorders. In addition to credentialed professionals, the sober houses are staffed with men in stable, longer-term recovery, creating a blend of professionals and first-hand experience that immediately builds trusting relationships with residents and creates a treatment setting that facilitates the therapeutic milieu to the hours outside of formal treatment sessions.

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

Currently, Intensive Outpatient Programs are covered by most insurance and entitlement programs. By obtaining licensure, the Extended Care Program prolongs treatment started in the inpatient treatment center and delays exposure to relapse triggers until the resident is ready. Licensure will allow residents to use third-party payment (e.g. insurance coverage and state entitlement programs) to pay for the Intensive Outpatient Treatment component of their sober house experience.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 28, 2009

Luke Gilleran, LADC
Turning Point Foundation
980 Townsend Avenue
New Haven, CT 06512

Re: Letter of Intent, Docket Number 09-31436
Turning Point Foundation
Establish a Licensed Outpatient Treatment Facility for Residents in New Haven
Notice of Letter of Intent

Dear Mr. Gilleran:

On August 18, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Turning Point Foundation ("Applicant") to establish a licensed outpatient treatment facility for residents in New Haven at a total capital expenditure of $5,000.

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

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Enc.

HMO:DD:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 28, 2009

Requisition # HCA10-013
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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, September 1, 2009.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Attachment

HMO:DD:bko

c: Marie Dempsey, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Turning Point Foundation
Town:	New Haven
Docket Number:	09-31436-LOI
Proposal:	Establish a Licensed Outpatient Treatment Facility for Residents in New Haven
Total Capital Expenditure:	$5,000

The Applicant may file its Certificate of Need application between October 19, 2009 and December 16, 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 Applicant.

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

TRANSMISSION OK

TX/RX NO	0510
RECIPIENT ADDRESS	912038658360
DESTINATION ID	
ST. TIME	08/28 11:51
TIME USE	00'28
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 28, 2009

Requisition # HCA10-013
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

Gentlemen/Ladies:

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Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Harold M. Oberg

Harold M. Oberg
Certificate of Need Supervisor

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 28, 2009

via fax

Luke Gilleran, LADC
Turning Point Foundation
980 Townsend Avenue
New Haven, CT 06512

RE: Certificate of Need Application Forms, Docket Number 09-31436-CON
Turning Point Foundation
Establish a licensed outpatient treatment facility for residents in New Haven

Dear Mr. Gilleran:

Enclosed are the application forms for Turning Point Foundation's Certificate of Need ("CON") proposal to establish a licensed outpatient treatment facility for residents in New Haven, CT with an associated capital expenditure of $5,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between Monday, October 19, 2009, and Wednesday, December 16, 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 five (5) 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 along with the financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Diane Duran. Please contact her at (860) 418-7007 if you have questions.

Sincerely,

Harold M. Oberg
Certificate of Need Supervisor

Enclosure

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 19, 2009, and may be submitted no later than December 16, 2009. The Analyst assigned to your application is Diane Duran. She may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31436-CON
Applicant(s) Name:	Turning Point Foundation
Contact Person:	Luke Gilleran, LADC Turning Point Foundation
Contact Address:	980 Townsend Avenue New Haven, CT 06512
Project Location:	New Haven
Project Name:	Establish a licensed outpatient treatment facility for residents in New Haven
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$5,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How and where the proposed patient population is currently being served;

v. All existing providers (name, address, services provided) of the proposed service in the towns listed above and in nearby towns; and

vi. The effect of the proposal on existing providers.

2. Projected Volume

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
Total				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

d. Provide a copy of any articles, studies, or reports that support the statements made

in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

3. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

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

d. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

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

Table 2: Proposed Capital Expenditures/Costs

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 (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross sq. feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal, and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Revenues, Expenses, and Patient Population Projections

a. Patient Population Mix

i. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 3: Patient Population Mix

	Current FY *****	**Year 1 FY *****	**Year 2 FY *****	**Year 3 FY *****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.

** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

ii. Provide the basis for/assumptions used to project the patient population mix.

b. Financial Attachments I & II

i. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

ii. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

iii. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

v. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

vi. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

vii. Describe how this proposal is cost effective.

6. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
i. Voluntary efforts to improve productivity and contain costs;
ii. Changes to the Applicant's teaching or research responsibilities; and/or
iii. Special characteristics of the Applicant's patient or physician mix.

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 $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ 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)

Turning Point Foundation

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 Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$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.

JOURNAL REGISTER COMPANY **PROOF**

Ad Number: 2281266 **Account No: 222105**

Customer: OFFICE OF HEALTH CARE **Contact:** FAX **Phone:** 8604187001

Price: 209.75

Size: 2 X 28.00 **Notes:**

Class: 1200; LEGALS **Printed By:** SQUINN 08/28/2009

Ordered: 2 Times **Dates:** 09/01/2009 09/01/2009

Signature of Approval: Date:

LEGAL NOTICE

Statute Reference: 19a-638
Applicant: Turning Point Foundation
Town: New Haven
Docket Number: 09-31436-LOI
Proposal: Establish a Licensed Outpatient Treatment Facility for Residents in New Haven
Capital Expenditure: $5,000

The Applicant may file its Certificate of Need application between October 19, 2009 and December 16, 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 Applicant.