

**Attachment I**

Applicant p.

**State of Connecticut - Department of Social Services  
Office of CON & Rate Setting  
55 Farmington Avenue  
Hartford, CT 06105-3730**

**APPLICATION FOR CERTIFICATE OF NEED**

**AFFIDAVIT**

APPLICANT:

PROJECT TITLE:

I \_\_\_\_\_

Name

Position

Of \_\_\_\_\_ being duly sworn, depose

and state that the information in this Certificate of Need Application Entitled

" \_\_\_\_\_ " is accurate and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Subscribed and sworn to before me on \_\_\_\_\_

Date

\_\_\_\_\_

Notary Public/Commission of Superior Court – Commission expires:

**I. General Information****A. Identification of Applicant****1. Specify the Name and Address of the Applicant**

Applicant Name:	
Address 1:	
Address 2:	
City, State, Zip Code:	

**2. Specify the Name, Title, Address and Telephone Number of the Contact Person for this Application. The contact person shall be the person to whom all communications are directed.**

Name:	
Title:	
Address 1:	
Address 2:	
City, State, Zip Code:	
Telephone Number:	
Email Address:	
Fax Number:	

**3. Specify the Name, Title, Address and Telephone Number of another person who may be contacted regarding this application, in the event that the contact person specified above is not available.**

Name:	
Title:	
Address 1:	
Address 2:	
City, State, Zip Code:	
Telephone Number:	
Email Address:	
Fax Number:	

4. Specify existing (E) and/or proposed (P), Department of Health Services licensure categories.

If the applicant is an existing facility, provide the following information where appropriate:

- Number of licensed beds, by licensure category:
- Primary service area (specify basis for derivation and identify geographic area encompassed, by town.

(Select all that Apply)

“X”	Facility Type/Licensing Category	(E) and/or (P)	Licensed Beds	Service Area
	Home for the Aged			
	Rest Home with Nursing Supervision (RHNS)			
	Chronic and Convalescent Nursing Home (CCNH)			
	Other, specify:			
	Other, specify:			

**B. Type of Application**

1. Specify if a new or additional function(s) or service(s), and/or a termination of a function or service and/or a capital expenditure exceeding statutory thresholds for review, is being proposed:

“X”	Type of Application	Filing Fee Required
	New or Additional Function(s) or Service(s) Including staff expansion proposed by coordination, assessment, and monitoring ("CAM") agencies.	No
	Termination of Service(s);	No
	Capital Expenditures: (*see definition)	
	Major Medical Equipment, exceed statutory thresholds;	Yes
	Other Capital Expenditure, exceeding statutory thresholds	Yes
	Imaging Equipment, exceeding statutory thresholds;	Yes
	Facility Licensed Bed Reduction from __ to __ Licensed Beds	No
	Other, specify:	No

NOTE - Conversion to different licensure categories should be reported as a termination of service and also as an introduction of an additional function or service.

2. Specify the total amount of capital expenditures proposed:

<b>Proposed Capital Expenditures:*</b>	\$	**
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\* Capital Expenditures: The total of all expenditures or proposed expenditures for the acquisition, installation and initial operation of items which at the time of acquisition, have an estimated useful life of at least three years and a purchase price of at least \$500 for groups of related items, which are capitalized under generally accepted accounting principles. Such items shall include but not be limited to the following.

\*\*Should agree with page 5, Total Proposed Capital Expenditures.

- a. Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto.
- b. The total cost of all studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquisition, improvement, expansion or replacement of physical plant or equipment or both in question, when such total costs in aggregate exceed \$50,000.
- c. Lease assets. Purchase price for leased assets, including equipment, land and/or building(s), shall be the fair market value at lease inception.
- d. Maintenance expenditures capitalized in accordance with generally accepted accounting principles.
- e. Donated assets: Donations of property and equipment which under generally accepted accounting principles, are capitalized at the fair market value at the date of contribution.

C. Proposed Capital Expenditures and Funding Sources

1. Itemize all anticipated capital expenditures related to the proposal, as follows:

	<b>Itemized Capital Expenditure Category</b>	<b>Amount</b>
A	Total Building Work Costs	\$
B	Total Site Work Costs	\$
C	Total Off-Site Works Costs	\$
D	Total Construction Costs	\$
E	Fixed Equipment* (use fair market value, if leased)	\$
F	Movable Equipment* (use fair market value, if leased)	\$
G	Architectural & Engineering Costs	\$
H	Land (use fair market value, if leased)	\$
I	Building(s)(use fair market value, if leased)	\$
J	Works of Art	\$
K	Consultants (specify)	\$
L	Other Costs (specify)	\$
	<b>Total Proposed Capital Expenditures:</b>	<b>\$</b>
M	Financing Fees (specify)	\$
N	Construction Period Interest	\$
O	<b>Total Capitalized Financing Costs</b>	<b>\$</b>
	<b>Total Proposed Capital Expenditures, which include Capitalized Financing Costs</b>	<b>\$</b>
	<b>Total New Construction/Renovation Square Feet</b>	/
	<b>Cost Per Square Foot Renovation/New Construction</b>	\$ /
	<b>Cost Per Bed</b>	\$ /
	<b>Year Facility was Built</b>	

\* Include an itemized listing of equipment acquisitions identifying the amount of the proposed capital expenditure for each item. Major medical equipment acquisitions exceeding statutory thresholds, as well as any capital expenditures regardless of amount which result in a new or expanded service, should be listed separately and identified with a new or expanded service, where appropriate.

2. Itemize the anticipated proposed funding sources to be used in order to finance the proposed capital expenditures:

<b>Anticipated Funding Source</b>	<b>Amount</b>
Equity Contribution	\$
Debt Financing	\$
Lease Financing	\$
Other (Specify):	\$
<b>Total Proposed Funding Sources</b>	<b>\$</b>

D. Ownership

For new facilities complete the following items. For existing facilities, submit the most recent copy of the Disclosure Statement of Ownership and Operation, Part I, and complete pertinent sections of 1 through 5d if required information is not included in the Disclosure Statement. All applicants must submit a Certificate of Incorporation or a Certificate of Partnership.

## 1a: Ownership

Name of Facility:	
Doing Business As:	
Address 1:	
Address 2:	
City, State, Zip Code:	
Contact Person:	
Title:	
Telephone Number:	
Fax Number:	

## 2a: Type of Facility/Bed Configuration/Payer Mix/Utilization Statistics

Type of Facility	Licensed Bed Capacity	Census	Date of Census
Chronic and Convalescent Nursing Home			
Rest Home with Nursing Supervision			
Home for the Aged-Licensed Bed Capacity			
Chronic Disease Hospital-Licensed Capacity			
<b>Bed Configuration</b>	<b>Private</b>	<b>Semi Private</b>	<b>3/4 bed rooms</b>
Current Number of Rooms / Beds			
Proposed Number of Rooms / Beds			
<b>Payer Mix</b>	<b>Medicaid %</b>	<b>Medicare%</b>	<b>Private %</b>
Current			
Anticipated			
<b>Utilization Statistics</b>	<b>2007</b>	<b>2008</b>	<b>Anticipated</b>
Occupancy Percentage as of 9/30			

2b. Form of Ownership (Choose One)

<b>“X”</b>	<b>Ownership Type</b>	<b>“X”</b>	<b>Ownership Type</b>
	Sole Proprietorship		Profit Corporation
	General Partnership		Professional Corporation
	Limited Partnership		Non-Profit Corporation
	Municipality		Joint Venture
	Other (Specify):		Limited Liability Corporation (LLC)

2c. Owner(s) of Facility - Please list in descending order ownership share. Also include associates, incorporators, directors and sponsors.

<b>Name &amp; Address</b>	<b>Business Phone</b>	<b>Ownership Phone</b>

2d. If an above owner is a corporation or partnership or if the facility is operated by a corporation or partnership under a contract, identify the following related to owners or beneficial owners of ten percent (10%) or more of the stock of that corporation or for each general or limited partner of that partnership.

<b>Name &amp; Address</b>	<b>Business Phone</b>	<b>Ownership % *</b>	<b>Type **</b>

\*List in descending order by ownership share

\*\*Indicate general or limited

3a. Administrator of Facility - Individuals and/or contracted management company.

<b>Name &amp; Address</b>	<b>Title</b>	<b>Business Phone</b>

3b. If a management company has been contracted to manage the day-to-day operations, identify them and specify their responsibilities in relation to those of the owner(s) and/or operators.

4a. Land Information

Identify who holds the record title of the land on which the facility is located

Land Title Holder Name:	
Address 1:	
Address 2:	
City, State, Zip Code:	

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the landowner in the facility and the policy-making responsibilities as related to the facility's owners.

4b. Building Information

Identify who holds the record title of the building in which the facility is located.

Building Title Holder Name:	
Address 1:	
Address 2:	
City, State, Zip Code:	

If the above-named owner is not the same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners.

4c. Equipment Information

Note: Complete separate page for each owner of the Facility's equipment. Identify who holds title to the equipment of the facility.

Equipment Title Holder Name:	
Address 1:	
Address 2:	
City, State, Zip Code:	

List all the equipment to which the owner holds title. If the facility or specified owner holds title to all equipment, indicate "All".

If the above-named owner is not that same as that identified in 2(c), specify all owner interest of the building owner in the facility and the policy making responsibilities as related to the facility's owners.

- 5a. Submit the organization chart and a chart of legal corporate structure which identifies any relationship or affiliation with any parent or hold company, subsidiary of the facility and subsidiary of a parent or holding company.
- 5b. For each entity identified in 5a, above, identify:

Entity 1:

Name & Address:	
Form of Ownership:	
Ownership Interest in Facility:	
Type of Business Activity:	
Ownership Type:	

Entity 2:

Name & Address:	
Form of Ownership:	
Ownership Interest in Facility:	
Type of Business Activity:	
Ownership Type:	

Also indicate profit or non-for-profit.

## II. Project Description

### A. Summary

Provide a summary or overview of the project that includes the principal reason why the application should be approved.

### B. Linkages

Where the proposed service is intended as a regional resource or where other providers of care are integral to ensure an effective continuum of care, provide evidence of existing or proposed agreements/understandings with these providers.

**STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES  
CERTIFICATE OF NEED/MODIFICATION FILING FEE COMPUTATION SCHEDULE**

APPLICANT:  
PROJECT TITLE:  
DATE:

Is this a new CON application submitted for a capital expenditure exceeding \$2,000,000 or a capital expenditure exceeding \$1,000,000, which increases facility square footage by 5,000 sq. ft. or 5% of existing square footage, whichever is greater (Section 17b-353 C.G.S.)? If yes, complete section A.

Is this a request for a modification of a CON under Section 17b-353 C.G.S.? If yes, complete section B.

*CON applications submitted pursuant to Section 17b-352 C.G.S. or requests to modify a CON under 17b-352 only do not require a filing fee and this form should not be submitted.*

**SECTION A - NEW CERTIFICATE OF NEED APPLICATION**

- 1. Base Fee: \$1,000
- 2. Additional Fees: (Capital Expenditure Assessment)  
(To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied times .0005 and rounded to nearest dollar.) (\$ \_\_\_\_\_ x .0005) \$
- 3. Sum of base fee plus additional fee: (lines 1 + 2) \$
- 4. Enter the amount shown on line 3. on "Total Fee Due" line (SECTION C).

**SECTION B - REQUEST FOR MODIFICATION OF PRIOR APPROVED CON**

Docket Number of original CON

Docket Numbers of any previous modifications \_\_\_\_\_

- 1. If the total of this request and all previous requests for a modification of this CON is between \$100,000 and \$1,000,000 the fee is \$ 500 which should be entered in SECTION C
- 2. If the total of this request and all previous requests is greater than \$1,000,000 the filing fee is as follows:
  - a. Base Fee: \$1,000
  - a. Additional Fees: (Capital Expenditure Assessment) (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied times .0005 and round to nearest dollar.) (\$ \_\_\_\_\_ x .0005) \$
  - c. Sum of base fee plus additional fee: (lines B2a + B2b) \$
  - d. Enter the amount shown on line B2c. on "Total Fee Due" line (SECTION C).

**SECTION C TOTAL FEE DUE:** **\$**

**ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY  
(Payable to: Commissioner of Social Services)**