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 an Applicant, 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	Pastoral Counseling Center of West Hartford, Inc.	
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	12 South Main Street West Hartford, CT 06107	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	(Yes) No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	The Rev. Dr. Claire W. Bamberg	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	12 South Main Street West Hartford, CT 06107	

Contact Person's Telephone Number	860-233-0548 ext. 18	
Contact Person's Fax Number	860 236-0283	
Contact Person's e-mail Address	clareb@pccwh.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Closing the Pastoral Counseling Center of West Hartford, Inc.

b. Type of Proposal, please check all that apply:

☑ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

- ☐ New (F, S, Fnc)
- ☐ Replacement
- ☐ Additional (F, S, Fnc)
- ☐ Expansion (F, S, Fnc)
- ☐ Relocation
- ☑ Service Termination
- ☐ Bed Addition`
- ☐ Bed Reduction
- ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

- ☐ Project expenditure/cost cost greater than $ 3,000,000
- ☐ Equipment Acquisition
  - ☐ New
  - ☐ Replacement
  - ☐ Major Medical (> $3,000,000)
  - ☐ Imaging
  - ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

280 Country Club Rd. Avon, CT 06001
12 South Main Street, West Hartford, CT 06107
2 N. Eagleville Rd., Storrs, CT 06268

d. List each town this project is intended to serve:
Storrs, Mansfield, Willimantic, Hartford, West Hartford, Bloomfield, Canton, Avon, Simsbury, Collinsville, Granby, East Granby, West Simsbury, Unionville, Torrington

e. Estimated starting date for the project: ___, As needed, Please see enclosed

f. Type of project: 18
(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $_____

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	
Major 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	
Capitalized Financing Costs (Informational Purpose Only)	

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

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

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 the major medical/imaging equipment.

d. 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

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 are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and who is 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?

Pastoral Counseling Center of West Hartford, Inc.
Office of Health Care Access
Letter of Intent Form
Form 2030

1) Current services being provided:
    a. Pastoral Counseling
    b. Marriage and Family Therapy
    c. Psychotropic Medication evaluations
    d. Drug and Alcohol Abuse Counseling

   Copies of Licenses enclosed.
2) Proposed action: Closing the Pastoral Counseling Center of West Hartford, Inc. due to insolvency/ impending bankruptcy.
3) Current populations served are individuals, couples, families, groups and area businesses and not-for-profits in the Greater Hartford area. The Center specifically serves individuals from (included but not limited to) the towns of Mansfield, Storrs, Willimantic, Middletown, Middlesex, Glastonbury, Hartford, West Hartford, Bristol, Burlington, Enfield, Bloomfield, Canton, Avon, Farmington, Simsbury, Granby, East Granby, Suffield, West Suffield, New Britain, and Newington.
4) N/A
5) Yes, there are several mental health clinics and pastoral counselors in private practice in these areas.
6) The Pastoral Counseling Center of West Hartford, Inc is the only dually accredited, state-licensed Pastoral Counseling Center in the State of Connecticut. However, as mentioned in # 5, there are several alternative approaches by which clients served here can have their mental health and pastoral counseling needs met.
7) See # 5 and # 6 (see enclose Yellow Pages listing, lists that we have compiled for referrals and staff who are willing to be listed to receive referrals.
8) Current payers:
    a. Clients
    b. Insurance Companies
    c. Medicaid and Medicare
    d. Congregational donations of Counseling Assistance Funds
    e. Grants made for the specific purpose of filling the gap between cost of providing the services and reimbursement collected.

AFFIDAVIT

To be completed by each Applicant

Applicant: Pastoral Counseling Center of West Hartford, Inc.

Project Title: Closing 3 facilities / Parent Organization

I, The Rev. Dr. Claire W. Bramberg, Executive Director
(Name) (Position – CEO or CFO)

of Pastoral Counseling Center of West Hartford, 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 Prescott (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.

Claire W. Bramberg
Signature

1/30/2009
Date

Subscribed and sworn to before me on Joanne V. Jandon

Joanne V. Jandon
Juris # 309541

Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services) b
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

30. Facility Development
31. Non-Medical Equipment
32. Land and Building Acquisitions
33. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
34. Renovations
35. Other Non-Clinical

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Claire Bamberg, M.D.
Pastoral Counseling Center of West Hartford, Inc.
12 South Main Street
West Hartford, CT 06107

Re: Letter of Intent, Docket Number 07-30913
Pastoral Counseling Center of West Hartford, Inc.
Closure of Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs
Notice of Letter of Intent

Dear Dr. Bamberg,

On January 30, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Pastoral Counseling Center of West Hartford, Inc. ("Applicant") to close its Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Hartford Courant & The Chronicle* 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:PF:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Requisition # HCA07-121
Email: Publicnotices@courant.com

The Hartford Courant
285 Broad Street
Hartford, CT 06115

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 **Monday, February 12, 2007**.

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 **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

The Hartford Courant
Docket Number 07-30913

Letter of Intent
February 8, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Pastoral Counseling Center of West Hartford, Inc.
Towns:	Avon, Storrs and West Hartford
Docket Number:	07-30913-LOI
Proposal:	Closure of Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between March 31, 2007 and May 30, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Requisition # HCA07-120
Fax: (860) 423-7641

The Chronicle
One Chronicle Road
Box 148
Willimantic, CT 06226-0148

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 **Monday, February 12, 2007**.

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 **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

The Chronicle
Docket Number 07-30913

Letter of Intent
February 8, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Pastoral Counseling Center of West Hartford, Inc.
Towns:	Avon, Storrs and West Hartford
Docket Number:	07-30913-LOI
Proposal:	Closure of Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between March 31, 2007 and May 30, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

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

TRANSMISSION OK

TX/RX NO	1744
RECIPIENT ADDRESS	918604237641
DESTINATION ID	
ST. TIME	02/08 16:50
TIME USE	00'21
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

Requisition # HCA07-120
Fax: (860) 423-7641

The Chronicle
One Chronicle Road
Box 148
Willimantic, CT 06226-0148

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 **Monday, February 12, 2007**.

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 **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, February 08, 2007 3:53 PM
To: 'publicnotices@courant.com'
Subject: Legal Ad
Attachments: 07-30913 LOI Hartford Courant.doc

February 8, 2007

Dear Legal Ad,
Please post the attached legal ad in your paper by February 12, 2007. Please notify me that you have received this request.

Thank you,

Leslie M. Greer
Office of Health Care Access
(860) 418-7001
Leslie.Greer@po.state.ct.us

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 8, 2007

The rev. Claire W. Bamberg
Executive Director
Pastoral Counseling Center of West Hartford, Inc.
12 South Main Street
West Hartford, CT 06107

RE: Certificate of Need Application Forms, Docket Number 07-30913-CON
Pastoral Counseling Center of West Hartford, Inc.
Closure of Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs

Dear Rev. Bamberg:

Enclosed are the application forms for Pastoral Counseling Center of West Hartford, Inc.'s Certificate of Need ("CON") proposal for the closure of Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs with an associated capital expenditure of $0. According to the parameters stated in Sections 19a-638 of the Connecticut General Statutes the CON application may be filed between March 31, 2007, and May 30, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and three (3) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7035, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than March 31, 2007, and may be submitted no later than May 30, 2007. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30913-CON

Applicant(s) Name: Pastoral Counseling Center of West Hartford, Inc.

Contact Person: The Rev. Claire W. Bamberg
Contact Title: Executive Director
Pastoral Counseling Center of West Hartford, Inc.
Contact Address: 12 South Main Street
West Hartford, CT 06107

Project Location: Avon, West Hartford and Storrs

Project Name: Closure of Pastoral Counseling Center of West Hartford in Avon, West Hartford and Storrs

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

Est. Capital Expenditure: $0

1. State Health Plan

No questions at this time.

2. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

3. Clear Public Need

A. Regarding this termination of services, please answer the following for each of the Avon, West Hartford and Storrs service locations:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) Has the Applicant determined there will be no or insufficient public need for the continuation of this program?

iii) Will the Applicant be reimbursed by payers for these services prior to termination? Has reimbursement levels entered into the determination to terminate?

iv) Will this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination will be discussed and voted on.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Avon, West Hartford and Storrs location. Identify what the hours of operation are for these service locations.

ii) Identify the primary and secondary service area towns for each of the Avon, West Hartford and Storrs service locations.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for each of the Avon, West Hartford and Storrs service locations.

iv) Discuss any scheduling backlogs that exist at each of the Avon, West Hartford and Storrs service locations, at the time of the decision to terminate.

v) Are there any waiting lists in place? If so, identify the number of patients on the waiting list at each of the Avon, West Hartford and Storrs service location.

vi) Describe the pattern of referrals to each of the Avon, West Hartford and Storrs service location that exist.

C. Regarding the impact on the patient and provider community at each service location of the termination of services, provide the following information:

i) Explain the procedures that the Applicant follows in terminating these services and transferring patients to other community providers.

ii) Discuss how the services described above are continuing to be made available to the patients that are utilizing each of these service locations. List any special populations that are utilizing the services and explain how these clients will continue to access these service after they will be terminated.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Avon, West Hartford and Storrs service area:

Description of Service	**Provider Name and Location**	**Hours and Days of Operation[1]**	**Current Utilization[2]**

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

iv) Has your facility contacted any other providers in the Wethersfield service area to see if they are willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation,

including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.

v) What will be the effect of the termination of the Avon, West Hartford and Storrs service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

vi) Will this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

vii) Provide information and supporting documentation addressing the issue of transportation for the Avon, West Hartford and Storrs patients. Describe how patients would be able to travel to a new service location if without benefit of a personal vehicle.

D. 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, please provide an explanation.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____

_____

_____

_____

4. Quality Measures

A. Provide or answer the following:

i) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Pastoral Counseling Center of West Hartford, Inc. in Avon, West Hartford and Storrs.

ii) Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

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

B. 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 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 States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

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

[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.

5. 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 ☐ Group purchasing

☐ Reengineering ☐ None of the above

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

☐ Other (identify)_____

6. Miscellaneous

A. Provide or answer the following:

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

ii) 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.

7. Financial Information

A. Type of ownership: (Please 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. Verify that this termination of services will not result in any capital expenditures or capital costs to the Applicant.

8. Revenue, Expense and Volume Projections

A) Provide the following financial information for each of the Avon, West Hartford and Storrs location:

i) Please submit an audited or unaudited Balance Sheet and Income Statement or Statement of Operations for the two most recently completed fiscal years. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Provide a discussion of any incremental gains or losses from operations that will be a direct result of the termination of the services

B) Please provide the current payer mix for the Total Facility based on Net Patient Revenue in the following reporting format for each of the Avon, West Hartford and Storrs location:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

*Includes managed care activity.

D. Provide the following for the financial and statistical projections for **each** of the Avon, West Hartford and Storrs location:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** 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) Please complete the enclosed, OHCA's **Financial Attachment II**.

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

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) Please provide a report that lists, for each service location (Avon, West Hartford, Storrs) by month, for FYs 2004, 2005, 2006, to date, the following: average daily census; number of clients on the last day of each month; the number of clients admitted during the month; and the number of clients discharged during the month.

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

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
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

*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.