50 Hospital Hill Road
Sharon, CT 06069
860-364-4141
FAX 860-364-4011

SHARON HOSPITAL

June 28, 2007

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

Re: Letter of Intent Form 2030
Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
Adult Intensive Outpatient Behavioral Health Service

Dear Commissioner Vogel:

Enclosed please find a letter of intent for Sharon Hospital with respect to the project entitled "Adult Intensive Outpatient Behavioral Health Service".

If either you or members of your staff have any questions regarding the enclosed, please feel free to contact me at (860) 364-4010.

Sincerely,

Charles Therrien
Chief Executive Officer

Enclosures

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	**Essent Healthcare of CT, Inc.**	
Doing Business As	**Sharon Hospital**	
Name of Parent Corporation	**Essent Healthcare, Inc.**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	**PO Box 789** **50 Hospital Hill Road** **Sharon CT 06069**	
What is the Applicant's Status: P for Profit or NP for Nonprofit	**For Profit Acute Care Hospital**	
Does the Applicant have Tax Exempt Status?	**No**	
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	**Charles Therrien** **President and CEO**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**PO Box 789** **50 Hospital Hill Road** **Sharon CT 06069**	

Contact Person's Telephone Number	**860-364-4010**	
Contact Person's Fax Number	**860-364-4011**	
Contact Person's e-mail Address	**charles.therrien@sharonhospital.com**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Adult Intensive Outpatient Behavioral Health Service

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:
50 Hospital Hill Road, Sharon CT

d. List each town this project is intended to serve:
Connecticut Towns: Sharon, Lakeville, Salisbury, Canaan, East Canaan, Falls Village, West Cornwall, Cornwall, Kent and Warren Bridge.

New York Towns: Amenia, Dover Plains, Millerton, Wassaic, Pine Plains, Millbrook, Wingdale, Stanfordville, Copake and Ancramdale.

Massachusetts Towns: Ashley Falls, Sheffield, Great Barrington and Southfield.

e. Estimated starting date for the project: **10/1/2007**

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
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **No Capital Expense Required**

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.
   Inpatient and Outpatient Medical

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?

AFFIDAVIT

To be completed by each Applicant

Applicant: **Essent Healthcare of CT, Inc. (DBA Sharon Hospital)**

Project Title: **Adult Intensive Outpatient Behavioral Health Service**

I, **Charles Therrien**, **CEO of Sharon Hospital** 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 **Sharon Hospital** 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 6/28/07

Subscribed and sworn to before me on June 28, 2007

Patricia B. Mustaçl

Notary Public/~~Commissioner of Superior Court~~

My commission expires: 10/31/09

RECEIVED
2007 JUL 12 A 11:35

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 Amuse Services)
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

Adult Intensive Outpatient Behavioral Health Service (IOP)
Proposal Description

Sharon Hospital has provided an inpatient behavioral health diagnostic and treatment program for men and women ages 55 years and older since 1998. The Senior Behavioral Health Center is housed on a distinct 12-bed unit within the hospital.

This proposal is to provide a 10-slot intensive outpatient behavioral health program for men and women ages 50 years and older. The program would be located within Sharon Hospital. The program would consist of outpatient therapy groups and psychiatric care for 2-3 hours per day, up to three weekdays per week. Additional individual or family therapy sessions may be scheduled as determined by patient need. The estimated length of stay will be 10-14 treatment days for each patient. Each patient will have an individualized Treatment Plan in which the patient will be involved in the development and will be overseen by a psychiatrist. Each patient involved in the program will be assessed by RN's, a psychiatrist, a Social Worker and/or a Clinical Specialist. Sharon Hospital will be responsible for billing this proposed service and will own the space dedicated to the program. Horizon Mental Health Management, Inc., the organization that manages the existing inpatient program, will manage the IOP.

Admission Criteria

- Men and women ages 50 years and older. A psychiatrist will determine appropriateness individually.
- Person's exhibiting psychiatric symptoms that significantly impair social, occupational, or other areas of functioning.
- There is a reasonable expectation that treatment and intervention will improve the person's condition and the person requires more than occasional outpatient therapy.
- Potential patients are determined to not be in imminent danger to themselves or others
- Persons must have sufficient cognitive function to allow successful participation in Group Therapy.

Sharon Hospital has determined that there are no similar services in our service area. The closest available Adult IOP service is provided by Charlotte Hungerford Hospital in Torrington CT. This proposal is to develop a level of care that is currently not available in the Sharon Hospital service area.

As a key component to the proposed service, Sharon Hospital would arrange for transportation to the program. It is anticipated that the payers for this service will be comprised of 86% Medicare, 7% Medicaid, and 7% commercial insurers.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 24, 2007

Charles Therrien
Chief Executive Officer
Essent Healthcare of Connecticut, Inc.
50 Hospital Hill Road
Sharon, CT 06069

RE: Certificate of Need Application Forms, Docket Number 07-31006-CON
Essent Healthcare of Connecticut, Inc.
Establish an Adult Intensive Outpatient Behavioral Health Service

Dear Mr. Therrien:

Enclosed are the application forms for Essent Healthcare of Connecticut, Inc.'s Certificate of Need ("CON") proposal to establish an Adult Intensive Outpatient Behavioral Health Service with an associated capital expenditure of $0. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between September 10, 2007, and November 9, 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 hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7001, 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 September 10, 2007, and may be submitted no later than November 9, 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: 07-31006-CON

Applicant(s) Name: Sharon Hospital

Contact Person: Charles Therrien
Contact Title: President and CEO
Sharon Hospital
Contact Address: P.O. Box 789
50 Hospital Hill Road
Sharon, CT 06069

Project Location: **Sharon**

Project Name: Establish an Adult Intensive Outpatient Behavioral Health Service in Sharon

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

Est. Capital Expenditure: **$0**

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment:

Replace:

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, please provide an explanation.

4. Clear Public Need

Note: Sections 19a-634 and 19a-637 of the Connecticut General Statutes specifically mandate that OHCA consider the availability, scope and need for services for the residents of Connecticut. Therefore, OHCA does not consider out-of-state volume in its evaluation of need for the proposed service.

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

B. Provide the primary and secondary service area towns.

C. Provide the rationale for choosing the proposed primary and secondary service area towns.

D. If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.

E. Scheduling backlogs in service area

F. Travel distance from proposed site to service area towns

G. Hours of operation of existing/proposed service

H. Provide the information as outlined in the following table concerning the existing providers' in the Applicant PSA & SSA current operations:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

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

J. Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

K. 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.

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

☐ Epidemiological studies
☐ Public information reports
☐ Needs assessments
☐ Market share analysis
☐ Other (Identify)

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

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 ☐ Not Applicable

If "No", please provide an explanation.

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

☐ American College of Cardiology
☐ National Association of Child Bearing Centers
☐ Report of the Inter-Council for Radiation Oncology
☐ National Committee for Quality Assurance
☐ American College of Obstetricians & Gynecologists
☐ American College of Radiology
☐ Public Health Code & Federal Corollary
☐ American College of Surgeons
☐ 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 provide 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 Report
☐ 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 any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant, Physicians and any staff related to the proposal, for the past five (5) years.

G. Provide a copy of any plan of action which has been formulated to address the above action against the Applicant, Physician(s) working at the Hospital and/or any staff related to the proposal.

H. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

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:

[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.

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) If not applicable, please explain why.

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) 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 Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) Provide the total current assets balance as of the date of submission of this application.

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

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

v) 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 of the proposed new construction/renovation including the related gross square feet of 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:

Item 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 agreement.

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

vi) Describe how this proposal is cost effective.

12.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
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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

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

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	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.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 25, 2007

Mr. Charles Therrien
Chief Executive Officer
Essent Healthcare of Connecticut, Inc.
50 Hospital Hill Road
Sharon, CT 06069

Re: Letter of Intent, Docket Number 07-31006
Essent Healthcare of Connecticut, Inc.
Establish an Adult Intensive Outpatient Behavioral Health Service
Notice of Letter of Intent

Dear Mr. Therrien,

On July 12, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Essent Healthcare of Connecticut, Inc. ("Applicant") to establish an adult intensive outpatient behavioral health service, at a total capital expenditure of $0.

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

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 25, 2007

Requisition # HCA08-015
FAX: (203) 754-0644

Waterbury Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

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, July 30, 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

Hartford Courant **Letter of Intent**
Docket Number 07-31006 **July 25, 2007**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Essent Healthcare of Connecticut, Inc.
Town:	Sharon
Docket Number:	07-31006
Proposal:	Establish an Adult Intensive Outpatient Health Service
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between September 10, 2007 and November 9, 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.

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*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

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