STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 5, 2007

Ms. Leanne M. Dillian
President and Chief Executive Officer
Community Prevention and Addiction Services, Inc.
d/b/a Transitions Outpatient Services
1491 West Main Street
Willimantic, CT 06226

RE: The Elimination of Psychiatric Outpatient Facility licenses for three locations
Transitions Outpatient Services

Dear Ms. Dillian:

On June 21, 2007, the Office of Health Care Access ("OHCA") received a copy of the attached Department of Public Health ("DPH") Change in Facility Licensure forms for the elimination of the Psychiatric Outpatient Facility license for Community Prevention and Addiction Services, Inc. ("CPAS") d/b/a Transitions Outpatient Services for three locations:

(1) 87B Oak Street in Manchester – License #C-0299
(2) 37 Commerce Avenue in Danielson – License #C-0301
(3) 1491 West Main Street in Willimantic – License #C-0300.

Under Report Number 99-Y2, OHCA had previously allowed an exemption for the establishment of these licensed services at these three locations. CPAS described that program as the establishment of "*psychiatric services at outpatient locations in order to serve clients who are dually diagnosed and may be in need of psychiatric evaluation and medication management.*"

In light of the above, please provide a letter to this agency which explains whether CPAS d/b/a Transitions Outpatient Services has terminated or is planning to terminate, close or discontinue any existing health care service or service location. If it is not CPAS's plan or intention to terminate a service at these three locations, please provide a letter which explains the reason for this change in DPH licensure. Please contact me at (860) 418-7041 if you have any questions regarding this letter. Please file a response letter to OHCA by July 20, 2007.

Sincerely,

Karen Roberts

Karen Roberts
Compliance Officer

Enclosure

STATE OF CONNECTICUT

Community Prevention and Addiction Services

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS UNIT

LP-173
Rev. 5/04

TO: Office of Health Care Access
Dept. of Social Services
O.P.M. Budget Division
Building & Fire Safety -
Health Statistics
Facility File
DMHAS

FROM: Sandra C. Bauer
Licensing Examination Assistant
Facility Licensing & Investigations Section

DATE: June 21, 2007

Subject: Change in Facility Licensure Information

Please adjust your records accordingly.

[ ] Substance Abuse Facility
[x] Psychiatric Outpatient Facility
[ ] Mental Health Day Treatment
[ ] Residential Care Home
[ ] Mental Health other:
[ ] Other _____

Transitions Outpatient Services, 87B Oak St, Manchester, Lic# C-0299

[ ] Opened effective _____ with __ licensed beds.
[x] Closed effective 6/11/07 with ___ licensed beds.
[ ] Increase in bed capacity from _____ to _____ EFF: _____
[ ] Decrease in bed capacity from _____ to _____ EFF: _____
[ ] Relocated to: _____ Effective:_____
[ ] Changed d/b/a name to: _____ Eff:____
[ ] Changed ownership effective _____
[ ] Operating entity: [ ] New License # is _____
[ ] Changed licensee name to: _____
[ ] Real Property: _____
[ ] Stock Change within the entity that operates the facility.
[ ] Other: _____

Type of Ownership:

[ ] Proprietorship
[ ] Limited Liability
[ ] Profit Corporation
[ ] Partnership
[x] Non-Profit Corporation
[ ] Municipality
[ ] Trust

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12FLIS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS UNIT

LP-173
Rev. 5/04

TO: Office of Health Care Access
Dept. of Social Services
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FROM: Sandra C. Bauer
Licensing Examination Assistant
Facility Licensing & Investigations Section

DATE: June 21, 2007

Subject: Change in Facility Licensure Information

Please adjust your records accordingly.

[ ] Substance Abuse Facility
[x] Psychiatric Outpatient Facility
[ ] Mental Health Day Treatment
[ ] Residential Care Home
[ ] Mental Health other:
[ ] Other _____

Transitions Outpatient Services, 37 Commerce Ave, Danielson, Lic# C-0301

[ ] Opened effective _____ with __ licensed beds.
[x] Closed effective 6/11/07 with ___ licensed beds.
[ ] Increase in bed capacity from _____ to _____ EFF: _____
[ ] Decrease in bed capacity from _____ to _____ EFF: _____
[ ] Relocated to: _____ Effective:_____
[ ] Changed d/b/a name to: _____ Eff:____
[ ] Changed ownership effective _____
[ ] Operating entity: [ ] New License # is _____
[ ] Changed licensee name to: _____
[ ] Real Property: _____
[ ] Stock Change within the entity that operates the facility.
[ ] Other: _____

Type of Ownership:

[ ] Proprietorship
[ ] Limited Liability
[ ] Profit Corporation
[ ] Partnership
[x] Non-Profit Corporation
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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS UNIT

LP-173
Rev. 5/04

TO: Office of Health Care Access
Dept. of Social Services
O.P.M. Budget Division
Building & Fire Safety -

Health Statistics
Facility File
DMHAS

FROM: Sandra C. Bauer
Licensing Examination Assistant
Facility Licensing & Investigations Section

DATE: June 21, 2007

Subject: Change in Facility Licensure Information

Please adjust your records accordingly.

[ ] Substance Abuse Facility
[x] Psychiatric Outpatient Facility
[ ] Mental Health Day Treatment
[ ] Residential Care Home
[ ] Mental Health other:
[ ] Other _____

Transitions Outpatient Services, 1491 West Main St, Willimantic, Lic# C-0300

[ ] Opened effective _____ with __ licensed beds.
[x] Closed effective 6/11/07 with ___ licensed beds.
[ ] Increase in bed capacity from _____ to _____ EFF: _____
[ ] Decrease in bed capacity from _____ to _____ EFF: _____
[ ] Relocated to: _____ Effective:_____
[ ] Changed d/b/a name to: _____ Eff:_____
[ ] Changed ownership effective _____
[ ] Operating entity: [ ] New License # is _____
[ ] Changed licensee name to: _____
[ ] Real Property: _____
[ ] Stock Change within the entity that operates the facility.
[ ] Other: _____

Type of Ownership:

[ ] Proprietorship
[ ] Limited Liability
[ ] Profit Corporation
[ ] Partnership
[x] Non-Profit Corporation
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[ ] Trust

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Community Prevention and Addiction Services
1491 West Main Street • Willimantic, Connecticut 06226
Telephone: (860) 456-3215 • Fax: (860) 423-3351

July 17, 2007

Ms. Karen Roberts
Compliance Officer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134-0308

Dear Ms. Roberts:

I am in receipt of your letter dated July 5, 2007 regarding the elimination of the licenses for Psychiatric Outpatient Facilities for Community Prevention and Addiction Services, Inc for the following locations:

1. 87B Oak Street in Manchester-License #C-0299
2. 37 Commerce Avenue in Danielson- License # C-0301
3. 1491 West Main Street in Willimantic- License # C-0300

The elimination of those programs was proposed as a result of site visit performed by the Department of Public Health which occurred in May of this year. CPAS was sited for a violation of Department of Public Health regulation 19a-495-550 9 (b) which mandates that a licensed psychiatric facility must provide psychiatric services. When CPAS was first awarded the license, CPAS provided psychiatric services at all three locations listed above. These psychiatric services were an adjunct therapy for substance abusing clients who were suffering from co-occurring mental illness. Due to increased costs and level funding, CPAS was unable to continue to provide psychiatric services. As a result of our fiscal inability to provide the psychiatric services, the Department of Public Health demanded that we surrender our license, thereby closing the psychiatric outpatient facilities. Please be aware that the substance abuse treatment facilities located at those sites will remain licensed and open.

If you have any further questions or concerns please call me or William Gilbert, Vice President, Operations at the above number. Thank you.

Sincerely,

Leanne Dillian

Leanne Dillian
President/CEO

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 31, 2007

Ms. Leanne Dillian
President and Chief Executive Officer
Community Prevention and Addiction Services
1491 West Main Street
Willimantic, CT 06226

RE: Certificate of Need Determination; Report Number 07-31011-DTR
Community Prevention and Addiction Services
Termination of Psychiatric Outpatient Services at three service locations

Dear Ms. Dillian:

On July 24, 2007, the Office of Health Care Access ("OHCA") received your response to the July 5, 2007 Office of Health Care Access ("OHCA") inquiry regarding the termination of Psychiatric Outpatient Facility licenses at three service locations by Community Prevention and Addiction Services ("CPAS"). OHCA is reviewing this matter under Certificate of Need ("CON") Determination Report Number 07-31011-DTR. Please be advised that OHCA has reviewed this matter and makes the following findings:

1. In a 1999 CON Determination under Report Number 99-Y2, OHCA had previously allowed an exemption for the establishment of these licensed services at these three locations. CPAS described that program as the establishment of "*psychiatric services at outpatient locations in order to serve clients who are dually diagnosed and may be in need of psychiatric evaluation and medication management.*"

2. On June 21, 2007, OHCA received a copy of Department of Public Health ("DPH") Change in Facility Licensure forms for the elimination of the Psychiatric Outpatient Facility licenses for Transitions Outpatient Services (the doing business name for these services) effective June 11, 2007 for three locations:

87B Oak Street in Manchester – License #C-0299
37 Commerce Avenue in Danielson – License #C-0301
1491 West Main Street in Willimantic – License #C-0300.

3. In the July 24, 2007 response to OHCA, CPAS indicates the following:

    a) The elimination of these licenses was a result of a site visit performed by DPH in May, 2007. CPAS was sited for a violation of DPH regulations which mandates that a licensed psychiatric facility must provide psychiatric services.

    b) When CPAS was first awarded the psychiatric outpatient facility licenses, CPAS provided psychiatric services at all three locations as an adjunct therapy for substance abusing clients suffering from co-occurring mental illness.

    c) Due to increased costs and level funding, CPAS was unable to continue to provide psychiatric services. Because CPAS was not providing psychiatric outpatient services under its three licenses, DPH demanded that CPAS surrender the licenses.

    d) The substance abuse treatment services at these three locations remain licensed and open.

4. Section 19a-638 (3) of the Connecticut General Statutes ("C.G.S.") states that *"(3) Each health care facility or institution or state health care facility or institution which intends to terminate a health service offered by such facility or institution or reduce substantially its total bed capacity, shall submit to the office, prior to the proposed date of such termination or decrease, a request to undertake such termination or decrease."*

OHCA determines that Community Prevention and Addiction Services' June 11, 2007 termination of its outpatient psychiatric facility licenses constitutes a termination of services pursuant to Section 19a-638, C.G.S. and therefore a Certificate of Need application is required related to this matter.

If CPAS is agreeable, OHCA will consider the submission of information received on July 24, 2007 as the Letter of Intent for this matter. Therefore, CPAS may file a completed CON application with OHCA between September 22, 2007 and November 21, 2007. The CON application is being mailed to your attention separately.

If CPAS is not agreeable with this process and wishes to secure CON authorization for the June 11, 2007 termination of services, CPAS must immediately notify OHCA in writing of its position and submit a Letter of Intent to OHCA regarding this matter.

If you have any questions regarding this CON determination, please contact Karen Roberts, OHCA Compliance Officer, at (860) 418-7041. If you have any questions regarding the Letter of Intent and Certificate of Need application process, please contact Kimberly Martone, Supervisor of Certificate of Need, at (860) 418-7029.

Sincerely,

Cristine A. Vogel
Commissioner

CAV:kr

Copy: Sandra C. Bauer, Licensing Examination Assistant, Facility Licensing and Investigations Section, DPH
Kimberly Martone, Supervisor of CON process, OHCA
Karen Roberts, Compliance Officer, OHCA

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 14, 2007

Leanne Dillian
President, Chief Executive Officer
Community Prevention and Addiction Services, Inc.
1491 West Main Street
Willimantic, CT 06226

Re: Letter of Intent, Docket Number 07-31011
Community Prevention and Addiction Services, Inc.
Termination of Outpatient Psychiatric Services at Locations in Manchester, Danielson and Willimantic
Notice of Letter of Intent

Dear Ms. Dillian:

On July 24, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Community Prevention and Addiction Services, Inc. ("Applicant") for the termination of outpatient psychiatric services at locations in Manchester, Danielson and Willimantic, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Journal Inquirer* 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

August 14, 2007

Requisition # HCA08-031
FAX: (860) 646-9867

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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 **Sunday, August 19, 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

Journal Inquirer
Docket Number 07-31011

Letter of Intent
August 14, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Community Prevention and Addiction Services, Inc.
Town:	Danielson
Docket Number:	07-31011
Proposal:	Termination of Outpatient Psychiatric Services at Locations in Manchester, Danielson and Willimantic
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between September 22, 2007 and November 21, 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	2446
RECIPIENT ADDRESS	96469867
DESTINATION ID	
ST. TIME	08/14 15:54
TIME USE	00'20
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 14, 2007

Requisition # HCA08-031
FAX: (860) 646-9867

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

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 **Sunday, August 19, 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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 14, 2007

Leanne Dillian
President, Chief Executive Officer
Community Prevention and Addiction Services, Inc.
1491 West Main Street
Willimantic, CT 06226

RE: Certificate of Need Application Forms, Docket Number 07-31011-CON
Community Prevention and Addiction Services, Inc.
Termination of outpatient psychiatric services at locations in Manchester, Danielson and Willimantic

Dear Ms. Dillian:

Enclosed are the application forms for Community Prevention and Addiction Services, Inc.'s Certificate of Need ("CON") proposal for the Termination of outpatient psychiatric services at locations in Manchester, Danielson and Willimantic 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 22, 2007, and November 21, 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

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 22, 2007, and may be submitted no later than November 21, 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: 07-31011-CON

Applicant(s) Name: Community Prevention and Addiction Services

Contact Person: Leanne Dillian
Contact Title: President and Chief Executive Officer
Community Prevention and Addiction Services
Contact Address: 1491 West main Street
Willimantic, CT 06226

Project Location: Manchester, Danielson, Willimantic

Project Name: Termination of Psychiastric Outpatient Services in Manchester, Danielson and Willimantic

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

Est. Capital Expenditure: $ 0

1. Expansion of Existing or New Service

What services are currently offered at your facility? Please list.

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

A. Regarding this termination of services in Manchester, Danielson and Willimantic, please answer the following for each service location:

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

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

iii) Is the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

iv) Did 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 was 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 Manchester, Danielson and Willimantic location. Identify what the hours of operation were for each service location.

ii) Identify the primary and secondary service area towns for the Manchester, Danielson and Willimantic service location.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Manchester, Danielson and Willimantic service location.

iv) Discuss any scheduling backlogs that exist at the Manchester, Danielson and Willimantic service location.

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

vi) Describe the pattern of referrals to the Manchester, Danielson and Willimantic service location that currently exist.

C. Regarding the impact on the patient and provider community of the termination of services at each service location, 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 will continue to be made available to the patients that had previously utilized each of these service locations. List any special populations that utilize the services and explain how these clients will continue to access this service after each service location closed.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Manchester, Danielson and Willimantic 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 Manchester, Danielson and Willimantic 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 Manchester, Danielson and Willimantic service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

vi) Will each of these terminations 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 Manchester, Danielson and Willimantic 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:

_____
_____
_____
_____

5. 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 Community Prevention and Addiction Services in Manchester, Danielson and Willimantic.

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.

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 ☐ Group purchasing

☐ Reengineering ☐ None of the above

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

☐ Other (identify)_____

7. 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.

8. 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 has not resulted in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the **each** of the service location (Manchester, Danielson, Willimantic):

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 were 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 service location (Manchester, Danielson, Willimantic):

	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 service location (Manchester, Danielson, Willimantic):

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.

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: _____

12. C (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: 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.

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 Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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