State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	**Hartford Hospital**	
Doing Business As		
Name of Parent Corporation	**Hartford Healthcare Corporation**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	**80 Seymour Street Hartford, CT 06102**	
Identify Applicant Status: P for Profit or NP for Nonprofit		
Does the Applicant have Tax Exempt Status?	**Yes** No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	**J. Kevin Kinsella Vice President**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	**Hartford Hospital 80 Seymour Street Hartford, CT 06102**	
Contact Person Telephone Number	**860-545-4155**	
Contact Person Fax Number	**860-545-4193**	
Contact Person e-mail Address	**kkinsel@harthosp.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Cheshire Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)**

b. Project Proposal: **Termination of services**

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☒ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

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

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☒ Termination of Service

☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

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

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

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

725 Jarvis Street, Cheshire, CT 06410

g. List each town this project is intended to serve:

Bristol, Meriden, Plainville, Southington, Waterbury

h. Estimated starting date for the project: **Immediately**

i. If the proposal includes change in the number of beds provide the following information:

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ **N/A**

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

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

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

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity	☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	

☒ Other *(specify)* **N/A**

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

   See attached explanation for questions 1-8.

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

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

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

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

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

7. Who will be responsible for providing the service?

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

AFFIDAVIT

To be completed by each Applicant

Applicant: **Hartford Hospital**

Project Title: **Cheshire Partial Hospital Program**

I, **John Meehan** (Name), **President & CEO** (Position – CEO or CFO)

of **Hartford 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 **Hartford Hospital** (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.

John Meehan
Signature

March 3, 2008
Date

Subscribed and sworn to before me on March 3, 2008

Diana Nino
Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2012

RECEIVED
2008 MAR -7 A 10:47
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Cheshire Partial Hospitalization Program (PHP)/ Intensive Outpatient Program (IOP)
Submission of Certificate of Need
For Termination of Service

Hartford Hospital Institute of Living acquired the Apple Valley Partial Hospital program located in Southington, CT from Saint Francis Care in May 2004. This was part of the overall HHCC Behavioral Health network acquisition of all of all of the ambulatory programs previously owned by Elmcrest. The program was small and unable to be cost effectively maintained at the Southington site. It was moved to Cheshire into the building where IOL operates the Webb School at Cheshire. It was envisioned that the Cheshire location along with co-locating with the Webb School would allow the program to be successful. This has not been the case and over time the program has become gradually smaller and currently has no patients.

In 2005 the daily volumes (5 to 7 children/day) did not support two van routes to transport the children to the program; therefore the program began to operate one route. This change in routes impacted a small but steady number of referrals from Waterbury. In the same time frame, CMHA's Family Connections II IOP Program for Children opened in Waterbury, Waterbury Hospital was operating a PHP/IOP program and the Parent Resource Center became available in Naugatuck. Referrals from that area more appropriately began going to those programs.

In this same timeframe, the program staff designed and implemented an outreach and marketing program and visited many potential referral sources in order to increase referrals and admissions. This included area hospitals such as Yale and Hospital of St. Raphael who treated children as well as private providers and Child Guidance Clinics.

By April of 2006, the average daily census was two to three children a day. Six children were registered in the program. The Program could not maintain a sufficient number of patients on a daily basis to sustain a group-based program. The staff completed a combination of group, individual and family treatment of the six children enrolled in the program.

By 2007 there were no patients in the program, the program manager continued to answer the phone for referrals for another six months. Referrals were facilitated to another existing program for each call that came in. These referrals were based on the town the child lived in. The majority of children were referred to the programs mentioned above, though some went to various Rushford Center sites as well as programs at Yale and Hospital of St. Raphael. Call volume was low from the beginning and after two months the calls fell to approximately one a month for the next three months. There were no calls in the sixth month. The program telephone number was held for 12 more months and the voice mail checked regularly. There were no referrals to the program.

The two most prominent reasons for this program becoming nonviable were the closure of the St. Francis Care Portland facility as an inpatient unit and the development of the programs in Waterbury and Naugatuck area that met the local access need. The program has had no patients for a year, it is our position that patients are being adequately served at other programs.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 17, 2008

Kevin Kinsella
Vice President
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

Re: Letter of Intent, Docket Number 08-31116
Hartford Hospital
Termination of Intensive Outpatient Program in Cheshire Partial Hospitalization Program Services

Dear Mr. Kinsella,

On March 7, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hartford Hospital ("Applicant") for the Termination of Intensive Outpatient Program in Cheshire Partial Hospitalization Program Services, 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 & Record Journal* 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

March 17, 2008

Requisition # HCA08-151
Email: Publicnotices@courant.com

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 **Saturday, March 22, 2008.**

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 Diane Duran at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:DD:lmg

c: Sandy Salus, OHCA

Hartford Courant
Docket Number 08-31116

Letter of Intent
March 17, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Hartford Hospital
Town:	Hartford
Docket Number:	08-31116-LOI
Proposal:	Termination of Intensive Outpatient Program in Cheshire Partial Hospitalization Program Services
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between May 6, 2008 and July 5, 2008. 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

March 17, 2008

Requisition # HCA08-150
Fax (203) 317-2233

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

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 **Saturday, March 22, 2008.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:DD:lmg

c: Sandy Salus, OHCA

Record Journal
Docket Number 08-31116

Letter of Intent
March 17, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Hartford Hospital
Town:	Hartford
Docket Number:	08-31116-LOI
Proposal:	Termination of Intensive Outpatient Program in Cheshire Partial Hospitalization Program Services
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between May 6, 2008 and July 5, 2008. 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.

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

TRANSMISSION OK

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RECIPIENT ADDRESS	912033172233
DESTINATION ID	
ST. TIME	03/17 16:21
TIME USE	00'45
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 17, 2008

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

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Real Estate
Mortgages
Apartments
Items For Sale
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Public Notices

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PUBLIC NOTICE
Statute Reference: 19a-638
Applicant: Hartford Hospital
Town: Hartford
Docket Number: 08-31116-LOI
Proposal: Termination of Intensive Outpatient Program in Cheshire Partial Hospitalization Program Services
Capital Expenditure: $0
The Applicant may file its Certificate of Need application between May 6, 2008 and July 5, 2008. 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.

Appeared in: ***Hartford Courant*** on Friday, 03/21/2008

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STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

March 19, 2008

J. Kevin Kinsella
Vice President
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

RE: Certificate of Need Application Forms, Docket Number 08-31116-CON
Hartford Hospital
Termination of Intensive Outpatient Program and Partial Hospitalization Program in Cheshire

Dear Mr. Kinsella:

Enclosed are the application forms for Hartford Hospital's Certificate of Need ("CON") proposal for the Termination of Intensive Outpatient Program and Partial Hospitalization Program in Cheshire 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 May 6, 2008, and July 5, 2008.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five 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 that the scanned copy be in Adobe PDF format. Please submit the Financial Attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Diane Duran. Please feel free to contact her 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 May 6, 2008, and may be submitted no later than July 5, 2008. The Analyst assigned to your application is Diane Duran and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31116-CON

Applicant(s) Name: Hartford Hosptial

Contact Person: Kevin Kinsella
Contact Title: Vice President
Hartford Hospital
Contact Address: 80 Seymour Street
Hartford, CT 06102

Project Location: Cheshire

Project Name: Termination of Intensive Outpatient Program and Partial Hospitalization Program in Cheshire

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.

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

A. Regarding this termination of services in Cheshire, please answer the following:

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 (e.g. was patient feedback solicited, board authorization received, an analysis conducted of transportation issues for patients who will need to travel to other sites for services, etc).

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program at this site? Please explain.

iii) Is the Applicant being reimbursed by payers for these services? Did reimbursement levels enter 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 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 Cheshire location. Identify what the hours of operation are for the service location.

ii) List the service area towns. Provide a rationale for choosing the selected towns.

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 Cheshire service location.

iv) Discuss any scheduling backlogs that exist at the Cheshire service location.

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

vi) Describe the pattern of referrals to the Cheshire service location that currently exist.

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

i) Explain the procedures that the Applicant will follow 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 the Cheshire service locations. List any special populations that utilize the services and explain how these clients will continue to access this service after the Cheshire service location will close.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Cheshire 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 Cheshire 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 Cheshire 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 Cheshire 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:

_____

_____

_____

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

5. Quality Measures

A. Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Hartford Hospital in Cheshire.

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

☐ Yes ☐ No

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

B. 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 Cheshire service location:

i) Please submit one of the following;

(a.) an Audited or Unaudited Balance Sheet.

(b.) an Income Statement or Statement of Operations for the two most recently completed fiscal years.

***Note*:** 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 both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on actual patient payor mix in the following reporting format:

	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 the Cheshire service 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, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment II**.

iii) Provide 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.

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: _____

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