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	Jewish Family Services of Greater Hartford	
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	333 Bloomfield Ave. Suite A W Hartford CT 06117	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Joan Margolis, Director of Operations and Community Programs	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Jewish Family Services 333 Bloomfield Ave. Suite A W Hartford, CT 06117	
Contact Person Telephone Number	860-236-1927	
Contact Person Fax Number	860-570-1593	

Contact Person e-mail Address	jmargolis@jfshartford.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Farmington Valley Satellite Office

b. Project Proposal: __Mental Health 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
X☐ 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.?

X☐ 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 X☐ 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 X☐ 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:

The Chai Center, 166 West Main Street, Avon, CT 06002

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

Avon, Farmington, Canton, New Hartford, Granby, E. Granby, Simsbury, Collinsville

h. Estimated starting date for the project: 7-16-08

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: $ 0

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

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.

The Clinic is a licensed outpatient mental health facility. Individual and family counseling provided by a licensed clinical social worker is the type of service.

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

Proposal is to cease offering the above service.

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

No one is currently served. The target population was people seeking behavior health therapy, but this service was not sought at the location in question.

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

None

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

Private practices.

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

The termination of this service will have no effect, as only a dozen clients were served at the location in 3 years. Presently no clients are being served at the location.

7. Who will be responsible for providing the service?

N/A

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

N/A.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0382

Psychiatric Outpatient Clinic for Adults

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Jewish Family Services Of Greater Hartford of West Hartford, CT, d/b/a Jewish Family Services Of Greater Hartford, Farmington Office is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Jewish Family Services Of Greater Hartford, Farmington Office is located at 166 West Main Street, Avon, CT 06001 with:

Anne M. Danagher as Executive Director
Janice Rothstein as Director

This license expires **March 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, June 10, 2005. INITIAL

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

AFFIDAVIT

To be completed by each Applicant

Applicant: _Jewish Family Services of Greater Hartford

Project Title: Farmington Valley Satellite Office

I, Anne M. Danaher (Name), Executive Director (Position – CEO or CFO)

of Jewish Family Services of Greater Hartford 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 Jewish Family Services of Greater Hartford (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.

Signature 9-22-08 Date

Subscribed and sworn to before me on September 22, 2008

Notary Public/Commissioner of Superior Court

PATRICIA W. WEINER
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2011

My commission expires:

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 7, 2008

Joan Margolis
Director of Operations and Community Programs
Jewish Family Services of Greater Hartford
333 Bloomfield Avenue, Suite A
West Hartford, CT 06117

Re: Letter of Intent; Docket Number: 08-31245
Jewish Family Services of Greater Hartford
Termination of a Psychiatric Outpatient Clinic for Adults at 166 West Main Street in Avon

Dear Ms. Margolis:

On September 23, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Jewish Family Services of Greater Hartford ("Applicant") for the termination of a psychiatric outpatient clinic for adults at 166 West Main Street in Avon, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published by *The Hartford Courant* 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

October 7, 2008

Requisition # HCA09-045
Email: Publicnotices@courant.com

The Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, October 11, 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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

The Hartford Courant
Docket Number 08-31245

Letter of Intent
October 7, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicants:	Jewish Family Services of Greater Hartford
Town:	Avon
Docket Number:	08-31245-LOI
Proposal:	Termination of a psychiatric outpatient clinic for adults at 166 West Main Street
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between November 22, 2008 and January 21, 2009. 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.

Greer, Leslie

nt: Wednesday, October 08, 2008 4:57 AM

----IMA4bcae30.48ec/pop.state.ct.us
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.
Unless the delivery fails, this will be the only delivery notification.

----IMA4bcae30.48ec/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;lgreer04@hotmail.com
Action: relayed
Status: 2.0.0

----IMA4bcae30.48ec/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-9.23) id AE0E01E0; Wed, 08 Oct 2008 08:56:46 -0400
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Wed, 08 Oct 2008 09:03:49 -0400
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
X-MimeOLE: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: FW: RALLY
Date: Wed, 8 Oct 2008 08:54:57 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B101B7D920@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: RALLY
Thread-Index: Ackon20sDf4xV69BQE+Se2bE2ih/lQABzIjAAABUI3AAAGqX4AAl2sKwAAEAlyA=
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: lgreer04@hotmail.com
X-WSS-ID: 64F2703F2C4581189-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C92945.110F47ED"

----IMA4bcae30.48ec/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

October 8, 2008

Joan Margolis
Director of Operation and Community Programs
Jewish Family Services of Greater Hartford
333 Bloomfield Avenue
Suite A
West Hartford, CT 06117

RE: Certificate of Need Application Forms
Docket Number: 08-31245-CON
Proposal to Terminate Psychiatric Services at the Behavioral Health Outpatient Clinic in Avon

Dear Ms. Margolis:

Enclosed are the application forms for Jewish Family Services of Greater Hartford's Certificate of Need ("CON") proposal for the termination of psychiatric services at the behavioral health outpatient clinic in Avon with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between November 22, 2008, and January 21, 2009.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of the submission, each in 3-ring binders.

- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data, as appropriate, in MS Excel format.

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

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosure

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 November 22, 2008, and may be submitted no later than January 21, 2009. 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: 08-31245-CON

Applicant(s) Name: Jewish Family Services of Greater Hartford

Contact Person: Joan Margolis
Contact Title: Director of Operation and Community Programs
Jewish Family Services of Greater Hartford
Contact Address: 333 Bloomfield Ave
Suite A
West Hartford, CT 06117

Project Location: Avon

Project Name: Terminate Psychiatric Services at our Behavioral Health Outpatient Clinic in Avon

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 Avon, 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.

ii) When did the Applicant start offering Psychiatric Services at Avon?

iii) Did the Applicant seek CON authorization to start offering Psychiatric Outpatient Services for Adults at the Avon location?

iv) When did the Applicant decide to terminate psychiatric services at Avon?

v) When did the Applicant return its "Psychiatric Outpatient Clinic for Adults" license to the Department of Public Health?

vi) When was the Department of Mental Health and Addiction Services notified of the termination of the program at Avon and their role in the provision of this service?

vii) Provide a list of all the Jewish Family Services of Greater Hartford's facilities, location of each facility, types of services offered and available capacity for each service offered.

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

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

x) 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 Avon 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 Avon service location.

iv) Provide the units of service (i.e. number of admissions) for the past three fiscal or calendar years by patient town of origin, for the Avon service location.

v) Discuss any scheduling backlogs that did exist at the Avon service location.

vi) Were there any waiting lists in place at the Avon service location? If so, identify the number of patients on the waiting list.

vii) Describe the pattern of referrals to the Avon service location that did exist.

viii) Please provide a report that lists, by year, for FYs 2005, 2006, and 2007, to date, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharges during the month.

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

i) Explain the procedures that the Applicant followed 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 Avon service locations. List any special populations that utilized the services and explain how these clients will continue to access this service after the Avon service location closed.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Avon 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) Did your facility contact any other providers in the Avon service area to see if they were 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 was the effect of the termination of the Avon service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

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

vii) Provide information and supporting documentation addressing the issue of transportation for the Avon patients.

D. Did 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 Jewish Family Services of Greater Hartford in Avon.

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]

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.

[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.

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 did not result in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the Avon service location:

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

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

B) Please provide 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 Avon 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 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: _____

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

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

Total Facility: Description	FY Actual Results	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Thursday, October 09, 2008 10:13 AM
To: Greer, Leslie
Subject: RE: Legal Ad 08-31245

Leslie,
Here is the notice that I have scheduled for tomorrow, 10/10 for a total of $158.56.
Ad# 2236522.

NOTICE

Statute Reference: 19a-638
Applicants: Jewish Family Services of Greater Hartford
Town: Avon
Docket Number: 08-31245-LOI
Proposal: Termination of a psychiatric outpatient clinic for adults at 166 West Main Street
Capital Expenditure: $0

The Applicant may file its Certificate of Need application between November 22, 2008 and January 21, 2009. 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.

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Wednesday, October 08, 2008 8:19 AM
To: publicnotices@courant.com
Subject: Legal Ad 08-31245

Legal Ad,
Please run the attached public notice in your newspaper no later than Saturday, October 11, 2008. Please notify me that you have received this request.

Thank you,

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca