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LOUIS B. TODISCO
(203) 772-7718
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July 5, 2007

VIA HAND DELIVERY

Cristine Vogel
Commissioner of Health Care Access
Office of Health Care Access
410 Capitol Avenue, MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Windsor Dispensary Clinic, Inc.
Letter of Intent

Dear Commissioner Vogel:

Enclosed please find an original and five copies of the Letter of Intent of Windsor Dispensary Clinic, Inc.

We look forward to receiving certificate of need application forms and instructions.

Sincerely yours,

Louis B. Todisco

Louis B. Todisco

Enclosures

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

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

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	**Windsor Dispensary Clinic, Inc**	
Doing Business As	**Windsor Dispensary Clinic**	
Name of Parent Corporation	**N/A**	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail ---	**180 Poquonock Ave. Windsor, CT 06095**	
What is the Applicant's Status: P for Profit or NP for Nonprofit	**NP**	
Does the Applicant have Tax Exempt Status?	**Yes** **IRC § 501(c)(3)**	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	**Louis B. Todisco** **Murtha Cullina, LLP**	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	**Two Whitney Ave.** **4th Floor** **New Haven, CT 06510**	

Contact Person's Telephone Number	**(203) 772-7718**	
Contact Person's Fax Number	**(203) 772-7723**	
Contact Person's e-mail Address	**ltodisco@murthalaw.com**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Establish a Methadone Maintenance, Ambulatory Detoxification, Intensive Outpatient Day-Evening Treatment Program in Windsor, CT.

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

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

☒ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control

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

☐ Project expenditure/cost cost greater than $ 3,000,000

☐ Equipment Acquisition

☒ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

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

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

180 Poquonock Ave, Windsor, CT.

d. List each town this project is intended to serve: **The primary service area for this facility will include the following municipalities: Windsor, Bloomfield, East Granby, East Windsor, Enfield, Granby, Simsbury, Suffield, South Windsor, Windsor Locks, Somers, Ellington, Avon and Canton. Please see also Section IV, Project Description.**

e. Estimated starting date for the project: **January 1, 2008**

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

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

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: **$14,150**

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

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	**$10,150**
Land/Building Purchases	
Construction/Renovation	**$2,000**
Other (Non-Construction) Specify: **Miscellaneous**	**$2,000**
Total Capital Expenditure	**$14,150**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	

Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all non-medical equipment to be purchased and leased.
(See Attached List)

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

☐ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

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

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

Major Medical and/or Imaging Equipment Acquisition: N/A

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☒ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

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

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

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

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

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

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

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

7. Who will be responsible for providing the service?

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

(See Attached Project Description)

AFFIDAVIT

To be completed by each Applicant

Applicant: Windsor Dispensary Clinic, Inc

Project Title: Establish a Methadone Maintenance, Ambulatory Detoxification, Intensive Outpatient Day-Evening Treatment Program in Windsor, CT.

I, Edwin A. Njoku, MD (Name), CEO (Position – CEO or CFO)

of East 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 Windsor Dispensary Clinic, Inc. (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

7/5/07
Date

Subscribed and sworn to before me on 7/5/07

Lauri B. Todisco
~~Notary Public~~/Commissioner of Superior Court

~~My commission expires:~~

RECEIVED
2007 JUL -5 PM 2:5[illegible]

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 3).

Inpatient

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

Outpatient

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

Non-Clinical

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

Section IV. Project Description

Windsor Dispensary Clinic, Inc. (WDC) is a non stock Connecticut Corporation. WDC has been determined by the Internal Revenue Service to be a public charity and exempt from Federal income taxes under section 501(c)(3) of the Internal Revenue Code. WDC proposes to establish a methadone maintenance, ambulatory detoxification, intensive outpatient day-evening treatment program (the "Program") in Windsor CT. WDC is a new organization which is not currently providing services.

The Director of the program will be Edwin A. Njoku, M.D. Dr. Njoku is the principal of Christus Medical Group, P.C., a professional corporation which provides primary medical services in East Hartford and Windsor. The Program will be conducted at the same location as Dr. Njoku's existing medical practice at 180 Poquonock Ave, Windsor, Connecticut. The Program will be licensed by the Department of Public Health as a "Facility for the Care and Treatment of Substance Abusive or Dependent Persons." The Program will offer detoxification services utilizing methadone, drug counseling and other services appropriate to a detoxification program and treatment program.

The population to be served by the Program will be persons age 18 and over, who are addicted to opiates such as heroin and synthetic opiates such as percocet, vicodin, oxycontin and morphine and who desire to cease using these drugs. WDC will also service individuals that are dependent on alcohol or dependent on cocaine, amphetamines and other drugs of abuse in its intensive day and evening treatment program. It is anticipated that the Program will serve primarily persons from the anticipated primary service area which includes Windsor, Bloomfield, East Granby, East Windsor, Enfield, Granby, Simsbury, Suffield, South Windsor, Windsor Locks, Somers, Ellington, Avon and Canton. A secondary service area is believed to include West Hartford, East Hartford, Manchester, Vernon and Hartford. The Program will, of course, serve any persons who seek its services. It is believed that there is a need for services by persons from the suburban communities to be served and that the suburban location will provide an accessible location and encourage treatment of persons who are reluctant to seek treatment in urban areas.

There are currently no providers of maintenance and detoxification and related services in the primary service area which WDC expects to serve. WDC anticipates that the establishment of its maintenance treatment Program will have a beneficial effect in the health care delivery system in its service area. The existence of the WDC Program will make detoxification and treatment services more accessible as a result of its suburban location. Persons who may not have otherwise sought drug treatment services will do so because of its location. Also, it will provide an alternative program for persons who for one reason or another do not wish to utilize an existing provider of services.

Dr. Edwin Njoku, the principal of WDC, will be responsible for the providing services together with all other staff necessary to provide the services involved.

It is anticipated that payers will include Medicaid, commercial insurance and self pay patients. Also, WDC has been designated a public charity under the Internal Revenue Code and is qualified to receive tax deductible bequests, devises, transfers and gifts under applicable sections of the Internal Revenue Code. It is the intent of WDC to undertake fundraising to assist in financing its treatment initiatives and to have an "open-door" treatment policy for persons requesting treatment and or counseling services. WDC intends to implement a "sliding scale" fee schedule.

Itemized list of non-medical equipment to be purchased

1. Alarm System (including installation)	$3,000
2. Camera System (including installation)	$5,000
3. Steel Safe (including installation)	$2,150
	$10,150

Construction/Renovation

1. Reinforcing Floor for safe	$2,000

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 13, 2007

Louis Todisco, Esq.
Murtha Cullina, LLP
Two Whitney Avenue, 4th Floor
New Haven, CT 06510

Re: Letter of Intent, Docket Number 07-30999
Windsor Dispensary Clinic, Inc.
Establish and operate Windsor Dispensary Clinic to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor
Notice of Letter of Intent

Dear Attorney Todisco,

On July 5, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Windsor Dispensary Clinic, Inc. ("Applicant") to establish and operate Windsor Dispensary Clinic, Inc. to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor, at a total capital expenditure of $14,150.

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

July 13, 2007

Requisition # HCA08-006
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 **Tuesday, July 17, 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 **Laurie Greci** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LG:lmg

c: Sandy Salus, OHCA

Hartford Courant
Docket Number 07-30999

Letter of Intent
July 13, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Windsor Dispensary Clinic, Inc.
Town:	Windsor
Docket Number:	07-30999
Proposal:	Establish and operate Windsor Dispensary Clinic, Inc. to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor
Capital Expenditure:	$14,150

The Applicant may file its Certificate of Need application between September 3, 2007 and November 2, 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.

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Friday, July 13, 2007 10:26 AM
To: Greer, Leslie
Subject: RE: Legal Ad 07-30999

Leslie,
This notice is set to run statewide on 7/17, 1x3.00 inches, for $156.50
Ad #2058363

Thank you!
Caitlin

From: Greer, Leslie [mailto:Leslie.Greer@po.state.ct.us]
Sent: Friday, July 13, 2007 10:07 AM
To: publicnotices@courant.com
Subject: Legal Ad 07-30999

July 13, 2007

Legal Department,
Please post the attached legal ad in your newspaper by July 17, 2007. Please notify me that you have received this request.

Thank you,

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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 16, 2007

Louis Todisco, Esquire
Murtha Cullina LLP
Two Whitney Avenue, 4th Floor
New Haven, CT 06510

RE: Certificate of Need Application Forms, Docket Number 07-30999-CON
Windsor Dispensary Clinic, Inc.
Establish and Operate Windsor Dispensary Clinic, Inc. and provide methadone maintenance, ambulatory detoxificaiton, intensive outpatient, and day-evening treatment programs for substance abuse.

Dear Attorney Todisco:

Enclosed are the application forms for Windsor Dispensary Clinic, Inc.'s Certificate of Need ("CON") proposal to establish and operate Windsor Dispensary Clinic, Inc. and provide methadone maintenance, ambulatory detoxificaiton, intensive outpatient, and day-evening treatment programs for substance abuse, with an associated capital expenditure of $14,150. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between September 3, 2007, and November 2, 2007.

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 in Adobe Acrobat format. OHCA also requests that an electronic copy of the application be provided in MS Word format and that the financial attachments and other data, as appropriate, be provided in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. 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 September 2, 2007, and may be submitted no later than November 2, 2007. The Analyst assigned to your application is Laurie Greci and she may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30999-CON

Applicant's Name: Windsor Dispensary Clinic, Inc.

Contact Person: Louis Todisco, Esq.
Contact Title: Attorney
Murtha Cullina, Inc.
Contact Address: Two Whitney Avenue, 4th Floor
New Haven, CT 06510

Project Location: Windsor

Project Name: Establish and Operate Methadone Maintenance, Ambulatory Detoxification, Intensive Outpatient, and Day-Evening Treatment Programs for Substance Abuse

Type proposal: Section 19a-638

Est. Capital Expenditure: $14,150

1. Expansion of Existing or New Service

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

Augment:

Replace:

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4. Clear Public Need

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

B. Provide the primary and secondary service area towns.

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

D. If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town

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

F. Scheduling backlogs in service area

G. Travel distance from proposed site to service area towns

H. Hours of operation of existing/proposed service

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

Primary Service Area:

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

Secondary Service Area:

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

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

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

L. 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.

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

- ☐ Epidemiological studies
- ☐ Public information reports
- ☐ Needs assessments
- ☐ Market share analysis
- ☐ Other (Identify)
- ☐ None, *Explain* why no reports, studies or market share analysis was undertaken related to the proposal:

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

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

- ☐ American College of Cardiology
- ☐ National Association of Child Bearing Centers
- ☐ Report of the Inter-Council for Radiation Oncology
- ☐ National Committee for Quality Assurance
- ☐ American College of Obstetricians & Gynecologists
- ☐ American College of Radiology
- ☐ Public Health Code & Federal Corollary
- ☐ American College of Surgeons
- ☐ Substance Abuse Society and Mental Health Services Administration
- ☐ Other, Specify:

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: *For physicians, please provide a list of hospitals where the physicians have admitting privileges.*

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

- ☐ DPH
- ☐ Fire Marshall Report
- ☐ AAAHC
- ☐ Other:
- ☐ JCAHO
- ☐ Other States Health Dept. Reports
- ☐ (New Out-of-State Providers) AAAASF

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

F. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital (Applicant), Physicians and any staff related to the proposal, for the past five (5) years.

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

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

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

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ None of the above
- ☐ Other (identify):
- ☐ Group purchasing
- ☐ Reengineering

[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.

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

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

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

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

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) The service levels you are seeking to provide.

iv) If licensing is not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.)
☐ Partnership
☐ Joint Venture
☐ Other (Specify):
☐ Limited Liability Company (LLC)
☐ Professional Corporation (PC)

B. Provide the following financial information:

i) Submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Explain how the proposed new construction or renovations will affect the delivery of patient care.

D. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Capital Equipment Lease/ Purchase

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

What is the anticipated residual value at the end of the lease or loan term?	$_____
What is the useful life of the equipment?	____ Years
Please submit a copy of the vendor quote or invoice as an attachment.	
Please submit a schedule of depreciation for the purchased equipment as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	_____
CON Proposed lease financing	_____
Fair market value of leased assets at lease inception	_____
Interest rate	_____ %
Monthly payment	_____
Term	_____ Years

☐ Other financing alternatives:

Amount	_____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) Provide 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.** ***Note:*** *The actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.*

ii) Please provide three years of projections of incremental revenue, expense, and volume statistics attributable to the proposal **by payer. See attached, Financial Attachment II.**

iii) List the assumptions utilized in developing the projections reported on Financial Attachments I and II (e.g., FTE's by position, volume statistics,

other expenses, revenue and expense % increases, project commencement of operation date, etc.).
Note: *Include consideration of The Deficit Reduction Act of 2005 and the reduction of Medicaid and Medicare reimbursements in the development of the financial projections.*

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

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

vi) Describe how this proposal is cost effective.

vii) Provide a copy of the facility's charity care policy and sliding fee scale applicable to the proposal.

13. 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.

13. C. ii) Please provide three years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description									
Type of Unit Description:									
# of Months in Operation									
Year 1	(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 Payer Category:								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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 NonGovenrment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

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: _____

Pick Up Trucks

TOYOTA TACOMA '05
2.7L 4 Cyl, 4x4, Ext Cab, 20K Miles, 5 Speed, AC, CD, PW, PL, White, $14,500 **(860)614-1257**

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2007 CLASS "A" - 35' bunkhouse w/2 slides, 3-TVs & sleeps 8.

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FLAGSTAFF CAMPER '97
19 ft. Sleeps 4, 1 owner, fully equipped, good condition,

Recreational Vehicles

FOREST RIVER SUNSEEKER LE 31-ft Class C '02 Hardly Used, Low Miles, Garaged, Loaded,

Recreational Vehicles

LOW, LOW
monthly payments on pop-ups, travel trailers, and motor-

Recreational Vehicles

SALEM 5TH WHEEL '99 - 28-ft. $10,500. A/C, stereo, microwave, 2 slide outs, p/u mount, awning. **Call (860)487-4738**

may also be purchased from Merritt Graphics. Go to www.merrittgraphics.com, click on the PlanWell link, select "Public Plan Room" and then select this project. Fees to purchase sets are non-refundable and will be posted on the site.

Additionally, plans may be ordered by calling Merritt Graphics at 800.344.4477 and requesting an order form.

Businesses without internet access equipment, may contact the Procurement Services Department at 860.522.4888 for any Bid information. Our fax number is 860.722.6607.

A PRE-BID Conference will be held on July 25, 2007 at 11:00 A.M. at the Bushnell Park Playground. All prospective Bidders are requested to meet at this location. Further access to the sites can be arranged through Antonio J. Matta, (860) 522-4888 x 6523. Bidding Contractors are expected to either attend the pre-bid conference or make other arrangements to review the project sites. Bidding Contractors are advised to review all the conditions at the various sites.

and it not living, her widower and heirs.

The plaintiff has named you as a party defendant in the complaint which he is bringing to the above-named court seeking to foreclose municipal tax liens on 72 Charles Street, in East Hartford, Connecticut ("the premises"), gain possession of said premises, and recover interest, fees and costs associated with said liens. This complaint if returnable to the court on Aug. 21, 2007, and will be pending therein after that date.

The subscribing authority finds that the residence of each of the following defendants is unknown, and all reasonable efforts have been made to ascertain the same and have failed: **HENRY D. WHITNEY**, if living, and if not living, his widow and heirs, whose address is unknown;
ELNORA M. NEWTON, now or formerly of West Hartford, Connecticut, if living, and if not living, her widower and heirs whose residence(s) is/are unknown;
ISSAC J. NEWTON, now or formerly of West Hartford, Connecticut, if living, and if not living, his widow and heirs whose residence(s) is/are unknown;
ROBERT ELISHA STANLEY OLMSTED, now or formerly of East Hartford, Connecticut, also known as **ROBERT E.S. OLMSTED**, if living, and if not living, his widow and heirs whose residence(s) is/are unknown;
STERLING PITKIN OLMSTED, now or formerly of East Hartford, Connecticut, if living, and if not living, his widow and heirs whose residence(s) is/are unknown; and
ELLA SMITH OLMSTED, now or formerly of East Hartford, Connecticut, if living, and if not living, her widower and heirs whose residence(s) is/are unknown.

Now therefore, it is hereby ordered that notice of the institution of this action be given to each such defendant by causing a true and attested copy of this order to be published in the Hartford Courant, once a week for 2 consecutive weeks, commencing on or before July 28, 2007 and that return of such service shall be made to the court.

Linda A. Cohn
Deputy Chief Clerk, Superior Court
Judicial District of Hartford

Copies of the Drawings and Specifications may be obtained at **Office of Business Manager, Naugatuck, upon a Tuttle House School, 380 Church Street, Naugatuck, upon a non-refundable** deposit of **$15.00** for EACH SET. Make check payable to the **Naugatuck Board of Education**. Addenda will be issued to all Bidders registered with the Naugatuck Board of Education. Faxes of Addenda will not be provided.

Federal Express orders will only be considered if accompanied by a properly filled out Federal Express form (one form for each set ordered), charging the order to the Contractor's account.

General Contractor List of Bidders may be mailed to Contractors if requested. Faxes of Bidders Lists will not be provided.

As Security, each Bid must be accompanied by a Certified Check or Cashier's Check drawn upon either a State Bank and Trust Company or a National Banking Association, to the order of the **Naugatuck Board of Education**, or the Bid must be accompanied by a Bid Bond having as surety thereto, such Surety Company or Companies as are authorized to do business in the State of Connecticut of an amount not less than **(10%)** of the Bid. NO BID WILL BE ACCEPTED UNLESS ACCOMPANIED BY THE REQUIRED BID DEPOSIT.

A 100% Performance, Labor and Material Payment Bond and other Bonds subject to the conditions provided for in the Bid Specifications are required.

All Bidders must submit a Contractors Qualification Statement AIA Document A305 with the bid.

Bidders shall not include Federal Excise Taxes or State of Connecticut Sales Taxes on which Public Buildings are exempt.

After the opening of the Bids, no Bid can be withdrawn for a period of sixty (60) days.

The **Naugatuck Board of Education** reserves the right to waive any informalities in Bids, to reject any or all Bids, or to accept any proposal that, in their judgment will be in the best interest of the Town.

The **Naugatuck Board of Education** does not discriminate on the basis of sex, race, age, physical disability, religion or national origin.

The **Naugatuck Board of Education** is an Affirmative Action/Equal Opportunity Employer. Minority/Women's Business Enterprises are encouraged to apply.

Mr. John Petuch, Business Manager
Naugatuck Board of Education

MARLBOROUGH

INVITATION FOR BID
TOWN OF MARLBOROUGH, CONNECTICUT
TOWN CENTER ENHANCEMENT
SCHOOL DRIVE SIDEWALK IMPROVEMENTS

Sealed bids for the Town Center Enhancement/School Drive Sidewalk improvements Project, for the Town of Marlborough, Connecticut (the "Town"), will be received at the Town Hall, 26 North Main Street, Marlborough, Connecticut in the Town Clerk's Office until 2:00 p.m. prevailing time, on Thursday, August 16, 2007, at which time and place said bids will be publicly opened and read aloud. Faxed or e-mailed bids will not be accepted. Bids submitted after this date and time will be

THOMASTON

WINDSOR

NOTICE OF INTENT
Statute Reference: 19a-638
Applicant: Windsor Dispensary Clinic, Inc.
Town: Windsor
Docket Number: 07-30999
Proposal: Establish and operate Windsor Dispensary Clinic, Inc. to provide methadone maintenance, ambulatory detoxification, intensive outpatient, and day-evening treatment programs for substance abuse in Windsor.
Capital Expenditure: $14,150

The Applicant may file its Certificate of Need application between September 3, 2007 and November 2, 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.

CONNECTICUT