CONNECTICUT Renaissance
Change the direction of your life.

President
SARA HERZ, Ph.D.

Chief Executive Officer
PATRICK McAULIFFE

April 1, 2008

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

Dear Commissioner Vogel:

Enclosed, please find a Letter of Intent completed by Connecticut Renaissance, Inc. The request is to terminate Psychiatric and Substance Abuse Services at our Behavioral Health Outpatient Clinic located at 705 Bloomfield Ave, Bloomfield, Ct. Enclosed is the original Letter of Intent and three copies.

Should you have any questions, please do not hesitate to give me a call at (203) 336-5225 x2108 or email me at kristeni@ctrenaissance.com.

Sincerely,

Kristen Isham
Director of Quality Improvement

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	Connecticut Renaissance, Inc.	
Doing Business As	Connecticut Renaissance, Inc.	
Name of Parent Corporation	N/A	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	350 Fairfield Ave. Ste 701 Bridgeport, CT 06604	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
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.	Kristen Isham Director of Quality Improvement	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	350 Fairfield Ave. Ste 701 Bridgeport, CT 06604	
Contact Person Telephone Number	203-336-5225 x2108	
Contact Person Fax Number	203-336-2851	
Contact Person e-mail Address	kristeni@ctrenaissance.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Behavioral Health Outpatient Program

b. Project Proposal: Termination of Psychiatric & Substance Abuse 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 & 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:

705 Bloomfield Ave Suite 102, Bloomfield, CT 06002

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

Bloomfield, CT

h. Estimated starting date for the project: April 1, 2008

i. If the proposal includes change in the number of beds provide the following information: **N/A**

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: **N/A**

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: **N/A**

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): **N/A**

- ☐ Applicant's Equity
- ☐ Capital Lease
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* _____

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 Connecticut Renaissance Behavioral Health Outpatient Clinic located at 705 Bloomfield Ave., Bloomfield has been licensed to provide both Psychiatric and Substance Abuse services by the Department of Public Health. Connecticut Renaissance has not provided Psychiatric or Substance Abuse services at this location since it has opened. Connecticut Renaissance plans to terminate both its DPH licenses.

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

We are proposing to terminate our Psychiatric and Substance Abuse Licenses at our 705 Bloomfield Ave., Bloomfield address.

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

We have not provided Psychiatric or Substance Abuse services at this location, since its inception. We have held the license in the event that this was a service that Connecticut Renaissance wanted to offer to persons in need.

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

We have not utilized our Psychiatric or Substance Abuse licenses in the past.

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

Yes

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

None – We have not utilized this license.

6. Who will be responsible for providing the service?

N/A

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

N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: Connecticut Renaissance, Inc.

Project Title: Behavioral Health Outpatient Program – Termination of Psychiatric & Substance Abuse Services

I, Patrick McAuliffe (Name), CEO (Position – CEO or CFO)

of Connecticut Renaissance, Inc. 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 Connecticut Renaissance, 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.

P. McAuliffe, CEO — Signature

3/28/08 — Date

Subscribed and sworn to before me on March 28, 2008

Notary Public/Commissioner of Superior Court

My commission expires: 06/30/08

RECEIVED
2008 APR -2 P 2:08
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 9, 2008

Kristen Isham
Director of Quality Improvement
Connecticut Renaissance, Inc.
350 Fairfield Ave.
Bridgeport, CT 06604

Re: Letter of Intent, Docket Number 08-31132
Connecticut Renaissance, Inc.
Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield
Notice of Letter of Intent

Dear Ms. Isham:

On August 17, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Connecticut Renaissance, Inc. ("Applicant") for the Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in 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:DD:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 9, 2008

Requisition # HCA08-173
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 Sunday, April 13, 2008.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) 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:bko

c: Sandy Salus, OHCA

The Hartford Courant **Letter of Intent**
Docket Number 08-31132 **April 8, 2008**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Connecticut Renaissance, Inc.
Town:	Bloomfield
Docket Number:	08-31132-LOI
Proposal:	Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between June 1, 2008 and July 31, 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.

Olejarz, Barbara

`ent: Wednesday, April 09, 2008 1:15 PM

----IMAd04f98f.47fc/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.

----IMAd04f98f.47fc/pop.state.ct.us
Content-Type: message/delivery-status

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

----IMAd04f98f.47fc/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 A98F0514; Wed, 09 Apr 2008 13:14:55 -0400
Received: from 159.247.77.55 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email
irewall v6.0.0)); Wed, 09 Apr 2008 13:16:38 -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: "Olejarz, Barbara" <Barbara.Olejarz@po.state.ct.us>
MIME-Version: 1.0
Disposition-Notification-To: "Olejarz, Barbara"
<Barbara.Olejarz@po.state.ct.us>
Subject: Legal Ad
Date: Wed, 9 Apr 2008 13:10:31 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1D4B684@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad
Thread-Index: AciaZJ1cOowWj5cGR+K2hM8C1ZGMtw==
From: "Olejarz, Barbara" <Barbara.Olejarz@po.state.ct.us>
To: publicnotices@courant.com
X-WSS-ID: 6BE2267C2EG317561-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C89A64.9DDF5783"

----IMAd04f98f.47fc/pop.state.ct.us--

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 16, 2008

Kristen Isham
Director of Quality Improvement
Connecticu Renaissance, Inc.
350 Fairfield Avenue
Bridgeport, CT 06604

RE: Certificate of Need Application Forms, Docket Number 08-31132-CON
Connecticut Renaissance, Inc.
Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield

Dear Ms. Isham:

Enclosed are the application forms for Connecticut Renaissance, Inc's Certificate of Need ("CON") proposal for the termination of psychiatric and substance abuse services in Bloomfield with an estimated total 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 June 1, 2008, and July 31, 2008.

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.**

- All pages must be paginated and date referenced.
- Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be number sequentially from the Applicant's document preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit to OHCA in 3-Ring Binders, one (1) original and six (6) hard copies.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in a Adobe (.pdf) format.
- Also include an electronic copy of the documents in MS word format and 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,

Barbara Durdy
Director of Operations

Enclosures

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** _____ 19a-638 and 19a-639. **Fee Required.** 2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section. 3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000 4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ $ 1,000.00 b. Additional Fee: (Capital Expenditure Assessment)_____ $_____.00 (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ $_____.00 d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

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: _____

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 June 1, 2008, and may be submitted no later than July 31, 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:	08-31132-CON
Applicant(s) Name:	Connecticut Renaissance, Inc.
Contact Person: **Contact Title:**	Kristen Isham Director of Quality Improvement
Contact Address:	Connecticut Renaissance, Inc. 350 Fairfield Avenue Bridgeport, CT 06604
Project Location:	Bloomfield
Project Name:	Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield
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 termin ation of services in Bloomfield, 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) Did the Applicant determine there was no or insufficient public need for the continuation of this program? 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 Bloomfield 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 Bloomfield service location.

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

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

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

vii) 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 Bloomfield 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 Bloomfield service locations. List any special populations that utilize the services and explain how these clients will continue to access this service after the Bloomfield service location will close.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Bloomfield 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 Bloomfield 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 Bloomfield 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 Bloomfield patients. Describe how patients would be able to travel to a new service location if without benefit of a personal vehicle.

D. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked *other than None of the above*, please provide an explanation.

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

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

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

_____
_____
_____
_____

5. Quality Measures

A. Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Community Mental Health Affiliates, Inc. d/b/a Family Services of Central CT in Bloomfield.

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.)

C. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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 Bloomfield 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.

9. 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.

9.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

Apartments For Rent

HARTFORD Historic Charter Oak Place. Restored Studio apt. $525. H/HW, prkg incl. 860-560-0144.

Hartford West end Executive House. Renov Eff $520/m, 1 BR $635/m, 2 BR $825/m. Peaceful, modern, well kept elevator bldgs. H/HW, ldry, hrwd/carpet, gat pkg. **549-3181 office 9-4 (M-Sat) or 966-8284, No pets.**

HARTFORD West End
Large 1 BR heat/hw incl $650, Large 2 BR heat/hw incl $775/mo Call 841-5356

HARTFORD- WESTEND 408 Prospect Ave. 1BR $720. Appl's, lrg closets, heat, a/c. (parking 30 dollars), laundry. Game room. No pets. Super 232-1024. Mgmt 549-3330.

HARTFORD WESTEND CLEMENS PLACE 233-2618 M-F 9-5, Sat 10-2

HARTFORD
Brand New Units!
184 Sigourney St.
Studio $495, HT/HW
Section 8, No Pets

Manchester
Damato Enterprises
646-1021 1&2BR THs/Apts
Apply for waiting list
M-F 9-5, Sat 11-2
damatoapartments.com

MANCHESTER
FOUNTAIN VILLAGE
ACROSS FROM WICKHAM PARK
- HEAT & HOT WATER
- NO PETS
- Fully appliianced
- Great closets
- Air conditioner
- Laundry & storage
- TENNIS COURT
- OLYMPIC POOL
- BIKE TRAILS

Please come visit our furnished models. Truly country living with city conveniences. On busline mins. from Downtown Hartford, Buckland Mall, & the new Rte 291. Spacious 1 & 2 BR Apts & Twnhses

Mon.-Fri., 8AM-7PM Sat. 10-5, Sun. Closed
860-528-1300

Manchester Townhouse 2 BR 1½ bths, gar, all appl's, heat & hot water incl, no pets. $1100/mo. **568-4400**

MANCHESTER
Squire Village Apts
The 1, 2 & 3 Bedroom Section 8 wait lists are closed.
EHO - CHFA FINANCED.

MANCHESTER-The Oaks Apts
Movein 5/1 MAY RENT FREE!
1 & 2BRs. Incl HT/HW, closets

Apartments For Rent

NEW BRITAIN
Recently refurbished. 3 Rooms, 1 bedroom, second floor. Off street parking. Available May 1. $600/month plus utilities and security deposit. 860-229-7255 Leave a message.

NEWINGTON
Salem & Gloucester Village
1&2BR TH units incl. H/HW & 24-hr maint. **667-2233**

NEWINGTON
STONEGATE APARTMENTS
****Spring Special****
1st Month Free 2br, in clean quiet building, C/A, balcony. $950+utils. **860-665-9828**

Newington
FENN-WOODE DEVELOPMENT
www.fennwoode.com
M-F 11-4 Ph 860-667-0496

PORTLAND Spacious 2 & 3 BR Includes appliances, AC, W/D, Lrg front porch. Start-

Open wkdys, wknds by appt. **www.atcountrywood.com**

VERNON LEE & LAMONT REALTY - 1 & 2 bedroom, 24 hr maintenance, some w/gar., strg, w/d hookup, deck. www.leelamont.com **860-872-4690** EHO

Vernon Springville Mill 1&2Br Apts from $795 & 1025. Dogs & cats welcome. 875-8380

VERNON
1150 square foot 2 BR garden style end unit available for immediate occupancy. Features private entry, central air, full sized w/d and large deck. $1300 per mo. Incl h/all water. **Call 872-7384**

VERNON
VERNON TERRACE
HEAT & ALL WATER INCLUDED
Save up to $2000 on your heating bill.

Move in Now, Pay May 1st!
All townhomes include
- no one above or below you
- parking at your front door
- finished rec room
- storage room

1 BR starting at $1025

Apartments For Rent

WEST HARTFORD 2 bedroom updated, hardwood floors, porch, great shape $1,100 plus util/ 2 bedroom, updated, w/w carpeting, heat & hot water $1,075 860-231-1879

WEST HARTFORD Clean, sunny, remod. 1 & 2 bd, quiet area. Appls, w/w, lndry. On busline, great schools, community rm. **FREE HT/HW.** $740 to $860. **953-8030** EOH

WEST HARTFORD Large 1BR. HT/HW, appls, parkong. No pets. **$925/m (860)570-1321**

WEST HARTFORD LINE
Prospect/Farm. Ave.
Active Adult Living
55 & OVER
• 1 BEDROOM APTS •
On busline. Walk to shopping. Entry intercom incl. HT, HW, AC, prking, elevator, Social Rm. $580/mo.
Mon.-Fri. 9-6; Sat. 9-1
• (860) 233-6281 •
intertownrealty.com

Pkg. Storage. **$695/mo + Sec. Call 860-289-6356**

FARMINGTON- BRISTOL LINE Immaculate, 2 large bdrms, 1½ Bath, Full basement, C/A, Lawn, No Pets.$970/m+Utils. **(860)677-6880**

Farmington - 2 BDRM CONDO HT & HW incl. Lakeside pool. Bright 2nd floor unit. Bus Line. Laundry/Storage.No Dogs. $995/m. Call 860-906-4262. Available immediately.

ROCKY HILL
Townhouse avail. 5/1. 1300 sq ft. end unit, 2 BR, 1.5BA, large country kitchen w/deck, fireplace, A/C, full basement, gar, no pets, non-smoking, lease, sec. $1300/mo. 860-559-3648

VERNON
1 & 2 BR condo like townhomes, multi-level, finished rec rooms, private storage rooms, no one living over or under, deck/patios. Starting at $1025 incl. heat and all water. **Villa Apts. Call 872-7384**

WEST HARTFORD 1 BR w/ den, luxury condo in Blueback Sq. 860-805-1860

W HARTFORD 1 BR, heat & hot water incld, exc loc, 2 prkg spaces $850/mo. 860-882-7805 236-4904

Houses for Rent

EAST HAMPTON, 4 bedroom, new construction, 3 bath, 1st floor laundry, 3 car garage, too much to list, rent neg. Please contact 860-478-3836

E LONGMEADOW MA
New executive home on golf course 4BR 4BA 1 yr lease $2200. Avail 6-1

Rooms without Board

East Hartford & Manch. apts & rms. Furn, util inc $125wk & up. app fee, sec dep **291-0000**

Condos Connecticut

AVON
FARMINGTON WOODS
CHARMING FOURPLEX
First flr 2BR 2BA in pristine cond. Available for immed. occup. Asking $184,900.
CALL US FOR APPOINTMENT ON THESE & MANY OTHERS
FARMINGTON WOODS REALTY 673-0411
farmingtonwoodsrealty.com

Cheshire/Wallingford
Luxury Condos built by Pulte Homes **877-785-8328 for info**

EAST GRANBY
4/13 1-3pm. Beautiful 4060 sf colonial on 1.98 acs in one of Burlington's most desirable neighborhoods! Privt patio, 9ft ceilings. 860-673-2150

EAST HARTFORD Mohawk Dr. Stately custom 8 room Colonial, siding, spacious kitchen, extras. Price Reduced! **Shimkus Murphy & Lemkuil 249-1396 x124; x123**

ELLINGTON
OPEN SUNDAY 1-3
7 Brittaini's Way
$539,900 New const. Cust built col with dream kitchen. Call Todd Hany. Dir: Wappingwood, to Grant to Brittani's Way.
CALL 860-871-2775
Sentry

Farmington Thinking of Selling? **William Pitt Sotheby's Int'l Realty 860-677-1278.**

Glastonbury- For a FREE market evaluation of your home. **Executive R.E @ 633-8800**

★HEBRON & VICINITY★
Mobile Ranch 924sf, **$37,900**
Lot 1.98ac, nr lake **$109,900**
Ranch Close to beach, 2 BR Screened porch. **$124,900**
Remod'l Ranch close to lake, 3BR, 1½Bath, FPl. **$161,900**
Updated Ranch, 3 bd, full bsmnt, grge, wd flrs **$199,900**
Ranch, 2 car, 3 bd, close to beach, sunrm **$199,900**
Remod Ranch cedar porch, 3br, barn, beaut. **$219,900**
RR close to beach, 10 rms, 5 bd, 2 car, new kitch **$254,900**
Ranch 2.90acs with new kit, oak flrs, 2 car, snrm **$249,900**
Updated Cape, 3BR, 2ba FP, C/A, 1st flr master **$289,900**
New Cape 5.81 ac Great level lot, horses allowed **$309,900**
Cape 2.90 acs, 2040sf, FP, 3 car gar., cul-de-sac **$304,900**
Col 1.61ac, 10 rms, 5 br, 3 ba, in-law, lease avail **$329,900**
Col 2.10 ac, 4 bd, 2 car, front porch, great lot **$364,900**

Homes Connecticut

Tolland, BELVEDERE RIDGE
New homes as low as $289,900. Open House Thurs-Sun 12 to 3 601 Old Post Rd 860-896-0101

TOLLAND
OPEN SUNDAY 1-3
33 Mihaliak Rd.
$359,900 Cont. w/open floor plan, 3 season snrm. Call Frank Ingerson. Dir: Old Stafford to Crossen to Mihaliak.
47 Shenipsit Lake Rd.
$279,900 RR w/brand new kit. Updated. Call Terri Doyle. Dir: Rt 30/74 to Shenipsit Lake Rd.
CALL 860-871-2775
Sentry

WEST HARTFORD
Considering buying or selling **RE/MAX Premier, 561-6106**

WEST HARTFORD-ELMWOOD Compact 2 bedroom Ranch, siding. Eat-in kitchen. Minimum cash. $150's. **Shimkus Murphy & Lemkuil 249-1396 x124; x123**

WEST HARTFORD $224,000

Homes CT Shoreline

SHORELINE PROPERTIES
Open Sunday 1-3
OLD LYME
10 & 54 West End Drive
Direct Long Island Sound Year Round Waterfront. Classic seaside home, white sand to water's edge - enjoy swimming, boating, sailing. Views from all rooms, open floor plan. 54 West End sold separately Dir: RT156 to Hawks Nest Rd right onto West End Drive $829,000
margueritemattison.com 767-2636 x133

WESTBROOK - 10 Sunrise Newly furnished & accessorized year-round home located in sought after Island View Beach. Updated kitchen & baths, open floor plan gas fp. Brick patio for outdoor entertaining. Water views! Dir: Grove Beach So. To L On Lilac To Rd to 10 Sunrise $579,000
virginiadicorleto.com 767-2636 x157

WESTBROOK 34 Bellstone

Land Connecticut

Meriden Approved 10 Lot Sub-Division $425,000...**Call Joseph Fazekas @ 250-2488.**

Land Out of State

•Land Auction•
240 Props Must be Sold! Low Down / E-Z Financing Free Brochure 800-756-2087.
www.LANDAUCTION.com

NYS WATERFRONT
Lake & River Bargains
Over 40 tracts- FREE LIST!

25 Ac-Upstate NY Lake- $69,900
13 Ac-Adk Fishing River- $79,900
30 Ac-Bass Lake- $89,900
Many more! Low fixed rate financing!
Call 800-229-7843 or visit www.landandcamps.com Christmas & Associates

Vacation Property For Sale

ADVERTISE YOUR WATERFRONT PROPERTY HERE and reach over 680,000 daily and 850,000 Sunday Hartford Courant readers. **Call 525-2525 today.**

MADISON
Summer Beach Cottage, 2 bedroom, quiet, private, $79,000. 203-245-2889

Commercial for Rent

NEW BRITAIN Warehouse Approximately 3300 Square Feet. Also Zoned for retail. Please contact 860-873-8823 or 860-810-6688

NEWINGTON approx 1200sf oversized 2 car garage, for storage with office area. $750/month (860)666-2966

Industrial for Rent

East Windsor Ind. Park
6,000 S.F.
Junction I-91 & Rt 5. Front prestige loc in 1 of our most attractive bldgs in the park. 5,000 SF fin ofc, 1,000 SF w/ loading dock ideal for ofc, svc, engineering, environmental, computer fabrication hi-tech etc. Also 2,000SF w/ loading dock. 4 ofcs. **Call Jimmy Gessay at 860-875-0134**

West Hartford Area 7500SF Drive in Door. Bernard Mussman R.E. 860-246-3096

Investment/ Income

For all your real estate services www.CTREIA.com 860-561-8821

Public Notices

SOUTH WINDSOR

TOWN OF SOUTH WINDSOR
1540 SULLIVAN AVENUE
SOUTH WINDSOR, CONNECTICUT 06074

INVITATION TO BID

Notice is hereby given that the Town of South Windsor, Connecticut, shall accept sealed bids for the lease of Two (2) 2008 OR 2009 model year mid-size, four (4) door, front wheel drive, automobiles to be used as unmarked and administrative police vehicles.

Bids shall be accepted at the Office of the Town Manager, Town Hall, 1540 Sullivan Avenue, South Windsor, CT **until Thursday, May 15, 2008 at 11:00 A.M.,** at which time said bids shall be opened. Bids shall be in a sealed envelope marked, "Bid – Police Vehicles."

"Specifications" and "Bid Forms" may be obtained from the South Windsor Police Department at 151 Sand Hill Road, South Windsor, CT. The Town reserves the right to accept or reject any and all bids if in the best interest of the Town.

OLD SAYBROOK

LEGAL NOTICE
OLD SAYBROOK HISTORIC DISTRICT COMMISSION
PUBLIC HEARING

The Historic District Commission of the Town of Old Saybrook, Connecticut will hold a public hearing at its regularly-scheduled meeting on Thursday, April 17, 7:30 p.m. at the Town Hall 2nd Floor Conference room, 302 Main Street, concerning the following Applications for Certificate of Appropriateness:

A. "Samuel Hart, Jr. House"
Certificate of Appropriateness to enclose a portion of open porch
64 Cromwell Place (Map 32/Lot 18)
Applicants: C.S. Gowrie, III & D. K. Gowrie, Owners/Denise Von Dassel, Agent

HARTFORD

City of Hartford

LEGAL NOTICE

In accordance with the provisions of Section 9-14 of the City of Hartford Municipal Code, a Notice of Intent to apply for a **Permit to demolish** a building has been filed with the Director of Licenses and Inspections of the City of Hartford.

This Notice was filed by: Vibeke V. Dressler
14 Whetton Road
West Hartford, CT 06117-2855

The address of the building to be demolished: **77 Wadsworth Street**

This application for a Demolition Permit will be filed on or after:
(Requesting Reduction of 90-Day Waiting Period)

June 9, 2008

Edison Silva, Administrative Operations Manager

MIDDLETOWN

LEGAL ADVERTISEMENT
ADVERTISEMENT FOR BIDS

The Housing Authority of the City of Middletown (HA) is seeking sealed bids for:

Electrical Upgrades at Traverse Square, Middletown, CT

Bid Opening dated and time at the HA, 40 Broad Street, Middletown, CT 06457, Thursday, May 15, 2008 at 1:00 p.m. All bids will be publicly opened and read aloud.

The work of the contract includes Upgrades to Apartment Units Electrical Panels.

Site review by all bidders will be on Thursday, May 1, 2008 at 10:00 a.m. at Traverse Square, Middletown, CT 06457.

Contract documents and specifications will be available at HA, on Monday, April 28, 2008 at 10:00 a.m. with a $25.00 non-refundable deposit. Additional sets at $25.00 each non-refundable.

CONNECTICUT

NOTICE
Statute Reference: 19a-638
Applicant: Connecticut Renaissance, Inc.
Town: Bloomfield
Docket Number: 08-31132-LOI
Proposal: Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield
Total Capital Expenditure: $0

The Applicant may file its Certificate of Need application between June 1, 2008 and July 31, 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.