



President
SARA HERZ, Ph.D.

Chief Executive Officer
PATRICK McAULIFFE

RECEIVED

2008 APR -2 P 2 08

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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**

<input type="checkbox"/> Applicant's Equity	<input type="checkbox"/> Capital Lease	<input type="checkbox"/> Conventional Loan
<input type="checkbox"/> Charitable Contributions	<input type="checkbox"/> Operating Lease	<input type="checkbox"/> CHEFA Financing
<input type="checkbox"/> Funded Depreciation	<input type="checkbox"/> Grant Funding	
<input type="checkbox"/> 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, CEO
(Name) (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. complies with the appropriate and (Facility Name) 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.

Patrick McAuliffe, CEO
Signature

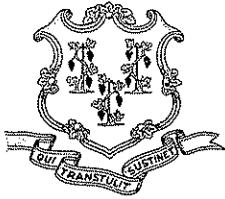
3/28/08
Date

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
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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:

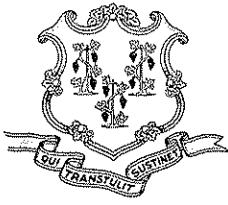
On August 17, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Connecticut Renaissance, Inc. ("Applicant") for the Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield with no capital expenditure.

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



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

April 9, 2008

Requisition # HCA06-173
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

An Affirmative Action / Equal Opportunity Employer

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308

Telephone: (860) 418-7001 • Toll free (800) 797-9688

Fax: (860) 418-7053

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

sent: 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
firewall 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
Connecticut 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 numbered 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: _____	FOR OHCA USE ONLY:	DATE	INITIAL
PROJECT TITLE: _____	_____		
DATE: _____	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):	
<p>19a-638. Additional function or service, change of ownership, service termination. No Fee Required.</p>	
<p>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.</p>	
<p>19a-638 and 19a-639. Fee Required.</p>	
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 <u>OR</u> if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	\$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment) _____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) (\$ _____ x .0005)	\$ _____ .00
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.

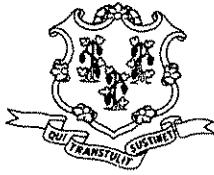
Signature

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: Kristen Isham

Contact Title: 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 termination 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

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:

<input type="checkbox"/>	Epidemiological studies	<input type="checkbox"/>	Needs assessments
<input type="checkbox"/>	Public information reports	<input type="checkbox"/>	Market share analysis
<input type="checkbox"/>	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:

<input type="checkbox"/> DPH	<input type="checkbox"/> JCAHO
<input type="checkbox"/> Fire Marshall Report	<input type="checkbox"/> Other States Health Dept. Reports (new out-of-state providers)
<input type="checkbox"/> AAAHC	<input type="checkbox"/> AAAASF
<input type="checkbox"/> 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:

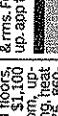
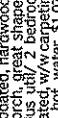
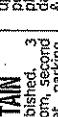
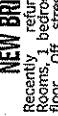
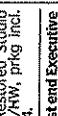
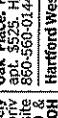
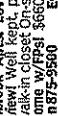
- i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited 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:

<u>Total Facility:</u> <u>Description</u>	<u>FY Actual Results</u>	<u>FY Projected W/out CON</u>	<u>FY Projected Incremental</u>	<u>FY Projected With CON</u>	<u>FY Projected W/out CON</u>	<u>FY Projected Incremental</u>	<u>FY Projected With CON</u>	<u>FY Projected W/out CON</u>	<u>FY Projected Incremental</u>	<u>FY Projected With CON</u>
NET PATIENT REVENUE										
Non-Government					\$0	\$0	\$0	\$0	\$0	\$0
Medicare					\$0	\$0	\$0	\$0	\$0	\$0
Medicaid and Other Medical Assistance					\$0	\$0	\$0	\$0	\$0	\$0
Other Government					\$0	\$0	\$0	\$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
OPERATING EXPENSES										
Salaries and Fringe Benefits					\$0	\$0	\$0	\$0	\$0	\$0
Professional / Contracted Services					\$0	\$0	\$0	\$0	\$0	\$0
Supplies and Drugs					\$0	\$0	\$0	\$0	\$0	\$0
Bad Debts					\$0	\$0	\$0	\$0	\$0	\$0
Other Operating Expense					\$0	\$0	\$0	\$0	\$0	\$0
Subtotal					\$0	\$0	\$0	\$0	\$0	\$0
Depreciation/Amortization					\$0	\$0	\$0	\$0	\$0	\$0
Interest Expense					\$0	\$0	\$0	\$0	\$0	\$0
Lease Expense					\$0	\$0	\$0	\$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
Plus: Non-Operating Revenue										
Revenue Over/(Under) Expense					\$0	\$0	\$0	\$0	\$0	\$0
FTEs					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.

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)
FY Projected Incremental		Rate	Units	Gross	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total
Total Facility by Payer Category:									
Medicare								\$0	\$0
Medicaid								\$0	\$0
CHAMPUS/TriCare								\$0	\$0
Total Governmental			0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial Insurers								\$0	\$0
Uninsured								\$0	\$0
Total NonGovernment			7	\$0	\$0	\$0	\$0	\$0	\$0
Total All Payers			7	\$0	\$0	\$0	\$0	\$0	\$0

Homes Without Board 		Condos Connecticut 	
Rooms without Board 		Condos Connecticut 	
Apartments For Rent 		Condos Connecticut 	
Apartment For Rent 		Condos Connecticut 	
Homes Without Board 		Condos Connecticut 	
Rooms without Board 		Condos Connecticut 	
Apartment For Rent 		Condos Connecticut 	
Homes Without Board 		Condos Connecticut 	
Homes Without Board 		Condos Connecticut 	

NOTICES		HARTFORD		MIDDLETOWN		ROOK	
WINDSOR		City of Hartford		LEGAL ADVERTISEMENT		DISTRICT COMMISSION	
WINDSOR AVENUE WINDSOR, CONNECTICUT 06074		TO BID		ADVERTISING FOR BIDS		BIDDING	
CONNECTICUT	NOTICE	Statute Reference: 19a-638	Applicant: Connecticut Renaissance, Inc.	Town: Bloomfield	Bucket Number: 08-31112-LOI	Proposal: Termination of Psychiatric & Substance Abuse Services at the Behavioral Health Outpatient Clinic in Bloomfield	Total Capital Expenditure: \$0
HARTFORD	LEGAL NOTICE	In accordance with the provisions of Section 9-14 of the City of Hartford Municipal Code, Notice is given to apply for a Permit to demolish a building that has been filed with the Director of Licenses and Inspections of the City of Hartford.	This Notice was filed by: Vibeka V. Dressler	14 Whetton Road West Hartford, CT 06117-2855	The address of the building to be demolished: 77 Washington Street	This application for a Demolition Permit will be filed on or after: (Requesting Reduction of 90-Day Waiting Period)	June 8, 2008
INDSOR	TO BID	The Town of South Windsor, Connecticut, for the period of one year, commencing on June 1, 2008, and ending on June 1, 2009, at which time the lease of two buildings will be terminated, and all fixtures, furniture, and equipment will be removed from the buildings, and the buildings will be used as unmarked graves.	This Notice may be obtained from the Town Manager, 151 Main Street, South Windsor, Connecticut, until 4:00 P.M. at which time the Town Manager reserves the right to extend the time if necessary.	The Town Manager reserves the right to extend the time if necessary.	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, June 12, 2008 at 1:00 P.M. All bids will be publicly opened and read aloud.

<h1>Industrial for Rent</h1> <p>ADVERTISE YOUR WATER-FRONT PROPERTY HERE and reach over 550,000 daily readers and 500,000 monthly print readers. Call 252-2525 today.</p>	<p>6,000 S.F.</p> <p>East Windham Ind. Park Junction 1-91 & Rt. 5 Front Prestige loc in the park. 5,000 sq. ft. 1,000 sq. ft. w/ loading dock. Ideal for SVC, engineering, environmental com- puter fabrication, hi- tech etc. Also 2,000sf w/loading dock. 4 offices. Call Jimmy Gessay at 860-315-0134</p>	<p>West Hartford Area 756000SF In Darien, Bernard Man M.R.E. 860-246-3096</p> <p>Investment Income</p> <p>For all your real estate services www.RETIREMENTUSA.COM 860-563-3882</p>
<p>Vacation Property For Sale</p> <p>ADVERTISE YOUR WATER-FRONT PROPERTY HERE and reach over 550,000 daily readers and 500,000 monthly print readers. Call 252-2525 today.</p>	<p>MADISON Commercial For Rent</p> <p>NEW BRITAIN Warehouse Ap- prox. 33,000 Square Feet. Also Zoned to Retail. Please contact 860-873-8213 or 860-810-6688</p>	<p>NEW BRITAIN approx 1200sf oversized 2 car garage for Storage with office area. \$1750 month (860)565- 2366</p>