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 Services at our Behavioral Health Outpatient Clinic located at 1120 Main St., Bridgeport, CT 06604. Enclosed is the original Letter of Intent and three copies as well as materials from the Department of Public Health requesting that we give up the Psychiatric License as we have not been providing Psychiatric services as this site.

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 – Psychiatric Services

b. Project Proposal: Termination of Psychiatric 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 Only**
☐ 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:

1120 Main St., Bridgeport, CT 06604

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

Greater Bridgeport Area

h. Estimated starting date for the project: March 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 1120 Main St. in Bridgeport has been licensed to provide both Psychiatric and Substance Abuse services by the Department of Public Health. Connecticut Renaissance has not provided Psychiatric services at this location since it has opened. DPH has recently found us in violation and has requested that we terminate the license. Please see attached documentation. Connecticut Renaissance is only terminating Psychiatric services. It will continue to provide Substance Abuse Services.

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

We are proposing to terminate Psychiatric Services located at our 1120 Main St., Bridgeport address.

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

We have not provided Psychiatric 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.

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

We have not utilized our Psychiatric license in the past, but have referred clients to our other facilities where we do offer Psychiatric services.

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

Yes

6. 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.

7. Who will be responsible for providing the service?

N/A

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

N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: Connecticut Renaissance, Inc.

Project Title: Behavioral Health Outpatient Program – Termination of Psychiatric 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.

Signature

3/26/08
Date

Subscribed and sworn to before me on March 26, 2008

Notary Public/Commissioner of Superior Court

My commission expires: 06/30/08

CONNECTICUT Renaissance
Change the direction of your life.

President
SARA HERZ, Ph.D.

Chief Executive Officer
PATRICK McAULIFFE

March 6, 2008

Cher Michaud, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, Connecticut 06134

Dear Ms. Michaud:

Enclosed please find our plan of correction for the violation received from our November 19, 2007 licensing inspection at our Bridgeport facility located at 1120 Main Street. In addition, please find the letter describing the client death that was reported to you on Tuesday March 4, 2008. If you have any questions please do not hesitate to contact me at (203) 336-5225 x2109.

Sincerely,

Linda Mosel

Linda Mosel
COO-Outpatient Services

Connecticut Renaissance, Inc. – Bridgeport Main Street Outpatient
Plan of Correction for Public Health Site Visit
Date of Visit: November 19, 2007

Violation	Plan of Correction	Completion Date
1. Based on observation, interview and a review of facility documentation, the facility failed to provide the services as identified on it's license The findings include: a. review of the clinical records and facility documentation failed to identify that the facility provided outpatient psychiatric services. The facility did not employ and/or contract with a psychiatrist. On 11/19/07 the Chief Operating Officer identified that clients with mental health issues are referred to other sites and/or agencies that provided psychiatric services. The facility also failed to notify the Department of a change in services.	Since this facility was first licensed by the Department of Public Health, no changes in services have taken place. The procedures in place have been the same since the license was first issued and this issue was never before brought into question. There will no longer be any adult psychiatric services at this location. Adult psychiatric services have been moved to another licensed clinic in Bridgeport approximately two blocks away. The original license is attached to this plan of correction.	March 4, 2008

Linda Mosel
Provider/Representative

COO - Outpatient Services
Title

3/6/08
Date

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0397

Psychiatric Outpatient Clinic for Adults

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

Connecticut Renaissance, Inc. of Bridgeport, CT, d/b/a Connecticut Renaissance, Inc. is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Connecticut Renaissance, Inc. is located at 1120 Main Street, Bridgeport, CT 06604 with:

Patrick McAuliffe as Executive Director
Dawn Patston as Director

The service classification(s) and if applicable, the residential capacities are as follows:

MULTI SERVICE

This license expires **December 31, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2008. RENEWAL.

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

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
Connecticu Renaissance, Inc.
350 Fairfield Avenue
Bridgeport, CT 06604

RE: Certificate of Need Application Forms, Docket Number 08-31133-CON
Connecticut Renaissance, Inc.
Terminate Psychiatric Services at our Behavioral Health Outpatient Clinic in Bridgeport

Dear Ms. Isham:

Enclosed are the application forms for Connecticut Renaissance, Inc's Certificate of Need ("CON") proposal for the termination of psychiatric services in Bridgeport 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.**

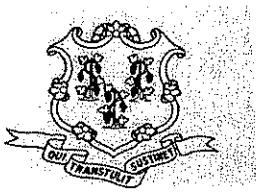
- All pages must be paginated and date referenced.
- Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be number sequentially from the Applicant's document preceding it. For example, if the application 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 Paolo Fiducia. Please feel free to contact him 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 June 1, 2008, and may be submitted no later than July 31, 2008. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 08-31133-CON

Applicant(s) Name: Connecticut Renaissance, Inc.

Contact Person: Kristen Isham
Contact Title: Director of Quality Improvement
Connecticut Renaissance, Inc.
Contact Address: 350 Fairfield Avenue
Bridgeport, CT 06604

Project Location: Bridgeport

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

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 Bridgeport, 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?

      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 Bridgeport 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 Bridgeport service location.

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

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

vi) Describe the pattern of referrals to the Bridgeport 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 Bridgeport 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 Bridgeport service locations. List any special populations that utilize the services and explain how these clients will continue to access this service after the Bridgeport service location will close.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Bridgeport 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 Bridgeport 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 Bridgeport 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 Bridgeport 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 or answer the following:

i) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Connecticut Renaissance, Inc. in Bridgeport.

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

☐ Yes ☐ No

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

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

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

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

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

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

6. Improvements to Productivity and Containment of Costs

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

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

7. Miscellaneous

A. Provide or answer the following:

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

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

☐ Yes ☐ No

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

8. Financial Information

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

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

_____

[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.

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 Bridgeport service location:

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

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

B) Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on actual patient payor mix in the following reporting format:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

*Includes managed care activity.

D. Provide the following for the financial and statistical projections for the Bridgeport service location:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the

CON project. **See attached, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

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

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

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

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

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

Type of Service Description

Type of Unit Description:

# of Months in Operation

FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by Payer Category:				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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

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

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

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

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 08-31133
Connecticut Renaissance, Inc.
Terminate Psychiatric Services at our Behavioral Health Outpatient Clinic in Bridgeport
Notice of Letter of Intent

Dear Ms. Isham:

On April 2, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Connecticut Renaissance, Inc. ("Applicant") to terminate psychiatric services at our behavioral health outpatient clinic in Bridgeport, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Connecticut Post* pursuant to Sections 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:PF:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 9, 2008

Requisition # HCA08-174
Fax: (203) 384-1158
Acct# 106794

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:bko

c: Sandy Salus, OHCA

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Connecticut Renaissance, Inc.
Town:	Bridgeport
Docket Number:	08-31133-LOI
Proposal:	Terminate Psychiatric Services at our Behavioral Health Outpatient Clinic in Bridgeport
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.

PUBLIC NOTICES

BID#28-89
CITY OF SHELTON

Sealed Bids IN DUPLICATE will be received at the Office of the Purchasing Agent, 54 Hill Street, Shelton, Connecticut 06484, until 12:00 P.M. local time on Thursday, April 24, 2008. At 6:30 pm on such date, in room 104 of City Hall, they will be publicly opened and read aloud for the following:

BID#28-89-REPLACEMENT OF A ROOF TOP UNIT AT
SHELTON SENIOR CENTER

The City reserves the right to reject any or all bids in whole or in part, or to waive any

Informality or technicalities in the bids received. IT IS REQUIRED THAT ALL BIDS SHOULD HAVE BID NUMBER, NAME OF COMPANY, NUMBER OF PACKAGES DELIVERED ON THE OUTSIDE OF ALL DELIVERED PACKAGES. Any award relative to this solicitation will be subject to the availability of funds. The successful Contractor shall be required to furnish a Certificate of Insurance acceptable to the City, naming the City as an additional insured. Also reference the Bid number on the Certificate of Insurance. IT IS MANDATORY TO RETURN THE NON-COLLUSION SHEET WITH ALL BIDS.

There will be a scheduled walk thru on April 16, 2008 at 10:00 am. Interested vendors should meet at Shelton City Hall, 54 Hill Street, Shelton, CT. at 9:30 am on such date in room 104.

Gene Sullivan
Acting Purchasing Agent
Dated April 2008

CITY OF SHELTON

SHELTON PLANNING AND ZONING COMMISSION

LEGAL NOTICE

At a regular meeting of the Shelton Planning and Zoning Commission held on April 8, 2008 at Shelton City Hall, 54 Hill Street, Shelton, CT the following actions were taken:

1. Approved 14 standard Appl. for Certificate of Zoning Compliance
2. Approved 24 standard Appl. for Certificate of Zoning Compliance
3. Tabled action on Applications #4615 and #4651
4. Approved with conditions on Appl. #08-01, Final Development Plans, Radcliffe Park, Canal Street, Radcliffe Park, LLC
5. Accepted and approved with conditions on Appl. #08-07, Minor Modificaiton of Detailed Development Plans for PDD #39, Waterview Drive, R. D. Scinto, Inc.
6. Reported favorably: rental of apartments located on Perry Hill Road
7. Approved second 90 day extension to record mylar map for Rich Subdivision
8. Approved extension to submit Detailed Development Plans for Berkshire Commons
9. Authorized legal action on zoning enforcement for 32 Spoke Drive, 430 Waverly Road, 27 Hearthstone Drive and 52 Howe Avenue
10. Added to the agenda Informal Discussion on Beacon Point Marina.

Anthony Pogoda, Chairman
Chris Jones, Secretary

LEGAL NOTICE OF APPLICATION

HUDSON VALLEY BANK, N. A.

Notification is hereby given that Hudson Valley Bank, N.A., 1055 Summer Street,

PUBLIC NOTICES

NOTICE
Statute Reference: 19a-638
Applicant: Connecticut Renaissance, Inc.
Town: Bridgeport
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NOTICE OF PUBLIC MEETING
USEPA/CTDEP/CITY OF BRIDGEPORT
BROWNFIELDS CLEANUP GRANT
INTERIM REMEDIATION PLANS
FOR FORMER
MOUNT TRASHMORE
PROPERTY
329 CENTRAL AVENUE

FORMER CHROME ENGINEERING
PROPERTY
405 CENTRAL AVENUE

FORMER PACELLI TRUCKING PROPERTY
79-119 TROWEL STREET AND
310-318 EAGLE STREET
BRIDGEPORT, CT.

A public meeting will be held on April 23, 2008 at 5:30 pm at the Ralphola Taylor Community Center YMCA located at 790 Central Avenue in Bridgeport to inform the public about and elicit comments on the proposed interim plans for the Former Mount Trashmore, Chrome Engineering and Pacelli Trucking properties to be funded by a USEPA Brownfields Cleanup Grant provided to the City of Bridgeport. The City of Bridgeport is the owner of the properties. The grant will be used to remediate environmental conditions at the properties. Information about the project may be found at the Bridgeport Newfield Branch Public Library, 1230 Stratford Avenue, Bridgeport, Connecticut, 06607, and can be viewed Mondays 12 pm to 8 pm, Tuesdays 10 am to 5 pm, Wednesdays 10 am to 5 pm, Thursdays 12 pm to 8 pm and Saturdays 10 am to 5 pm. Written comments about the Interim Remedial Action Plans may be submitted to Richard McHugh, Office of Planning and Economic Development, City of Bridgeport, 999 Broad Street, Bridgeport, Connecticut, 06604 or by email to McHugR0@CI.BRIDGEPORT.CT.US for 30 days following the publication of this notice. The public is invited to attend the public meeting on **April 23, 2008.**

NOTICE

THE PLANNING AND ZONING COMMISSION OF THE TOWN OF TRUMBULL WILL CONDUCT A PUBLIC HEARING IN THE TRUMBULL TOWN HALL, 5866 Main Street, Trumbull, CT, ON WEDNESDAY, APRIL 16, 2008 at 7:30 p.m., on the following applications:

SUBDIVISION/RESUBDIVISION:

08-07) Estate of F. Francis D'Addario. Data Accumulation Plan Depicting a Lot

PUBLIC NOTICES

SECTION 106 PUBLIC NOTICE

American Tower Corporation is proposing a 20.4 - by 42.3 - foot compound expansion. The existing telecommunications facility is located at 438 Bridgeport Avenue, Milford. New Haven County, Connecticut. For the purposes of this review process, this assessment addresses a 30-foot wide perimeter around the existing fenced equipment compound. American Tower Corporation seeks comments from all interested persons on the impact of the tower on any districts, sites, buildings, structures, or objects significant in American history, architecture, archaeology, engineering, or culture, that are listed or eligible for listing in the National Register of Historic Places. Specific information about the project, including the historic preservation reviews that American Tower Corporation has conducted pursuant to the rules of the Federal Communications Commission (47 C.F.R. Sections 1.1307(4)) and the Advisory Council on Historic Preservation (36 C.F.R. Part 800) will be made available to interested persons who request the information from the contact below. All questions, comments, and correspondence should be directed to American Tower Corporation, 10 Prudential Way, Woburn, MA. 01801, ATTN: Environmental Services or Enviro.Services@AmericanTower.com by May 10, 2008.

Foreclosures

Conditions Of All Sales: These properties are being foreclosed by public auction at the dates, times and places listed in each notice. Interested parties are encouraged to attend and bid on any properties of interest, but they should contact the person listed in the notice for complete details.
In general, foreclosure auctions follow these guidelines:
- Deposits must be by certified or bank check.
- Properties are sold "as is".
- The high bidder must sign a purchase agreement at the time of the auction.
- There is no financing contingency.
- Sale is subject to approval by the Superior Court.
- Closing must be within 30 days of the court's approval.
- Failure to close shall result in loss of deposit, unless otherwise ordered by the Court.

NOTICE OF PUBLIC AUCTION
FORECLOSURE SALE
APRIL 19, 2008 AT 12:00 NOON
SUPERIOR COURT, JUDICIAL DISTRICT
OF STAMFORD/NORWALK
AT STAMFORD
DOCKET NO. CV-05-4007509-S
PRIVATE CAPITAL GROUP, LLC v.
WALPUCK, ROBERT J., ET AL.

Pursuant to a Judgment of Foreclosure by Sale entered by the Court in the above captioned case on February 14, 2006 and revised on February 29, 2008, the undersigned Committee will sell "AS IS" the premises located at **18 Ladder Hill Road South, Weston, CT**, at public auction to be held on April 19, 2008 at 12:00 noon, unless sooner redeemed, on the premises, the following described real property:

ALL THAT CERTAIN piece or parcel of land, together with the buildings standing thereon, situated in the Town of Weston, County of Fairfield and State of Connecticut, containing 1.32 acres, and bounded and described as follows:

BEGINNING at a drill hole upon the northwesterly side of a highway known as Old Road at the northeasterly corner of land, now or formerly of Honor Leeming, thence bearing North 29 deg. 35' West of 74.02 feet; thence bearing North 28 deg. 54' West further along said land, now or formerly of Honor Leeming for a distance of 59.52 feet, thence bearing North 30 deg. 03' West further along said land, now or formerly of Honor Leeming for a distance of 27.05 feet to land now or formerly of Henry W. Gregor, the following courses: North 60 deg. 10' East for a distance of 83.30 feet; thence North 59 deg. 44' East for a distance of 77.86 feet; thence North

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