Serving underserved and uninsured patients at Connecticut's largest network of community health centers.

Administrative:
635 Main Street
Middletown, CT 06457
860.347.6971

Service Locations:

CHC of Clinton
114 East Main Street
Clinton, CT 06413
860.664.0787

CHC of Enfield
5 North Main Street
Enfield, CT 06082
860.253.9024

CHC of Groton
333 Long Hill Road
Groton, CT 06340
860.446.8858

CHC of Meriden
134 State Street
Meriden, CT 06450
203.237.2229

CHC of Middletown
635 Main Street
Middletown, CT 06457
860.347.6971

CHC of New Britain
One Washington Square
New Britain, CT 06051
860.224.3642

CHC of New London
One Shaw's Cove
New London, CT 06320
860.447.8304

CHC of Old Saybrook
263 Main Street
Old Saybrook, CT 06475
860.388.4433

Dental Center of Stamford
141 Franklin Street
Stamford, CT 06901
203.969.0802

Norwalk Smiles
49 Day Street
Norwalk, CT 06854
203.854.9292

www.chc1.com

Where health care is a right, *not a privilege*, since 1972.

Community Health Center, Inc.

28 April 2008

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

Dear Commissioner Vogel,

Enclosed is Community Health Center, Inc.'s application requesting CON exemption under the requirements of section 19a-639(e), C.G.S., as amended by Public Act 98-150 for our expansion at One Washington Square in New Britain.

Should you have any questions, please do not hesitate to contact me at 860.347.6971 x3620.

Peace & Health,

Mark Masselli
President/CEO

RECEIVED
2008 APR 28 P 2:43
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

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	Community Health Center, Inc.	
Doing Business As	Community Health Center of New Britain	
Name of Parent Corporation	Community Health Center, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	635 Main Street Middletown, CT 06457	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes X No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Mark Masselli President/CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	635 Main Street Middletown, CT 06457	
Contact Person Telephone Number	860.347.6971 x 3620	
Contact Person Fax Number	860.347.2043	
Contact Person e-mail Address	Mark@chc1.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: **Expanding Capacity for Primary Care at the Community Health Center of New Britain, One Washington Square, New Britain**

b. Project Proposal: **New construction of 21,500 sq.feet and renovation of 560 sq feet at current location for the purpose of expanding primary care for an underserved population.**

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 and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ 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: **N/A none 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: **One Washington Square, New Britain CT 06051**

g. List each town this project is intended to serve: **This project primarily serves residents of the city of New Britain; however, CHC of New Britain does not restrict services on the basis of town of residence.**

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

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

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: **$ 4.4m**

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

Major Medical Equipment Purchases*	**$**
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	**3.4**
Other (Non-Construction) Specify: **FFE**	**$1.0**
Total Capital Expenditure	**$4.4**
Major Medical Equipment – Fair Market Value of Leases Medical	**$**
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 $4.4m	**$4.4**
Total Project Cost $4.4m	**$4.4**
Capitalized Financing Costs (Informational Purpose Only)	**$**

* 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. **NA**

☐ 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: NA

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☐ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan
☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing
☐ Funded Depreciation ☐ Grant Funding
☐ Other *(specify)* **State of Ct. bond funds and applicant equity**

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.
See attachment 1

Project Description Summary
The Community Health Center, Inc. opened the Community Health Center of New Britain (CHC-NB) in July, 1996. CHC purchased and renovated a building at the corner of Washington and Lafayette Street and later purchased the adjoining lot at Lafayette and Beaver St. Today, CHC-NB is the major provider of primary care services to low income, uninsured, minority, and underserved persons in the city of New Britain.

CHC-NB is the medical home for 10,000 individuals who make 45,000 visits annually to the facility for medical, behavioral, and dental health services. Analysis of current demand to capacity data demonstrates that CHC must add two full time primary care providers to the current primary care practice. To do this. CHC-NB requires a substantial addition of clinical space. CHC, Inc. requests CON approval to construct a two story addition to its current facility. The 1st floor will be completed and equipped, with the 2nd floor left unfinished and available for future capacity development. CHC, Inc. will also renovate 560 square feet on the 1st floor of the current facility and install a sprinkler system throughout the entire first floor to create a unified, efficient primary care space.

Response to questions:
List the types of services that are currently being provided. If applicable, provide a copy of each Department of Public health (DPH) license held by the Applicant.
CHC-NB provides comprehensive primary medical, behavioral health, and dental services. **CHC-NB holds current DPH license as an out-patient facility, and is licensed by DMHAS for its adult behavioral health services and by DCF for its child behavioral health services.** Copies are attached.

List the type of services being proposed and what DPH licensure categories will be sought if applicable
CHC, Inc. is not proposing to add additional services and will not seek additional DPH licenses as a result of this project.

Identify the current population served and the target population to be served
CHC-NB currently serves a patient population that is overwhelmingly low income, publicly insured or uninsured, and representative of ethnic and racial minority groups.
Ten percent of patients are uninsured even after thorough screening by CHC's Access to Care workers, who screen all new uninsured patients for public insurance eligibility. More than 50% of patients identify as Hispanic or African American. A majority of patients speak a language other than English, primarily Spanish and Polish, as their first language. **The target population to be served by this facility expansion will increase in numbers, but is not expected to differ in income, racial/ethnic mix, or insurance status.**

Identify any unmet need and describe how this project will fulfill that need
Additional primary care providers, and associated clinical space, is needed to increase capacity to accept new patients and meet the demand for care by existing patients. CHC closely monitors a set of metrics to assess current met and unmet demand. Based on this data, CHC of NB requires an additional 2.15 providers to meet demand by existing and new patients. Under this project, CHC, Inc. will construct the clinical space necessary to support two additional full time primary care providers, adequate space to co-locate a behavioral health provider

within the new space, and sufficient clinical staff office space to support CHC's model of "planned care" in which individual solo offices are replaced with "pods" for teams of providers, nurses, and medical assistants.

Are there any similar existing service providers in the proposed geographic area?
CHC-NB is the sole federally qualified health center in the city of New Britain and in the surrounding towns.

Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
The anticipated effect of this proposal is to increase access to primary care and a medical home for those most likely to face barriers in accessing such care because of financial, social, linguistic, or provider availability issues. The expected outcomes are:

- increased and appropriate utilization of preventive and health promotion measures including routine screenings, immunizations, health counseling, and testing
- early detection, diagnosis, treatment and management of acute and chronic health problems
- reduced inappropriate utilization of the emergency room
- reduced admissions to the acute care setting for ambulatory care sensitive conditions

Who will be responsible for providing the service?

As a federally qualified health center, the Board of Directors of the Community Health Center, Inc. is ultimately responsible for the Corporation. CHC, Inc's President and CEO, Mark Masselli is the authorized executive of CHC, Inc. The daily operations of the CHC-NB are under the direction of Yvette Francis. Dr. Daren Anderson serves as the Medical Director and is responsible for oversight of the medical services delivered at CHC, Inc.

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

CHC, Inc. does not anticipate any significant change in the payer mix of patients based on the proposed project. The current payer mix of medical patients is as follows:

Uninsured	Medicare	Medicaid	Husky	SAGA	Private ins
9.4	13.6	20.5	38.2	12.2	6.1

AFFIDAVIT

To be completed by each Applicant

Applicant: **Community Heatlh Center, Inc**

Project Title: **Expanding capacity for primary care service delivery in New Britain CT**

I, **Mark Masselli, President and CEO of the Community Health Center, 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 **Community Health Center, Inc.,** 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 4/28/2008

Subscribed and sworn to before me on 4/28/08

Notary Public/Commissioner of Superior Court

My commission expires: 6/30/10

RECEIVED
2008 APR 28 P 2:43
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0264

Outpatient Clinic

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

Community Health Center, Inc. of Middletown, CT, d/b/a Community Health Center of New Britain is hereby licensed to maintain and operate an Outpatient Clinic.

Community Health Center of New Britain is located at One Washington Square, New Britain, CT 06051.

This license expires **June 30, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2004. RENEWAL.

Services:
Dental Services
Primary Care Services
Well Child Services

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

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

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0398

Psychiatric Outpatient Clinic for Adults

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

Community Health Center, Inc. of Middletown, CT, d/b/a Community Health Center of New Britain is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Community Health Center of New Britain is located at 1 Washington Square, New Britain, CT 06051 with:

Mark Masselli as Executive Director
R T. Kearney Ph.D. as Director

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

MULTI SERVICE

This license expires **March 31, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 17, 2006. INITIAL

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

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

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that, in accordance with the provisions of Section 17a-20 of the General Statutes of the State of Connecticut, as amended, COMMUNITY HEALTH CENTER, INC., located at 635 MAIN STREET in the town of MIDDLETOWN is hereby licensed as an OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN to provide OUTPATIENT PSYCHIATRIC SERVICES to children at the locations listed below.

This license is issued effective JANUARY 1, 2006 for a period of TWENTY-FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. OPCC-23
Signed at Hartford, CT this 8th day of February, 2007

QUI TRANSTULIT SUSTINET

James McPherson, Program Supervisor
Bureau of Continuous
Quality Improvement

*100 Pulaski School Clearview Avenue, Meriden CT
*124 Barry School Columbia St. Meriden, CT
*64 Sherman School N. Pearl St. Meriden, CT

Amended to reflect additional new satellite sites

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 5, 2008

Mark Masselli
President/CEO
Community Health Center, Inc.
635 Main Street
Middletown, CT 06457

Re: Letter of Intent, Docket Number 08-31148
Community Health Center, Inc.
Expand Capacity for Primary Care at the Community Health Center of New Britain
Notice of Letter of Intent

Dear Mr. Masselli

On April 28, 2008, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Community Health Center, Inc. ("Applicant") to expand capacity for Primary Care at the Community Health Center of New Britain, with a capital expenditure of $4,400,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Herald & Middletown Press* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 5, 2008

Requisition # HCA08-199
Fax: 347-3380

The Middletown Press
2 Main Street
Box 471
Middletown, CT 06457

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, May 10, 2008.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact 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:lmg

c: Sandy Salus, OHCA

The Middletown Press
Docket Number 08-31148

Letter of Intent
May 5, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Community Health Center, Inc.
Town:	New Britain
Docket Number:	08-31148-LOI
Proposal:	Expand capacity for Primary Care at the Community Health Center
Capital Expenditure:	$4,400,000

The Applicant may file its Certificate of Need application between June 27, 2008 and August, 26, 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.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3488
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DESTINATION ID	
ST. TIME	05/06 08:13
TIME USE	00'37
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGT
COMMISSIONER

May 5, 2008

Requisition # HCA08-199
Fax: 347-3380

The Middletown Press
2 Main Street
Box 471
Middletown, CT 06457

Gentlemen/Ladies:

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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 D. Martone

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 5, 2008

Requisition # HCA08-198
Fax: 225-2611

The Herald
One Herald Square
New Britain, CT 06050

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, May 10, 2008.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact 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:lmg

c: Sandy Salus, OHCA

The Herald
Docket Number 08-31148

Letter of Intent
May 5, 2008

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Community Health Center, Inc.
Town:	New Britain
Docket Number:	08-31148-LOI
Proposal:	Expand capacity for Primary Care at the Community Health Center
Capital Expenditure:	$4,400,000

The Applicant may file its Certificate of Need application between June 27, 2008 and August, 26, 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.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3489
RECIPIENT ADDRESS	92252611
DESTINATION ID	
ST. TIME	05/06 08:14
TIME USE	00'36
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 5, 2008

Requisition # HCA08-198
Fax: 225-2611

The Herald
One Herald Square
New Britain, CT 06050

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Saturday, May 10, 2008.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Diane Duran at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

JOURNAL REGISTER COMPANY **PROOF**

Ad Number: 2100123 **Account No: 337940**

Customer: OFFICE OF HEALTH CARE **Contact:** KIM MARTONE **Phone:** 8604187001

Price: 65.08

Size: 1 X 48.00 **Notes:**

Class: 1200; LEGALS **Printed By:** CSPENCER 05/06/2008

Ordered: 2 Times **Dates:** 05/08/2008 05/08/2008

Signature of Approval: Date:

LEGAL NOTICE

Statute Reference:
19a-638
Applicant:
Community Health Center, Inc.
Town:
New Britain
Docket Number:
08-31148-LOI
Proposal:
Expand capacity for Primary Care at the Community Health Center
Capital Expenditure:
$4,400.00

The Applicant may file its Certificate of Need application between June 27, 2008 and August 26, 2008. Interested persons are invited to submit written comments to Cristina A. Vogel, Commissioner, Office 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.

Thankyou
Sam

The Herald ATT: Kimberly Martone

JOURNAL REGISTER COMPANY **PROOF** From Marcie Jones

Ad Number: 2100044 Account No: 222160

Customer: OFFICE OF HEALTHCARE ACCESS Contact: FAX/KIMBERLY Phone: 8604187001

Price: 128.01

Size: 1 X 56.00

Class: 1200; LEGALS

Ordered: 2 Times

Notes:

Printed By: MJONES 05/06/2008

Dates: ~~05/07/2008~~ 05/07/2008

Signature of Approval: Date:

LEGAL NOTICE

State References:
19a-638

Applicant:
Community Health Center, Inc.

Town: New Britain

Docket Number:
08-31146-LOI

Proposal:
Expand capacity for Primary Care at the Community Health Center.

Capital Expenditure:
$4,400,00

The Applicant may file its Certificate of Need application between June 27, 2008 and August 28, 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.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

May 6, 2008

Mark Masselli
President/CEO
Community Health Center, Inc.
d/b/a Community Health Center of New Britain
635 Main Street
Middletown, CT 06457

RE: Certificate of Need Application Forms, Docket Number 08-31148-CON
Community Health Center, Inc. d/b/a Community Health Center of New Britain
Expand Capacity for Primary Care at the Community Health Center of New Britain

Dear Mr. Masselli:

Enclosed are the application forms for Community Health Center, Inc. d/b/a Community Health Center of New Britain's Certificate of Need ("CON") proposal for the Expand Capacity for Primary Care at the Community Health Center of New Britain with an associated total capital expenditure of $4,400,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between June 27, 2008, and August 26, 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.**

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

- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Diane Duran. Please contact her at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 27, 2008, and may be submitted no later than August 26, 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: 08-31148-CON

Applicant(s) Name: Community Health Center, Inc. d/b/a Community Health Center of New Britain

Contact Person: Mark Masselli
Contact Title: President/CEO
Community Health Center, Inc.
Contact Address: 635 Main Street
Middletown, CT 06457

Project Location: New Britain

Project Name: Expand Capacity for Primary Care at the Community Health Center of New Britain

Type proposal: Section 19a-638 and 19a-639, C.G.S.

Est. Capital Expenditure: $4,400,000

1) Expansion of Existing or New Service

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

Augment: _____

_____

Replace: _____

_____

2) State Health Plan

No questions at this time.

3) Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

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

4) Clear Public Need

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

B) Provide the following information:
(1) Primary and secondary service area towns
(2) The population to be served, including the number of individuals to receive the proposed service(s).
(3) Provide the # of referrals for the proposed service for the past year.
(4) Hours of operation of existing/proposed service

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

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

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

Primary Service Area:

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

Secondary Service Area:

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

F) 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.

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

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

☐ Other: Specify _____

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

C. 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.

D. 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]

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

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

6) Improvements to Productivity and Containment of Costs

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

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7) Miscellaneous

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

C. Provide the following licensing information:

[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.

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

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

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. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet

ii) Submit Statement of Operations for the most recently completed fiscal year.
Note: *These statements should be externally prepared and submitted on the preparer's letterhead.*

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

9. Major Cost Components/Total Capital Expenditure

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

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	

Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

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

10. Construction Information

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

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

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

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

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

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

11. Type of Financing

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

☐ Applicant's equity:

Source and amount:

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

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

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

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

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

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

☐ Other financing alternatives:

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

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

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

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

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

*Includes managed care activity.

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

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

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

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

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

vi) Describe how this proposal is cost effective.

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.

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				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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

THE HERALD Classifieds

www.NewBritainHerald.com

PLACING AN AD IS EASY 860-229-8687

Place your classified ad 7 days a week, 24 hours a day

Fax your ad in: 860-225-2611

error is made.

605-650 Employment

Instruction • Help Wanted • Health Care Opportunities

Financial

• Business Opportunities • Money to Loan

Transportation

• Transportation • Trucks & Vans • Recreation Vehicles

All ads are to be prepaid. For your convenience we accept:

Cash or Check
Check by Phone

PRIVATE PARTY SPECIALS

SELL IT IN 10 ... ... or We Run It Again:

Sell your item? This is the way to go!

3 lines/3 days $20.23
Each additional line: $1.87

Lost Items:
3 lines/3 days $3.26
Each additional line: $.55

BUSINESS HOURS: MONDAY-FRIDAY 8:00 AM - 5:30 PM SATURDAY 8:00 AM - NOON

LEGALS

LEGAL NOTICE

State References: 19a-638

Applicant: Community Health Center, Inc.

Town: New Britain

Docket Number: 08-31148-LOI

Proposal: Expand capacity for Primary Care at the Community Health Center.

Capital Expenditure: $4,400,00

The Applicant may file its Certificate of Need application between June 27, 2008 and August 26, 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.

LEGALS

Public Notice

Notice of sales or other disposition pursuant to Ct. State Statutes Section 42-106 to 42-169.

Notice is hereby given the PS ORANGECO, INC. will sell at PUBLIC AUCTION the personal property contained within the following units to satisfy unpaid storage rental accounts:

Allison Holdsworth, Space A043
Totes, Clothing, Bags

Robert Stepsis-Space A095
Household Items

Lorraine Winston-Space A170
Refrigerator, Office Chair, Folding Chair

Gerald Koch- Space C008
Kitchen Cabinet, Refrigerator
Portable TV

Lisette Otero- Space C115
Boxes, Pictures, Speakers

Sales to be paid by cash or credit card only at time of sale. Contents to be removed off the premises within 24 hours. Tenants may claim their goods up to the time of auction by paying their just debts and vacating the storage unit. Sale to be held on May 21, 2008 at 12:30 PM at Public Storage, 120 Berlin Turnpike, Berlin, CT 06037.

THE HERALD COVERS
The towns of...
New Britain
Plainville
Berlin
Newington
Southington
Farmington
Rocky Hill &
Wethersfield

110 LOST & FOUND

LOST PUPPY: 3 months old, Husky/Dachshund mix. Spotted black, grey, tan, white. White paws, curly tail, blue eyes. Wearing bright pink collar. Lost on May 2. Vicinity West Main St., New Britain area, near Blaze Barber Shop. Family devastated-she's just a baby! Contact NB Animal Control, NB PD, Twin City Vet Hosp. or us at 860-348-0211.

LEGALS

LEGAL NOTICE

Notice of sales or other disposition, pursant of Connecticut State Statutes Sec. 42-106 to 42-169.

Notice is hereby given that "Public Storage Orange Co." will sell at PUBLIC AUCTION the personal property contained within the following units to satisfy upheld storage rental accounts.

SPACE---NAME--CONTENTS

Space #CC066 - Eugene Niewirowicz - Misc household goods

Space #CC025 - Lisa Babella - Kitchen cabinet, end table, air conditioner

Space #FF038 - Anthony S. Sidoti, Sr. - Misc household goods

Space #BB015 - Linda Rasch - Kitchen table, exercise equipment

Space #N573 - Marcie Bonas - Kitchen cabinet, couch, dresser

Space #AA033 - Janice Schmidt

Sales to be paid in cash or credit card only at time of sale. Contents to be removed off the premises within 24 hours. Tenants may claim their goods up to the time of auction by paying just debts and vacating storage unit.

Sale to be held on 5/21/08 at 11:00 A.M. at Public Storage, Inc., 100-113 Spring Street, Southington, CT 06489.

220 ROOMMATES

NEW BRITAIN - Mature female. 1 rm w/priv. $300 mo. Everything incld. 919-6957

THE HERALD COVERS
The towns of...
New Britain
Plainville
Berlin
Newington
Southington
Farmington
Rocky Hill &
Wethersfield

LEGALS

LEGAL NOTICE

All real estate advertised in this newspaper is subject to the Federal Fair Housing Act of 1968 revised March 12, 1989 which makes it illegal to advertise any preference, limitation, or discrimination based on race, color, religion, national origin, gender, handicap, or familial status or intention to make any such preference, limitation, or discrimination. It is also subject to Connecticut Public Act 80449 and the New Haven Ordinance to stop discrimination against families/single parents with children. All residential property advertised in this newspaper is subject to the Connecticut General Statutes Sections 46a-64c which prohibits the making, printing, or publishing or cause to be made printed or published any notice, statement, or advertisement with respect to the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based on race, creed, color, national origin, gender, marital status, age, lawful source of income, familial status, physical or mental disability, or sexual orientation or an intention to make any such preference, limitation, or discrimination. This newspaper will not knowingly accept any advertising for real estate or for the sale or rental of residential property which is in violation of these laws.

230 APARTMENTS UNFURNISHED

AVAIL IMMED

NEW BRITAIN-Spacious 3 BR apts. on Putnam Street completely remodeled. Off street pkg. incl. & enclosed grg. avail. Small pet ok $825/mo+util & 1 mo. sec & crdt ck. Call 860-250-8440

★★★★★

NEW BRITAIN - 1, 2 & 3 BR townhouse. Appl, 24-hr maint & on-site laund. $650 & up. (860) 224-4366. Email: farmingtonhills06@sbcglobal.net

NEW BRITAIN: 1, 2, 3 br & studio apts. Modern. Some util. $495 & up. 860-827-1110

NEW BRITAIN: 1 BR, $600. including appliances. 860-985-5760.

NEW BRITAIN - 2 BR, 2nd fl. Arch St. Remodeled. Sep util. $700 + sec. 203-265-4664.

230 APARTMENTS UNFURNISHED

NEW BRITAIN - 2 BR, LR, kit. Clean. No pets. $825 + util. (860) 432-4126.

LOOK!

NEW BRITAIN: 2 BR apts. starting @ $625/month. Call 860-585-8094.

NEW BRITAIN: 2 BR, cmplx, h/hw, near college. (860) 225-7206/(860) 826-2721.

NEW BRITAIN. 2 BRs, good location. $750/mo. +. 860-836-1490.

★★★★★

NEW BRITAIN: 36 Silver St., 2 BR apts. Call 917-204-7686.

NEW BRITAIN- 3 br apts., $850. Newly renovated. Call 860-348-0353.

230 APARTMENTS UNFURNISHED

NEW BRITAIN. 3 BR, 3rd FL & 5 BR, 2nd FL. Remodeled. $850 & up. (413) 244-1201.

NEW BRITAIN - 5 RM, 3rd FL. W/d hkp in basement. Hdwd firs. (860) 826-8737.

NEW BRITAIN - 5 RM, 2 BR, 1st FL. Appt. NO PETS. $750. (860) 518-4351.

NEW BRITAIN. Beautiful large 3 br. apts. available. Please call 718--972-2828.

NEW BRITAIN. Beautiful 2 BR, in nice complex, available on East St. Parking & laundry. $850 includes heat. Near college. 718-972-2828.

LOOK!

NEW BRITAIN/BERLIN line: Clean 2 BR, w/w carpet, stove, fridge, storage, off st prkg. $715 + util. No pets. **860-229-6744.**

NEW BRITAIN - Evergreen Apartments. **Beautiful 2 & 3 BR townhouses.** Hardwood floors, appli, quiet neighborhood. Closets, new windows.$695 - $875, some, inc. heat 860-223-8866.

NEW BRITAIN-LG 2nd fl 3 fam. 2Br laundry, $860/mo ref & crt ck. 914-885-5961

NEW BRITAIN: New 3 BR, gas heat, garage, attic storage, fenced yard, laundry hookups, new appliances, family neighborhood at 344 Cherry St. 2nd flr. $1050. 829-1958.

230 APARTMENTS UNFURNISHED

LOOK!

NEW BRITAIN: Nice, 2bdrm, quiet bldg w/ pkg. $695. **Call 888-781-7313.**

NEW BRITAIN. Renovated 3 BR, 1st FL. $950/mo. (203) 788-8777.

NEW BRITAIN SPRING SPECIAL MUST BE 55 OR OLDER SENIOR COMMUNITY Studios, 1 & 2 BR's w/ht & hw, wall-wall carpet, pkd, appl & elevator. Community rm w/computers & Internet access. Recreational rm. Clean & quiet secure building. Access to Rte 9 & I-84. From $625-$695. For details, please call (860) 827-9910.

PLAINVILLE - Charming 2 BR, 3rd FL, repainted, appl. No dogs. $595. 677-7524

PLAINVILLE — TORRANT HOUSE, Efficiency subsidized apt. For an application call 860-747-4405. **Equal Housing Opportunity**

PLAINVILLE unique lofted 1 brm, clean, quiet, safe, no pets, N/S $600. + $600. sec. Call 860-966-6106.

SOUTHINGTON: Brand new Duplex, 4 BRs, 2-1/2 ba, nice yard, 1 car garage, $1600/mo. + security. Call 860-621-4766.

245 HOUSES FOR RENT

W. HTFD: Rent to own, no bank qualifying. Handyman special. $1000. 656-0216..